FILE NO. 24260

TARIQ ABDULAZIZ, Ph.D., M.S., M.B.A. AND NEUROSTRATEGIES, INC.	:	STATE OF CONNECTICUT
v.	:	OFFICE OF THE CLAIMS COMMISSIONER
STATE OF CONNECTICUT	:	SEPTEMBER 19, 2016

APPENDIX TO THE DEPARTMENT OF SOCIAL SERVICES' MOTION TO DISMISS

Appendix Page

A. Documents in the Neurostrategies, Inc., et al v. Connecticut Department of Social Services, No. HHB.-CV-15-6029943-S Court File (Claimants' Administrative Appeal from the First Declaratory Ruling dated May 28, 2015)

1. Docket Sheet as of August 31, 2016 1
2. Claimants' Administrative Appeal, dated July 9, 2015 4
3. Certified Index of Administrative Record, dated August 27, 2015 19
4. Claimants' Petition for Declaratory Ruling, filed December 9, 2014 20
5. Selective Exhibits to Claimants' Petition for Declaratory Ruling, filed December 9, 2014
   a. DSS, March 26, 2013 Notice of Intent to promulgate and to operate under proposed regulations implementing the Medicaid ABI Waiver Program pursuant to Conn. Gen. Stat. § 17b-10 27
   b. Proposed ABI Waiver Regulations 29
   c. Provider Agreement, dated January 15, 2004 58
   d. Letter from David Marder, Esq., Counsel for Claimants, to Joseph A. Smiga, Esq., Staff Attorney, dated May 22, 2014 59
   e. Letter from Joseph A. Smiga, Esq., Staff Attorney, DSS to David Marder, Esq., dated May 20, 2014 61

Appendix Page

f. Provider Agreement, dated January 15, 2004 63

g. Letter from Joseph A. Smiga, Esq., Staff Attorney, DSS, to David Marder, Esq., dated August 22, 2014 64

h. Letter dated September 12, 2014 from Joseph A. Smiga, Esq.to David Marder, Esq. dated September 12, 2014 66

i. Internal e-mails between Lara Stauning, Esq., DSS and Phyllis Hyman, Esq., DSS dated March 6 and March 7, 2013 67

6. DSS, Declaratory Ruling, dated May 28, 2015 69

7. Order, Granting the Department's Motion to Dismiss "for the reasons stated in court" 77

B. Documents in the Neurostrategies, Inc., et al. v. Connecticut Department of Social Services, No. HHB-CV-16-6034437-S, Claimants' Administrative Appeal from the Department's Second Declaratory Ruling, dated June 24, 2016

1. Docket Sheet as of September 14, 2016 78

2. Claimants' Administrative Appeal from the Department's Second Declaratory Ruling, dated August 8, 2016 . . . . 81-81d

3. Certified Index to Administrative Record, dated September 7, 2016 82

4. Claimants' Request for Declaratory Ruling, dated December 28, 2015, App. 83-282, including Claimants' Listing of Exhibits to Request for Declaratory Ruling, App. 278-281 83

5. Selected Exhibits attached to Claimants' Request for a Declaratory Ruling, dated December 28, 2015

a. Exhibit 1, Provider Agreement, dated January 15, 2004 283

b. Exhibit 2, DSS, March 26, 2013 NOI to Promulgate and Operate under Proposed Medicaid ABI Waiver Regulations 286

c. Exhibit 5, Exchange of emails between Lara Stauning, Esq., DSS and Phyllis Hyman, Esq., DSS dated March 6 and 7, 2013 288

Appendix Page

d. Exhibit 8, DSS Proposed ABI Waiver Regulations as notified in the March 26, 2013 Law Journal effective April 1, 2013 pursuant to Conn. Gen. Stat. § 17b-10(b) 291

6. DSS, Declaratory Ruling, dated June 22, 2016 with attached Exhibits A-J 321

C. Documents Relevant to Claimants' "Failure to Produce Documents" Claim

1. Affidavit of John McCormick, dated September 6, 2016 with attached Exhibits 382

Exhibit C-2, Letter from Michael Kogut, Esq., to John McCormick, DSS, dated July 10, 2015 requesting documents related to an "audit" 384

Exhibit C-3, Reply from John McCormick, DSS, to Michael Kogut, Esq., dated August 2, 2015 refusing to produce requested documents citing FOIA exemptions from disclosure 385

