



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

MEMORANDUM

TO: Office of the Secretary of State via regulations.sots@ct.gov

FROM: Lara Stauning, Staff Attorney
Department of Social Services

DATE: March 18, 2014

RE: Operations Policy Number: 12-12, Katie Beckett Waiver Program
Implementation date: April 1, 2014

In accordance with section 17b-10 of the Connecticut General Statutes, the Department of Social Services hereby electronically submits the above-referenced Notice of Intent and Operating Policy for posting online.

On and after the above referenced adoption date, the Department shall implement and operate under the said policy while it is in the process of adopting it in regulation form pursuant to Chapter 54 of the Connecticut General Statutes.

The Department shall publish the Notice of Intent to adopt regulations in the Connecticut Law Journal on March 25, 2014.

IMPORTANT: Read instructions on back of last page (Certification Page) before completing this form. Failure to comply with instructions may cause disapproval of proposed Regulations

State of Connecticut
REGULATION
of

NAME OF AGENCY

DEPARTMENT OF SOCIAL SERVICES

Concerning

SUBJECT MATTER OF REGULATION

Katie Beckett Waiver Program¹

Section 1. The Regulations of Connecticut State Agencies are amended by adding sections 17b-283-1 to 17b-283-18, inclusive as follows:

(NEW) Section 17b-283-1. Purpose.

The Katie Beckett waiver program permits persons with physical disabilities, 21 years of age or younger, with or without co-occurring developmental disabilities, who are institutionalized or at risk for institutionalization to qualify for Medicaid home and community-based services needed to avoid institutionalization. The Katie Beckett waiver program also provides, within the limitations described in sections 17b-283-2 to 17b-283-18, inclusive, of the Regulations of Connecticut State Agencies, nurse case management services to assist such persons to access and manage standard Medicaid services and other home and community-based services that enable them to live in the community. The Katie Beckett waiver program is not an entitlement; therefore, services and access to services under the Katie Beckett waiver program may be limited, based on available funding and program capacity.

(NEW) Sec. 17b-283-2. Scope.

Sections 17b-283-1 to 17b-283-18, inclusive, of the Regulations of Connecticut State Agencies set forth the eligibility requirements and administrative policies for the Katie Beckett waiver program. The Katie Beckett waiver program is a federal waiver under section 1915(c) of the Social Security Act, established pursuant to section 17b-283 of the Connecticut General Statutes.

(NEW) Sec. 17b-283-3. Definitions

As used in sections 17b-283-1 to 17b-283-18, inclusive, of the Regulations of Connecticut State Agencies:

- (1) “Alternative institutional care cost” means the monthly cost of the institutional care that the individual would otherwise incur, but for the support of Katie Beckett waiver services;

¹ Draft Sent to Public for Comment

- (2) “Applicant” means a person who, directly or through a representative, completes a Katie Beckett waiver program application form and submits it to the department;
- (3) “Assessment” means a comprehensive written evaluation conducted by a nurse case manager, using a standard assessment tool. The assessment is the basis for the department’s determination of whether or not an applicant meets the level of care criteria for participation in the Katie Beckett waiver program;
- (4) “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;
- (5) “Commissioner” means the Commissioner of Social Services or his or her designee;
- (6) “Cost-effective” or “cost-effectiveness” means the department’s determination that payments for an individual’s total monthly service costs under the plan of care, developed by the nurse case manager, do not exceed the monthly alternative institutional care cost;
- (7) “Department” or “DSS” means the state of Connecticut Department of Social Services;
- (8) “Developmental disability” has the same meaning as provided in section 102 of the Developmental Disabilities Act, 42 USC 6001.
- (9) “Individual” means a person who has applied for and has been found eligible for the Katie Beckett waiver program;
- (10) “Individual’s total plan of care cost cap” means the total maximum monthly cost of the individual’s plan of care;
- (11) “Intermediate Care Facility for Individuals with Intellectual Disabilities” or “ICF-IID” means a residential facility licensed by the Connecticut Department of Developmental Services for the care and treatment of intellectually and developmentally disabled persons;
- (12) “Legal representative” means a guardian, conservator or power of attorney appointed to act on the applicant or individual’s behalf;
- (13) “Level of care” means the type of facility, as determined by a DSS nurse consultant or social worker, that is needed to care for an individual. The types of facilities include: a nursing facility, CDH or ICF-IID;
- (14) “Medical assistance program” means, any and all of the medical programs administered by the state of Connecticut Department of Social Services;
- (15) “Medical necessity” or “medically necessary” has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;
- (16) “Nursing Facility” or “NF” means an institution, as defined in 42 USC 1396r, as amended from time to time, that participates in Connecticut’s medical assistance program pursuant to the terms of a provider agreement with the department;

- (17) “Other community-based services” means services provided by programs administered by the department that are not part of the Katie Beckett waiver program or services provided by programs administered by other state or local agencies that are necessary to maintain the individual in the community;
- (18) “Other medical services” means services that are normally included in the department’s payments to NFs, CDHs and ICF-IIDs, and that the individual requires, in addition to the Katie Beckett waiver services, to live in the community. Other medical services may include: home health care, nursing services, physical therapy, speech therapy and occupational therapy;
- (19) “Physical disability” has the same meaning as provided in section 1-1f of the Connecticut General Statutes;
- (20) “Plan of care” means an individualized written plan developed by the nurse case manager 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 plan of care includes measurable goals, objectives and the total service costs, including the calculation of those costs;
- (21) “Qualified provider” means a home health care agency that meets the qualifications established by the department to provide nurse case management services under the Katie Beckett waiver program;
- (22) “Total plan of care costs” means the monthly cost of Katie Beckett waiver services and medical services included in an individual’s plan of care that are required in order for the individual to live in the community instead of an institution; and
- (23) “Waiting list” means the record maintained by the department, after the program reaches the maximum capacity permitted under the waiver, that includes the names of applicants who have submitted applications for the Katie Beckett waiver program and specifies the date on which the completed waiver application was received from the applicant.

(New) Sec. 17b-283-4. Eligibility and Determination of Need

- (a) An applicant is eligible to receive coverage for the cost of nurse case management services through the Katie Beckett waiver program if the applicant qualifies by meeting all of the technical, income and programmatic requirements specified in subsections (b) to (d), inclusive, of this section.
- (b) The technical requirements for eligibility are as follows:
- (1) All applicants for the Katie Beckett waiver program shall meet the requirements for eligibility in the department’s medical assistance program that are applicable to children with disabilities as stated in the Regulations of Connecticut State Agencies and contained in the Uniform Policy Manual including, but not limited to, all regulations establishing medical assistance eligibility, requirements related to the filing of applications for assistance, verifications, redeterminations, existence of a

disabling condition, citizenship status, residency, institutional status, assistance unit composition and income and asset limits.