State of Connecticut Judicial Branch
Civil and Family Inquiry

Civil / Family Home
Attorney/Firm Case List
Attorney/Firm Look-up
Docket Number Search
Party Name Search
Property Address Search
Short Calendars
By Court Location
By Juris Number
Motions to Seal or Close
Calendar Notices
Short Calendar
Quick Guide
Court Events By Date
Court Events By Juris Number
Scheduling Inquiry
Pending Foreclosure Sales
Questions & Answers
Court Information
Legal Terms
Comments

HHB-CV15-6029943-S NEUROSTRATEGIES, INC. Et Al v. CT DEPARTMENT OF SOCIAL SERVICES Et Al

Prefix/Suffix: [none] **Case Type:** A64 **File Date:** 07/10/2015 **Return Date:** 07/28/2015

Case Detail Notices History Scheduled Court Dates E-Services Login Screen Section Help

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Information Updated as of: 08/31/2016

Case Information

Case Type A64 - Appeals - Social Services Commission
Court Location: NEW BRITAIN JD
List Type: ADMINISTRATIVE APPEALS (AA)
Trial List Claim: 07/10/2015
Last Action Date: 11/27/2015 (The "last action date" is the date the information was entered in the system)

Disposition Information

Disposition Date: 11/25/2015
Disposition: JUDGMENT OF DISMISSAL
Judge or Magistrate HON CARL SCHUMAN

Party & Appearance Information

Party		No Fee Party	Category
P-01	NEUROSTRATEGIES, INC **Attorney** MARDER ROBERSON & DEFELICE LAW OFFICES L (103095) File Date 07/10/2015 76 SOUTH FRONTAGE ROAD VERNON, CT 06066		Plaintiff
P-02	TARIQ ABDULAZIZ **Attorney** MARDER ROBERSON & DEFELICE LAW OFFICES L (103095) File Date 07/10/2015 76 SOUTH FRONTAGE ROAD VERNON, CT 06066		Plaintiff
D-01	CT DEPARTMENT OF SOCIAL SERVICES **Attorney** AAG HUGH BARBER (085484) File Date 07/20/2015 ATTY GEN-HEALTH PO BOX 120 HARTFORD, CT 061410120		Defendant
D-02	RODERICK L BREMBY, COMMISSIONER, DEPT. OF SOCIAL SERVICES **Attorney:** AAG HUGH BARBER (085484) File Date 07/20/2015 ATTY GEN-HEALTH PO BOX 120 HARTFORD, CT 061410120		Defendant

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Motions / Pleadings / Documents / Case Status

Entry No	File Date	Filed By	Description	Arguable
	07/20/2015	D	APPEARANCE Appearance	
100 30	07/10/2015	P	SUMMONS AND CITATION	No

100 31	07/10/2015	P	APPEAL TO JD SUPERIOR COURT	No
101 00	07/10/2015	P	RETURN OF SERVICE	No
102 61	07/10/2015	C	CERTIFICATE OF CLOSED PLEADINGS AND CLAIM FOR TRIAL LIST	No
103 00	07/20/2015	D	REQUEST FOR ACTION ADMINISTRATIVE AND TAX APPEALS (JD-CV-114) Notice of Appearance	No
104 00	07/30/2015	P	MOTION FOR CONTINUANCE *RESULT* Granted 7/31/2015 HON GEORGE LEVINE	No
104 01	07/31/2015	C	ORDER *RESULT* Granted 7/31/2015 HON GEORGE LEVINE	No
105 00	07/31/2015	D	RECORD IN ADMINISTRATIVE APPEALS Certified List of Papers in the Record	No
106 00	08/21/2015	P	APPLICATION Application for Stay	No
107 00	08/26/2015	D	MOTION TO DISMISS PB 10-30 *RESULT* Granted 11/25/2015 HON CARL SCHUMAN	Yes
107 01	11/25/2015	C	ORDER *RESULT* Granted 11/25/2015 HON CARL SCHUMAN	No
108 00	08/26/2015	D	MEMORANDUM IN SUPPORT OF MOTION	No
109 00	08/27/2015	D	NOTICE Notice of Submission of the Administrative Record	No
110 00	08/27/2015	D	RECORD IN ADMINISTRATIVE APPEALS	No
111 00	09/01/2015	D	MEMORANDUM Memorandum In Opposition To Application For Stay with Exhibit A	No
112 00	10/06/2015	P	MOTION FOR CONTINUANCE *RESULT* Granted 10/6/2015 HON CARL SCHUMAN	No
112 01	10/06/2015	C	ORDER *RESULT* Granted 10/6/2015 HON CARL SCHUMAN	No
113 00	10/06/2015	P	MOTION FOR CONTINUANCE Motion to Extend the Briefing Schedule by One Week *RESULT* Granted 10/7/2015 HON CARL SCHUMAN	No
113 10	10/06/2015	C	ORDER *RESULT* Granted 10/6/2015 HON CARL SCHUMAN	No
114 00	10/14/2015	P	APPLICATION Application for Leave to Present Additional Evidence by Expansion of the Record	No
115 00	10/19/2015	D	MEMORANDUM In Opposition to Application for Leave to Present Additional Evidence By Expansion of the Record	No
116 00	10/22/2015	P	MEMORANDUM IN SUPPORT OF MOTION Memorandum in Support of Application for Stay *RESULT* Rejected 10/28/2015 HON CARL SCHUMAN	No
116 10	10/28/2015	C	ORDER *RESULT* Rejected 10/28/2015 HON CARL SCHUMAN	No
117 00	10/22/2015	P	OBJECTION TO MOTION TO DISMISS	No
118 00	10/22/2015	P	MEMORANDUM IN SUPPORT OF OBJECTION	No
119 00	10/28/2015	D	MOTION TO STRIKE Plaintiffs' Out-of-Time October 22 2015 Memorandum in Support of Application for Stay *RESULT* Order 10/28/2015 HON CARL SCHUMAN	Yes
119 10	10/28/2015	C	ORDER *RESULT* Order 10/28/2015 HON CARL SCHUMAN	No
120 00	11/02/2015	P	EXHIBITS Exhibits 1 and 2 in Support of Pleading 118 00	No
121 00	11/04/2015	P	MOTION FOR ORDER Motion for Evidentiary Hearing *RESULT* Order 11/18/2015 HON CARL SCHUMAN	No
121 10	11/18/2015	C	ORDER *RESULT* Order 11/18/2015 HON CARL SCHUMAN	No
122 00	11/04/2015	P	MEMORANDUM IN SUPPORT OF MOTION Plaintiff's Memorandum in Support of Motion for Evidentiary Hearing	No

123 00	11/09/2015	P	REPLY MEMORANDUM To Defendant's Memorandum in Opposition to Application for Stay	No
124 00	11/12/2015	D	MEMORANDUM IN OPPOSITION TO MOTION Plaintiffs' Motion for an Evidentiary Hearing In Opposition to Defendant's Motion to Dismiss	No
125 00	11/18/2015	D	MOTION TO QUASH Motion to Quash with Exhibits A and B *RESULT:* Granted 11/20/2015 HON CARL SCHUMAN	No
125 10	11/18/2015	C	ORDER *RESULT:* Order 11/18/2015 HON CARL SCHUMAN	No
125 20	11/20/2015	C	ORDER *RESULT* Granted 11/20/2015 HON CARL SCHUMAN	No
126 00	11/20/2015	P	OBJECTION TO MOTION Plaintiff's Objection To Motion To Quash	No
127 00	11/20/2015	P	MOTION FOR ACCEPTANCE OF REPORT MOTION FOR ACCEPTANCE OF LATE PLEADING/RECONSIDERATION	No
127 10	11/23/2015	C	ORDER *RESULT:* Order 11/23/2015 HON CARL SCHUMAN	No
128 00	11/25/2015	C	JUDGMENT OF DISMISSAL *RESULT:* HON CARL SCHUMAN	No
129 00	11/25/2015	C	LIST OF EXHIBITS (JD-CL-28/JD-CL-28a) **Last Updated:** Legend Code - 11/27/2015	No

Scheduled Court Dates as of 08/30/2016

HHB-CV15-6029943-S - **NEUROSTRATEGIES, INC. Et Al v. CT DEPARTMENT OF SOCIAL SERVICES Et Al**

#	Date	Time	Event Description	Status
No Events Scheduled				

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Matters that appear on the Short Calendar and Family Support Magistrate Calendar are shown as scheduled court events on this page The date displayed on this page is the date of the calendar

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3

RETURN DATE: JULY 28, 2015	:	SUPERIOR COURT
NEUROSTRATEGIES, INC. and TARIQ ABDULAZIZ, Ph.D, M.S., MBA	:	J. D. OF NEW BRITAIN
VS.	:	AT NEW BRITAIN
CT DEPARTMENT OF SOCIAL SERVICES; RODERICK L. BREMBY, COMMISSIONER DEPARTMENT OF SOCIAL SERVICES	:	JULY 9. 2015