- (2) All applicants and recipients of the Katie Beckett waiver program shall meet all the medical assistance categorical eligibility rules that apply to recipients of medical assistance. Specifically, without limiting the scope of this section, applicants and recipients of Katie Beckett waiver services are subject to the rules that govern eligibility including, but not limited to, the transfer of assets and the treatment of the resources and income of spouses of institutionalized applicants and recipients.
- (c) The financial requirements for eligibility are as follows:
- (1) To be eligible, an applicant for the Katie Beckett waiver program, shall have a countable income that is equal to or less than 300% of the benefit amount that would be payable under the federal Supplemental Security Income program to a person who lives in their own home and has no income or resources.
 - (A) Income eligibility for the Katie Beckett waiver program under this section is determined solely by reference to the applicant's countable income and does not involve consideration of the incurred medical expenses or any other liabilities that may have been incurred by the applicant.
 - (B) The applicant's countable income for purposes of this subsection is determined by reference to the same methodologies the department employs in determining the countable income of an institutionalized applicant for medical assistance, as noted in subsection (c)(1) of this section.
 - (C) Applicants who qualify for medical assistance as medically needy, but who do not qualify for the Katie Beckett waiver program because their income exceeds the 300% of the Supplemental Security Income program income limit, shall receive coverage of medically necessary services to the extent such services are available generally to recipients of medical assistance, but shall not receive coverage for the nurse case management services that are provided only to those individuals who are covered under this or any other federal Medicaid waiver.
 - (2) An individual who receives services under the Katie Beckett waiver program is subject to the same rights and responsibilities as a recipient of medical assistance including, but not limited to, those requirements relating to third party liability, securing support, recovery and liens that are applicable to institutionalized recipients who receive public assistance.
- (d) The programmatic requirements for eligibility are as follows. An applicant shall:
- (1) Be 21 years of age or younger;
 - (2) Have a physical disability, as defined in section 1-1f of the Connecticut General Statutes, with or without a co-occurring developmental disability;

- (3) Meet the criteria for one of the Medicaid covered level of care categories described in subsection (f) of section 17b-283-7 of the Regulations of Connecticut State Agencies;
- (3) Pursue eligibility under the department's medical assistance program; and
- (4) Have a total plan of care cost that the department reasonably expects will not exceed 100% of the alternative institutional care cost.

(e) Notwithstanding subsections (b) to (d), inclusive, of this section, an applicant shall not be eligible for the Katie Beckett waiver program services if the applicant:

- (1) Receives services under any other medical assistance waiver programs;
- (2) Cannot live safely in the community, even with the assistance of the Katie Beckett waiver and other community-based services;
- (3) Having received and benefited from Katie Beckett waiver services, can now continue to reside in the community without the support of the Katie Beckett waiver program services;
- (4) Applies for the Katie Beckett waiver services after the department has reached its maximum capacity of persons able to be served under the Katie Beckett waiver program; or
- (5) Has a developmental disability without a co-occurring physical disability, as determined by a licensed medical professional.

(f) An individual actively receiving services through the Katie Beckett waiver program and 22 years of age or older prior to January 1, 2012, may remain on the Katie Beckett waiver until age 65, at which time the individual may transition to the Connecticut Home Care Program for Elders.

(New) Sec. 17b-283-5. Nurse Case Management Services

(a) Nurse case management services include the following:

- (1) Assistance to gain access to needed community-based and Medicaid services, as well as, needed medical, social, educational and other services, regardless of funding source;
- (2) Monitoring of on-going provision of services;
- (3) Monitoring of the individual's health and safety;
- (4) Completion of an initial assessment and reassessments every 6 months; and

(5) Development of a plan of care.

- (b) Nursing case management services provided through the Katie Beckett waiver program may be provided alone or in combination with other services, in accordance with the specific needs of the individual. The nurse case management services provided at any given time, in combination with other medical and community-based services, constitute the individual's plan of care. The need for each specific Medicaid service shall be documented in the plan of care.
- (c) Nurse case management services shall be provided to the individual at least once every six months.
- (d) The nurse case manager shall be a registered nurse licensed by the Connecticut Department of Public Health and employed by a home health agency that meets the requirements of subsection (e) of this section.
- (e) The nurse case management services shall be provided by a home health agency licensed by the Department of Public Health and enrolled in the Connecticut Medicaid program.
- (f) A physician's order is not required for nurse case management services.

(NEW) Sec. 17b-283-6. Services Not Covered Under the Katie Beckett Waiver Program

The department shall not pay for:

- (1) Nurse case management services that do not meet the requirements set forth in section 17b-283-5 of the Regulations of Connecticut State Agencies.
- (2) Nurse case management services provided by a person who is legally liable to provide care to the individual, a relative or a legal guardian of the individual.
- (3) Services that exceed the individual's total plan of care cost.
- (4) Home and community-based services provided to persons in facilities, pursuant to section 1616(e) of the Social Security Act.