ADMINISTRATIVE APPEAL

Pursuant to Section 4-183(a) of the Connecticut General Statutes, Appellant-Petitioners (hereinafter referred to collectively as "Tariq"), hereby appeal the final decision of the Appellee Depatment of Social Services made through the designee of Appellee Roderick L. Bremby, Commissioner of the Department ("Commissioner") (the Department of Social Services and the Commissioner are collectively referred to as the "Department" or "DSS"), as set forth in its Declaratory Ruling dated May 28, 2015, and from its denial on June 19, 2015, of Appellant-Petitioners Request for Reconsideration of the Declaratory Ruling dated June 19, 2015.

NATURE OF THE ACTION

1. This is an appeal by Tariq of the Department's May 28, 2015 Declaratory Ruling issued pursuant to Sections 4-176(e)(3) and 4-176(i) of the Connecticut General Statutes Sections 17-311-44 to 17-311-46, inclusive of the Regulations of Connecticut state Agencies;

and the denial of his Request for Reconsideration of the Declaratory Ruling dated June 19, 2015.

In the Department's Declaratory Ruling, the Commissioner addressed only three questions raised (1A, B) but failed to address additional questions raised in Tariq's Amended Petition for Declaratory Ruling dated March 31, 2015 adding questions 1 D-H. Tariq seeks judicial relief as hereinafter set forth.

PARTIES AND JURISDICTION

2. NeuroStrategies, Inc. is and at all times herein a Connecticut Corporation acting herein by Tariq Abdulaziz, Ph.D, M.S., MBA, its President and having its principal place of business at 23 Kate Way, Windsor Locks, Connecticut.

3. Tariq is a resident of the State of Connecticut residing at 23 Kate Way, Windsor Locks, Connecticut.

4. The Department is an agency of the State of Connecticut with an office at 55 Farmington Avenue, Hartford, Connecticut. Connecticut General Statutes § 17b-1. The Commissioner is the statutory head of the Department.

5. NeuroStrategies, Inc. and/or Tariq have, since January 15, 2004, been providing services under a signed provider agreement with the Department for the Acquired Brain Injury/Traumatic Brain Injury Waiver Program (ABI Waiver).

6. That pursuant to certain proposed regulations, which were the subject of Tariq's Petition for Declaratory Ruling, Tariq was audited by DSS on June 16, 2014, although Tariq has not as yet been notified of the audit results; Tariq was advised that the audit standards would be those set forth in the proposed regulations (17b-260a-1 to 17b-260a-17).

7. This Court has subject matter jurisdiction over this administrative appeal pursuant to Section 4-176(h) of the Connecticut General Statutes, and Tariq is aggrieved by the audit protocol being used by DSS in said audit.

LEGAL AND REGULATORY FRAMEWORK

8. Under Connecticut General Statutes §17b-10(b), DSS must adopt as regulation, in conformance with the Uniform Administration Procedures Act, any new policy needed to conform (i.e., conforming requirement) to a requirement of an approved federal Medicare waiver application.

9. That the "ABI Waiver" Program has been operating without any regulations from 1999 through March 26, 2013 (date proposed regulations were published in the Connecticut Law Journal), with an effective date of April 1, 2013.

10. The Connecticut Uniform Administrative Procedure Act, clearly states that a regulation is not valid until (1) it has been properly noticed; (2) it has had a public comment period; (3) it has been approved by the Attorney General and the Legislative Regulation

Review Committee (LRRC); and (4) it has been properly filed with the Secretary of State's Office (see Connecticut General Statutes §4-168, 4-168a, 4-169, 4-170 and 4-172).

There are three (3) exceptions to the aforesaid requirement, but none have been cited as a basis for any deviation by the Department of Social Services.

11. Any proposed regulation must be submitted to the LRRC within one hundred eighty (180) days of publication in The Connecticut Law Journal or notify the LRRC of its reason for non-compliance and the date it would comply.

12. Connecticut General Statutes §17b-10b requires for any new policy publication in the Connecticut Law Journal within twenty (20) days after adoption of the policy [§4-168(b)]; and a notice by publication in the Connecticut Law Journal at least thirty (30) days prior to adopting a proposed regulation [§4-168(h)].

13. Connecticut General Statutes §17b-99 were proposed regulations allowing DSS to audit providers, seek repayment and seek damages by extrapolation as set forth therein.