(NEW) Sec. 17b-283-7. Assessment and Development of a Service Plan

- (a) The department may accept completed applications for the Katie Beckett waiver program by mail, electronic mail, facsimile or by telephone. Completed applications shall be accepted in the order in which they are received. If the number of applications received exceeds the capacity of participants permitted under the waiver, the department shall maintain a waiting list of applicants.
- (b) When an opening in the program becomes available, applicants shall be chosen from the

waiting list in the order in which the department received the person's completed application.

- (c) The department shall notify the chosen applicant that an opening has become available. The department shall provide the applicant with a list of home health care agencies from which the applicant may contact the agency of their choice to arrange for a nurse case manager to conduct an assessment and develop a plan of care for the individual.
- (d) A nurse case manager, from the home health agency selected by the applicant, shall conduct an initial assessment and develop a plan of care. The assessment and the plan of care shall be based upon information obtained from the applicant; the applicant's legal representative; medical reports from the applicant's physician; and any other clinical personnel who are familiar with the applicant's case and history.
- (e) The nurse case manager shall submit the assessment and the proposed plan of care to the department. Based upon the information obtained from the nurse case manager, the department shall determine whether the applicant meets the programmatic requirements for eligibility as set forth in section 17b-283-4(d) of the Regulations of Connecticut State Agencies.
- (f) The applicant shall meet one of the following levels of care in order to qualify for services under the Katie Beckett waiver program:
 - (1) Nursing Facility - The applicant has a chronic condition and requires (A) skilled nursing services, nursing supervision or assistance with personal care on a daily basis; or (B) maintenance rehabilitation services to maintain the applicant's maximum level of functioning.
 - (2) Subacute Nursing Facility-The applicant has a chronic condition that requires (A) comprehensive medical monitoring but does not require diagnostic or invasive procedures; (B) intense medical supervision and therapy such as nursing intervention intermittently throughout the day or the need for ancillary or technological services; or (C) services such as brain injury rehabilitation, high intensity stroke or orthopedic programs, ventilator programs, complex wound care or specialized infusion therapy.
 - (3) Chronic Disease Hospital - The applicant has (A) an on-going unstable medical condition requiring intense medical supervision or nursing intervention continually throughout the day and the need for ancillary or technological services; or (B) a chronically unstable condition, is medically fragile and requires frequent physician intervention and monitoring.
 - (4) Intermediate Care Facility for Individuals with Intellectual Disabilities - The applicant has a condition, other than mental illness, found to be closely related to an intellectual disability that results in substantial functional limitations in three or more of the following major life activities: self-care; understanding and use of language; learning; mobility; self-direction; or capacity for independent living.
- (g) The department shall verify that the plan of care is cost-effective in accordance with section 17b-283-8 of the Regulations of Connecticut State Agencies.

- (h) If the applicant meets one of the level of care criteria in subsection (f) of this section and the plan of care is determined to be cost-effective, the department shall notify the individual and the nurse case manager that the plan of care may be implemented.
- (i) If the applicant does not meet one of the level of care criteria in subsection (f) of this section or the plan of care is determined to not be cost-effective, the department shall notify the applicant, provide information to the applicant regarding the right to request an administrative hearing and may refer the applicant to another waiver program that may be able to accommodate the applicant's needs.
- (j) The nurse case manager shall, for individuals eligible and receiving Katie Beckett waiver services, reassess the individual's condition and the department shall reevaluate the level of care required by an individual at least every six months or more frequently when necessary.