14. Connecticut General Statutes §17b-99 were published in the Connecticut Law Journal on October 16, 2012, but to date have not been approved, but are being used in audits in the interim.

15. Connecticut General Statutes §17b-10(b) provides in part, for implementation of new proposed regulations while they are in the process of adoption when there is a Federal Conforming Requirement.

16. DSS Developed and applied certain published regulations in 1999 (1999 Operation Policy) and certain Social Work Policies without proper notice submitting them to the Licensing Regulation and Review Committee (LRRC), the Office of Attorney General or Secretary of State.

17. The 1999 non-adopted regulation and social work policies, used by DSS and/or Department of Social Work since 2009, were not properly noticed, nor publicized to the general public, nor distributed to consumers, providers, the LRRC, Office of Attorney General or Secretary of State.

18. Connecticut General Statutes §17b-271 provides the basis for termination of agreements with DSS under Connecticut General Statutes §17b-267.

19. Connecticut General Statutes §17b-10(a) requires DSS to distribute copies of its proposed regulation and policies to all entities required to receive such copies.

20. Connecticut General Statutes §17b-10(a) requires that any proposed regulation be written in a clear and concise manner.

21. Allied Community Resources (ACR) failed as charged to provide Medicaid Provider Agreements to all providers who were to provide services.

BACKGROUND FACTS

22. Tariq has been providing services for the DSS for the ABI Waiver Program under a Provider Agreement since January 15, 2004.

23. The documentation requirements to maintain records in said provider agreement is as follows:

> "I will maintain records that fully disclose services and goods rendered to ABI Waiver participants. These records will be made available to authorized representatives of the Department upon request".

24. Until the proposed regulations were noticed in the Connecticut Law Journal on March 26, 2013, effective April 1, 2013, no attempt was made by DSS to provide any guidance in any forms such as written instruction, seminars, videos, proposed forms and the like, to define what the provider agreement refers to as "...maintain records that fully disclose services and goods rendered to ABI Waiver Participants...". Providers were left on their own to develop their own record keeping procedures and the content of those records.

24. (a) DSS further violated Connecticut General Statutes §17b-10, by not routinely publishing and distributing copies of its regulations and policies.

(b) The Department's failure to distribute copies of regulations and policies and its impact on providers becomes acute when service plans are not provided by DSS. Service plans outline what services are to be provided, available service hours, billing rates and the total cost of each service for the month and year.

Without distribution of service plans, providers may unintentionally bill in excess of allowable hours.

(c) The DSS commissioner in its Declaratory Ruling, failed to address this claimed failure.

25. The ABI Waiver Program has been operating without regulation from 1999 and is scheduled to be renewed in January 2016.

26. (a) DSS in submitting the proposed regulations and noticing them in the Connecticut Law Journal, did not do so under any "conforming requirement" required under Connecticut General Statutes §17b-10(b) when responding to a requirement of an approved Federal Medicare Waiver Application.

(b) DSS has been requested on repetitive occasions to state its "conforming requirement" but to date has failed to disclose the basis of its action and use of Connecticut General Statutes §17b-10(b). There were questions raised in Tariq's Request for Reconsideration (paragraphs 5D and E).

27. On March 26, 2013, DSS caused to be published in the Connecticut Law Journal a Notice of Intent (NOI) to adopt regulations under Section 17b-260b (effective April 1, 2013) for the ABI Waiver Program. Said NOI further noticed DSS's intent to implement its proposed regulations during the adoptive process under Connecticut General Statutes §17b-10, but did not identify its conforming requirement.

27. (a) The statutory reference in the NOI was incorrect. It should have referenced Connecticut General Statutes §17b-260(a). The Declaratory Ruling ignored the erroneous citation.

28. The NOI did not provide notice that during the adoptive process under Connecticut General Statutes §17b-10, DSS would also seek to audit providers seeking reimbursement and damages under Connecticut General Statutes §17b-99.

29. The NOI published on March 26, 2013, cited the wrong statutory provision in an attempt to comply with the Connecticut Uniform Administrative Procedure Act that states that any regulation is not valid unless properly noticed.

30. The proposed regulations were never submitted within One hundred eighty (180) days, or to date, to the Legislative Regulation Review Committee, as required by Connecticut General Statutes §17b-10(c), nor were they submitted to the Attorney General's Office (although they were initially submitted but then withdrawn) nor filed with the Secretary of State (Connecticut General Statutes §4-168, 4-168a, 4-169, 4-170 and 4-172).

31. DSS Commissioner, in its Declaratory Ruling, acknowledges non-compliance with the requirement to submit any proposed regulations to the LRRC, or explain their non-compliance or detail a date for compliance. The Commissioner contends its non-compliance isn't fatal to its proposed regulations since the statutory language in their opinion is directory and not mandatory.

32. The proposed regulations were not properly noticed under Connecticut General Statutes §17b-10(b), which requires publication of the NOI within twenty (20) days after adoption of the policy §17b-10(b), nor at least thirty (30) days prior to adopting a proposed regulation [§4-168(a)].

33. DSS Commissioner, in its Declaratory Ruling, contends that the publication of the NOI five (5) days prior to adoption of the regulations is in compliance with said notice requirements.

34. DSS notified Tariq that the audit procedure for his audit for claims prior to April 1, 2013, would be based on the existing provider agreement. For claims after April 1, 2013, DSS will use Connecticut General Statutes §17b-260a-16.

35. Tariq objected to the use of the Connecticut General Statutes §17b-260a-16, but cooperated with the audit.

36. At no time did DSS notify Tariq that his provider agreement dated January 15, 2004, was terminated as required by Connecticut General Statutes §17b-271.

37. DSS internal communication regarding the NOI published on March 26, 2013, effective April 1, 2013, required that all providers sign the Medicaid Provider Agreement effective April 1, 2013.

38. No such Medicaid Provider Agreement has been submitted to Tariq between March 26, 2013 and April 1, 2013, nor to date; Nor, when compared to the services Tariq provides does it apply to such services.

39. That by effectively terminating Tariq's January 15, 2004 provider agreement, in violation of Connecticut General Statutes §17b-271, Tariq's due process rights have been violated.

40. DSS has been inconsistent in applying its audit policy by applying non-promulgated regulations. Those were never noticed, published or distributed to the LRRC.

41. DSS's use of such non-promulgated regulations leaves providers at the mercy of a Department which can then retro-actively apply auditing proceedings which a provider had no way to prepare for.

42. DSS issued legal decisions against an ABI Waiver Program participant on June 17, 2013, June 21, 2013 and December 10, 2013, in which they cited the 1999 non-promulgated regulations.

43. DSS on June 19, 2015, denied Tariq's Request for Reconsideration of the Declaratory Ruling based solely on the basis that under Connecticut General Statutes §4-181a(1) only allows a right for a reconsideration in a contested case. DSS further stated that under Connecticut General Statutes §4-166(4) a declaratory ruling is not a contested case.

44. Tariq requested DSS by letter dated June 23, 2015, to reconsider it's denial of his Request for Reconsideration based on Connecticut General Statutes §4-176(h) which states that: "(h) A declaratory ruling shall have the same status and binding effect as an order issued in a contested case and shall be a final decision for purposes of appeal in accordance with the provisions of Section 4-183...".

45. By letter dated June 24, 2015, DSS denied the review Tariq requested under Connecticut General Statutes §4-176(h) and stated that their June 19, 2015, Ruling on Request for Reconsideration stands.

LEGAL CLAIMS

COUNT I:

DSS violated Tariq's rights to Procedural Due Process under the Fourteenth Amendment of the United States Constitution and under Article First, Sections 8 and 10 of the Connecticut Constitution.

46. Tariq hereby incorporates by reference the allegations in paragraphs 1 through 45 above as if fully set forth herein.

47. Tariq has a recognized legal interest to have his signed contract (Provider Agreement dated January 15, 2004) with the State of Connecticut treated under established law pursuant to Connecticut General Statutes §4-271, with proper notice, an opportunity to be heard and the application of proper statutory standards.

48. The position of DSS in requiring all providers to sign the Medicaid Provider Agreement effective April 1, 2013, deprived Tariq of his due process despite his continuing objections.

49. DSS further violated Tariq's rights by not complying with the Connecticut Uniform Administrative Procedure Act in not properly publishing their NOI within statutory time constraints; improper statutory referencing; not providing copies of the proposed regulations to the LRRC as statutorily required, not providing such copies to the Attorney General's Office and Secretary of State; not giving notice that it intended to audit providers pursuant to Connecticut General Statutes §17b-99; applying the proposed regulations while final approval was sought under Connecticut General Statutes §17b-10, but failed to disclose any Federal "conforming requirement" as required in Connecticut General Statutes §17b-10(b) and in denying Tariq's request for reconsideration.