(NEW) Sec. 17b-283-8. Determining the Cost-Effectiveness of the Service Plan

- (a) To determine the cost-effectiveness of the individual's plan of care, the department shall:
 - (1) Obtain the monthly alternative institutionalized care costs for the individual. For each level of care listed in subsection (f) of section 17b-283-7 of the Regulations of Connecticut State Agencies, the alternative institutional care cost is equal to the state's weighted average monthly cost for the specified facility type, as annually developed and published by the department;
 - (2) Determine the monthly cost of the individual's total plan of care by totaling the monthly cost of each Medicaid covered service included in the plan of care that may be provided to the individual, based on the department's established rates for such services;
 - (3) Determine the monthly cost of the nurse case management services to be provided to the individual under the proposed service plan;
 - (4) Add the monthly cost of each Medicaid covered service included in the plan of care to the monthly nurse case management services to obtain the individual's monthly total plan of care costs; and
 - (5) Compare the monthly alternative institutionalized care cost to the monthly cost of the individual's total plan of care.
- (b) Individual Total Plan of Care Cost Caps
 - (1) The individual cost cap is equal to 100% of the individual's alternative institutional care costs.
 - (2) The maximum dollar amount available to fund the plan of care cannot exceed 100%

of the individual's alternative institutional care costs.

- (c) The department shall not approve a plan of care that exceeds the individual's alternative institutional care costs as set forth in subsection (b) of this section.

(NEW) Sec. 17b-283-9. Individual's Responsibilities

The individual or the individual's legal representative shall:

- (1) Within 30 days of receiving notification from the department that an opening in the waiver program is available, choose a home health agency, from a list of participating home health agencies provided by the department, to perform the initial assessment and develop a plan of care;
- (2) Upon notification from the department that an opening in the waiver program is available, promptly notify the department if the individual does not want to receive Katie Beckett waiver services.
- (3) Provide accurate and clear information relevant to the individual, including any changes to the care plan, to the nurse case manager.
- (4) To the extent the individual or the individual's legal representative is able to do so, collaborate with the nurse case manager and participate in the plan of care development process.
- (5) Acknowledge agreement with the plan of care by signing the plan of care.
- (5) Report problems to the nurse case manager, nursing supervisor or home health agency.
- (6) Be capable of understanding and shall acknowledge that there are risks inherent in living in the community; that the individual's safety cannot be guaranteed; and that the individual or the individual's legal representative 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.

(NEW) Sec. 17b-283-10. Department Responsibilities

The department shall:

- (1) Inform individuals of any feasible alternatives available under the Katie Beckett waiver program and offer individuals the choice of either institutional care or home and community-based services;
- (2) Advise the individual of their right to an administrative hearing if they are aggrieved by the department's decision with respect to the individual's application or eligibility for the Katie Beckett waiver program;

- (3) Maintain a waiting list of persons who apply for the Katie Beckett waiver program after the department has reached the maximum capacity of individuals that may be served under the program;
- (4) Establish provider qualifications and establish and maintain a directory of qualified providers;
- (5) Establish payment rates for the nurse case management services offered under the waiver program;
- (6) Pay for approved nurse case management services delivered by qualified providers through its fiduciary agent, on behalf of the individual; and
- (8) If at the time of application there are no available openings and the applicant's name is placed on the waiting list, the department shall determine within 45 days of the applicant's acceptance of an opening in the program, the applicant's eligibility for the Medicaid program.

(NEW) Sec. 17b-283-11. Provider Responsibilities

- (a) All providers are required to report to the Department of Public Health an occurrence involving an individual that results in a physical injury to or by the individual that requires a physician's treatment or an admission to a hospital; results in someone's death; requires emergency mental health treatment for the individual; or requires the intervention of law enforcement. Critical incident reports shall be made in accordance with the manner, format and time frame set forth in the provider agreement or as directed by the Department of Public Health.
- (b) Provider agencies shall deliver training to staff members regarding the provision of services that are person-centered and culturally competent.
- (c) Provider agencies shall have policies and procedures in place regarding employee standards of conduct. These policies and procedures shall include the following topics:
 - (1) Person-centered provision of services;
 - (2) Respect of participant's rights, including privacy and self-determination;
 - (3) Neglect, abuse and harassment of participants, including any mandatory reporting requirements that may apply;
 - (4) The provision of services while using, or under the influence of, drugs or alcohol;
 - (5) Confidentiality of all participant information collected, used or maintained; and
 - (6) Critical incident reporting requirements.