COUNT II:

DSS violated Tariq's rights to Substantive Due Process under the Fourteenth Amendment of the United States Constitution and under Article First Sections 8 and 10 of the Connecticut Constitution.

50. Tariq hereby incorporates by reference the allegations in paragraphs 1-49 above as if fully set forth herein.

51. Tariq's signed contract (Provider Agreement dated January 15, 2004) with DSS was terminated without cause and in violation of Connecticut General Statutes §17b-271.

52. DSS's audit standards for the audit of Tariq's records after April 1, 2013, under proposed regulations defectively noticed and applied to the ABI Waiver Program.

53. DSS has been using the proposed regulations under Connecticut General Statutes §17b-10 while said regulations were in the process of being adopted, this action, it is alleged, is without any basis since DSS has not set forth any Federal "conforming requirement". This failure deprived Tariq of his substantive due process rights since he is not informed of the factual basis for the application of §17b-10 as aforesaid, to the ABI Waiver Program.

COUNT III:

DSS violated Tariq's Right to Fundamental Fairness in Administrative Proceedings.

54. Tariq hereby incorporates by reference the allegations in paragraphs 1-52 above as if fully set forth herein.

55. DSS applied Connecticut General Statutes §17b-10 without any basis to the ABI Waiver Program; failed to publicize and distribute copies of its regulations and policies to designated agencies and to providers; terminated signed contracts without following statutory requirements; used non-promulgated 1999 regulations in auditing providers; failed to notify providers of the intended use of Connecticut General Statutes §17b-99 in their audits; ignored their own attorney's warnings about the lack of notice to providers and possible lack of

authority to apply §17b-10; violated publication date restrictions in the NOI; sought to apply different standards in auditing Tariq before and after April 1, 2013; and intentionally worded the proposed regulations in a vague manner contrary to Connecticut General Statutes §17b-10(a) which requires regulations to be drafted in a clear and concise manner.

PRAYER FOR RELIEF

WHEREFORE, NeuroStrategies, Inc. and Tariq Abdulaziz, Ph.D, M.S., MBA pray that this Court:

1. Sustain its appeal;

2. Order the Department to set aside its Declaratory Ruling;

3. Order the Department to reconsider its Declaratory Ruling per the Appellant/Petitioners request;

4. Award it reasonable fees and expenses under Connecticut General Statutes §4-184a; and

5. Grant such other relief as the Court may deem appropriate.

APPELLANT-PETITIONERS,
NeuroStrategies, Inc. and
Tariq Abdulaziz,, Ph.D., M.S., MBA

By _____

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DOCKET NO. HHB-CV15-6029943-S	:	SUPERIOR COURT
NEUROSTRATEGIES, INC., ET. AL. *Plaintiff*	:	JUDICIAL DISTRICT OF NEW BRITAIN
v.	:	
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES, ET AL *Defendants*	:	AUGUST 27, 2015

INDEX OF ADMINISTRATIVE RECORD

Pursuant to Conn. Gen. Stat.§ 14-7A(b), the defendant, Connecticut Department of Social Services, et al submits the following documents, constituting the entire record of the proceedings before the Department of Social Services in this matter.

	PAGES
1. Petition for Declaratory Ruling, dated 12/9/2014	1-69
2. Agreement to Issue Declaratory Ruling, dated 12/30/2014	70
3. Letter to Attorney Smiga, dated 2/12/2015	71-72
4. Letter to Attorney Marder, dated 2/19/2015	73
5. Notice of Deposition, dated 2/20/2015	74-81
6. Order, dated 3/4/2015	82-83
7. Amended Petition for Declaratory Ruling, dated 3/31/2015	84-120
8. Declaratory Ruling, dated 5/28/2015	121-256
9. Request for Reconsideration	257-395
10. Ruling on Request for Reconsideration, dated 6/19/2015	396-397
11. Letter to Commissioner Bremby, dated 6/23/2015	398-399
12. Letter to Attorney Marder, dated 6/24/2015	400

The above and foregoing is hereby certified by the undersigned as the entire administrative record for Neurostrategies, Inc., et. al., v. Connecticut Department of Social Services, et al.

Joseph A. Smiga, Staff Attorney
Connecticut Department of Social Services

27 Aug 2015
Date

RECEIVED
DEC - 9 2014
Office of Administrative Hearings

PETITION FOR DECLARATORY RULING

The undersigned petitions the Commissioner of Social Services for a Declaratory Ruling, pursuant to Connecticut General Statutes §4-176 as amended, and the regulations adopted by said agency.