(NEW) Sec. 17b-283-12. Provider Participation

- (a) In order to participate in the Katie Beckett waiver program and receive payment from the department, the provider shall:

- (1) Enroll with the department or its agent and have on file a valid provider agreement;
- (2) Meet and maintain applicable programmatic credentialing criteria and federal and state licensing, certification and accreditation requirements;
- (3) Comply with all Medicaid documentation and other requirements set forth in the provider agreement;
- (4) Maintain good standing within the State of Connecticut (e.g., no fraud, loss of contract for cause, or suspension for any State of Connecticut-funded program within the past 5 years);
- (5) Deliver and bill for nurse case management services that are outlined in the participant's plan of care;
- (6) Accept Medicaid payment as payment in full; and
- (7) Comply with the stipulations outlined in any corrective action plans implemented by the department.

(b) The department, upon 30 days written notice, may terminate or suspend the provider agreement without cause.

(NEW) Sec. 17b-283-13. Corrective Action

(a) If a provider is out of compliance with sections 17b-283-1 to 17b-283-18 of the Regulations of Connecticut State Agencies or the provider agreement, the department shall have the discretion to implement a corrective action plan. Failure to develop or meet the requirements of the corrective action plan shall result in termination or suspension of the provider agreement.

- (1) The provider shall reply to, and cooperate in arranging compliance with, a program or fiscal audit or program violation exception that a state or federal audit or review discovers.
- (2) The provider shall cooperate fully with the department or its agent, prepare and send to the department a written plan of correction or response to any adverse findings.
- (3) The provider shall correct all deficiencies in the manner and times required by the department.
- (4) The provider shall report any arrests of agency officers or employees within 10 business days and provide status updates periodically at the request of the department.

(NEW) Sec. 17b-283-14. Fiscal responsibility

(a) For purposes of this section:

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

state law.

- (2) “Abuse” means practices that are inconsistent with generally accepted fiscal or business practices and result in unnecessary cost to the Katie Beckett waiver program.
- (b) The provider agrees that it shall not engage in or commit fraud or abuse including, but not limited to:
- (1) Billing for services not rendered;
 - (2) Billing for services not in the service plan;
 - (3) Billing for services not medically necessary;
 - (4) Inappropriate or lack of documentation to support services billed;
 - (5) Billing for nurse case management services for Katie Beckett waiver participants who are institutionalized during the dates of billed service provision; or
 - (6) Violating Medicaid policies, procedures, rules, regulations or statutes.

(NEW) Sec.17b-283-15. Quality Assurance

- (1) All providers shall submit program data in a form that is set forth by the department.
- (2) Agency providers shall provide supervision to nursing staff.
- (3) Agency providers shall establish a quality assurance plan at the time of application.

(NEW) Sec. 17b-283-16. Client Documentation and Provider Reporting

- (a) Providers are required to retain records to document services submitted for Medicaid reimbursement for at least five years from the date the service or item was provided. Documentation shall include the following:
 - (1) Individual’s name and the signature of the individual or their legal representative;
 - (2) Provider’s name and signature;
 - (3) Dates of service;
 - (4) Start time for each visit;
 - (5) End time for each visit; and
 - (6) A brief description of duties performed.
- (b) Upon written request presented to the provider, the department or its authorized agent 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 semiannual reports and written updates to the department on the individual’s progress in a form that is set forth by the department.
- (d) The failure of a provider to comply with subsections (a) to (d), inclusive, of this section, may result in the nonpayment of the services.

(NEW) Sec. 17b-283-17. Provider Termination or De-Qualification

Failure to comply with the provider requirements of the Katie Beckett waiver program or to remediate, within prescribed timeframes as set forth in the provider agreement or required by the department’s Katie Beckett waiver program manager or designee, any deficiencies herein may result in the suspension or termination of the provider’s service contract, removal from the Provider Directory, or disqualification as a provider.

(NEW) Sec. 17b-283-18. Administrative Hearings

Applicants for and recipients of services under the Katie Beckett waiver program may request an administrative hearing, in accordance with section 17b-60 of the Connecticut General Statutes, if the department:

- (a) Does not provide the individual with the choice of home and community-based services as an alternative to institutional care;
- (b) Denies, suspends, reduces or terminates the individual’s services;
- (c) Denies the application for any reason other than the limitations on the number of individuals who can be served as established by the approved waiver; or
- (d) Denies eligibility for enrollment because the total plan of care cost exceeds the alternative institutional care cost.

Statement of Purpose

Pursuant to CGS Section 4-170(b)(3), "Each proposed regulation shall have a statement of its purpose following the final section of the regulation." Enter the statement here.

Statement of Purpose: (A) The purpose of the regulation is to set forth the eligibility requirements and the administrative policies of the Katie Beckett Waiver program. The problems, issues or circumstances that the regulation proposes to address are: Currently, there are no regulations regarding the Katie Beckett Waiver program. Adoption of the proposed regulation will provide clear guidance regarding eligibility and administration of the program.

(B) The main provisions of the regulation provide: (1) Purpose; (2) Scope; (3) Necessary definitions; (4) Eligibility and determination of need requirements; (5) Requirements of nurse case management services; (6) Limitations under the Katie Beckett Waiver; (7) Assessment, development of the service plan and cost-effectiveness; (8) the Responsibilities of the individual, providers and the department; and (9) Administrative hearing rights.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws are: The proposed regulation will establish the eligibility requirements and administrative policies of the Katie Beckett Waiver program as law.

R-39 Rev. 03/2012
(Certification page—see Instructions on back)

CERTIFICATION

This certification statement must be completed in full, including items 3 and 4, if they are applicable.

- 1) I hereby certify that the above (check one) Regulations Emergency Regulations
- 2) are (check all that apply) adopted amended repealed **by this agency pursuant to the following authority(ies):** (complete all that apply)
 - a. Connecticut General Statutes section(s) 17b-283.
 - b. Public Act Number(s) _____.
(Provide public act number(s) if the act has not yet been codified in the Connecticut General Statutes.)
- 3) **And I further certify that notice of intent to adopt, amend or repeal said regulations was published in the Connecticut Law Journal on _____;**
(Insert date of notice publication if publication was required by CGS Section 4-168.)
- 4) **And that a public hearing regarding the proposed regulations was held on _____;**
(Insert date(s) of public hearing(s) held pursuant to CGS Section 4-168(a)(7), if any, or pursuant to other applicable statute.)
- 5) **And that said regulations are EFFECTIVE** (check one, and complete as applicable)
 - When filed with the Secretary of the State
 - OR** on (insert date) _____

DATE	SIGNED (Head of Board, Agency or Commission)	OFFICIAL TITLE, DULY AUTHORIZED Commissioner
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APPROVED by the Attorney General as to legal sufficiency in accordance with CGS Section 4-169, as amended

DATE	SIGNED (Attorney General or AG's designated representative)	OFFICIAL TITLE, DULY AUTHORIZED
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*Proposed regulations are **DEEMED APPROVED** by the Attorney General in accordance with CGS Section 4-169, as amended, if the attorney General fails to give notice to the agency of any legal insufficiency within thirty (30) days of the receipt of the proposed regulation.*

(For Regulation Review Committee Use ONLY)

- Approved Rejected without prejudice
- Approved with technical corrections Disapproved in part, (Indicate Section Numbers disapproved only)
- Deemed approved pursuant to CGS Section 4-170(c)

By the Legislative Regulation Review Committee in accordance with CGS Section 4-170, as amended	DATE	SIGNED (Administrator, Legislative Regulation Review Committee)
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Two certified copies received and filed and one such copy forwarded to the Commission on Official Legal Publications in accordance with CGS Section 4-172, as amended.

DATE	SIGNED (Secretary of the State)	BY
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(For Secretary of the State Use ONLY)

GENERAL INSTRUCTIONS

1. All regulations proposed for adoption, amendment or repeal, *except* emergency regulations, must be presented to the Attorney General for his/her determination of legal sufficiency. (See CGS Section 4-169.)
2. After approval by the Attorney General, the original and one electronic copy (in Word format) of all regulations proposed for adoption, amendment or repeal must be presented to the Legislative Regulation Review Committee for its action. (See CGS Sections 4-168 and 4-170 as amended by Public Act 11-150, Sections 18 and 19.)
3. Each proposed regulation section must include the appropriate regulation section number and a section heading. (See CGS Section 4-172.)
4. New language added to an existing regulation must be in underlining or CAPITAL LETTERS, as determined by the Regulation Review Committee. (See CGS 4-170(b).)
5. Existing language to be deleted must be enclosed in brackets []. (See CGS 4-170(b).)
6. A completely new regulation or a new section of an existing regulation must be preceded by the word "(NEW)" in capital letters. (See CGS Section 4-170(b).)
7. The proposed regulation must have a statement of its purpose following the final section of the regulation. (See CGS Section 4-170(b).)
8. The Certification Statement portion of the form must be completed, including all applicable information regarding *Connecticut Law Journal* notice publication date(s) and public hearing(s). (See more specific instructions below.)
9. Additional information regarding rules and procedures of the Legislative Regulation Review Committee can be found on the Committee's web site: <http://www.cga.ct.gov/rr/>.
10. A copy of the Legislative Commissioners' Regulations Drafting Manual is located on the LCO website at http://www.cga.ct.gov/lco/pdfs/Regulations_Drafting_Manual.pdf.

CERTIFICATION STATEMENT INSTRUCTIONS

(Numbers below correspond to the numbered sections of the statement)

1. Indicate whether the regulation is a regular or an emergency regulation adopted under the provisions of CGS Section 4-168(f).
2.
 - a) Indicate whether the regulations contains newly adopted sections, amendments to existing sections, and/or repeals existing sections. Check all cases that apply.
 - b) Indicate the specific legal authority that authorizes or requires adoption, amendment or repeal of the regulation. If the relevant public act has been codified in the most current biennial edition of the *Connecticut General Statutes*, indicate the relevant statute number(s) instead of the public act number. If the public act has not yet been codified, indicate the relevant public act number.
3. Except for emergency regulations adopted under CGS 4-168(f), and technical amendments to an existing regulation adopted under CGS 4-168(g), an agency must publish notice of its intent to adopt a regulation in the *Connecticut Law Journal*. Enter the date of notice publication.
4. CGS Section 4-168(a)(7) prescribes requirements for the holding of an agency public hearing regarding proposed regulations. Enter the date(s) of the hearing(s) held under that section, if any; also enter the date(s) of any hearing(s) the agency was required to hold under the provisions of any other law.
5. As applicable, enter the effective date of the regulation here, or indicate that it is effective upon filing with the Secretary of the State. Please note the information below.

Regulations are effective upon filing with the Secretary of the State or at a later specified date. See CGS Section 4-172(b) which provides that each regulation is effective upon filing, or, if a later date is required by statute or specified in the regulation, the later date is the effective date. An effective date may not precede the effective date of the public act requiring or permitting the regulation. Emergency regulations are effective immediately upon filing with the Secretary of the State, or at a stated date less than twenty days thereafter.