In support of said Petition, the undersigned states as follows:

1. **Questions Being Presented**:

A. Whether the regulations proposed by said Agency pursuant to Connecticut General Statutes §4-168, and being §17b-260a and §17b-260b were properly adopted pursuant to the Connecticut Uniform Administrative Procedure Act.

B. Whether the regulation proposed by said Agency, pursuant to Connecticut General Statutes §4-168 and being §17-99, were properly adopted.

C. Whether 17b-10 can be applied to the ABI Medicaid Waiver Program.

With respect to each question presented, the undersigned hereinafter identifies the particular aspects of his claim.

A. **As to Connecticut General Statutes §17b-260a and Connecticut General Statutes §17b-260b**

The text of Connecticut General Statutes §17b-260a and 17b-260b are attached as Exhibit 1.

1. The Connecticut Uniform Administrative Procedure Act, clearly states that a regulation is not valid until (1) it has been properly noticed; (2) it has had a public comment period; (3) it has been approved by the Attorney General and the Legislative Regulation Review

Committee (LRRC); and (4) it has been properly filed with the Secretary of State's Office (see Connecticut General Statutes §4-168, 4-168a, 4-169, 4-170 and 4-172).

There are three (3) exceptions to the aforesaid requirement, but none have been cited as a basis for any deviation by the Department of Social Services.

In addition, any proposed regulation must be submitted to the LRRC within one hundred eighty (180) days of publication in The Connecticut Law Journal.

Lastly, Connecticut General Statutes §17b-10b requires for any new policy publication in the Connecticut Law Journal within twenty (20) days after adoption of the policy [§4-168(b)]; and a notice by publication in the Connecticut Law Journal at least thirty (30) days prior to adopting a proposed regulation [§4-168(h)].

2. The notice published in the Connecticut Law Journal on March 26, 2013, by the Department of Social Services regarding the intent to adopt new regulations for the ABI Medicaid Waiver Program cites Connecticut General Statutes §17b-260b.

3. Connecticut General Statutes §17b-260b is not the citation for the ABI Medicaid Waiver Program.

4. The correct citation for the ABI Medicaid Waiver Program is Connecticut General Statutes §17b-260a.

5. Pursuant to the Connecticut Uniform Administrative Procedure Act and the Rules of the Legislative Regulation Review Committee, a Notice of Intent to Adopt, Amend, or Repeal a Regulation must include a reference to the statutory authority for the regulation.

6. The incorrect statutory reference makes the Notice of Intent defective since the procedures are mandatory.

7. This issue was presented to Attorney Smiga, Counsel for the Department of Social Services in a letter dated May 22, 2014, responding to his letter dated May 20, 2014 (copies attached).

8. By letter dated August 22, 2014, Attorney Smiga acknowledged the error but attempted to gloss over it by labeling it as a typographical error (copy attached).

9. We again by letter dated September 3, 2014, took issue with the "typographical" characterization and conclusion that the Notice of Intent was properly given but by letter dated September 12, 2014, the Department of Social Services stood by its conclusion that the Notice of Intent was proper (see attached copies of September 3, 2014 and September 12, 2014 letters).

10. In our search of the LRRC records, we did not find any record of compliance with the one hundred eighty (180) day requirement.

11. In our letter dated September 3, 2014, we asked the Department of Social Services, by Attorney Smiga, for any documentation to support compliance with the one hundred eighty (180) day requirement.

12. In his letter dated September 12, 2014, Attorney Smiga never responded to that request.

13. We further submit that the Department of Social Services has failed to comply with Connecticut General Statutes §4-168(b) and §4-168(h).

14. The Notice of Intent (copy attached) was published in the Connecticut Law Journal on March 26, 2013, with the proposed regulation to be implemented and operated under effective April 1, 2013.

15. Under the timeline set forth by the Department of Social Services, it is clear that neither §4-168(b) or §4-168(h) have been complied with.

B. <u>As to Connecticut General Statutes §17b-99</u>

The text of Connecticut General Statutes §17b-99 is attached as Exhibit 2.

1. A Notice of Intent to adopt such regulation was published in the Connecticut Law Journal on October 16, 2012.

2. The proposed regulation allows the Department of Social Services to audit and seek damages.

3. That said proposed regulation has not, as of this date, been approved.

4. That despite not yet being approved, the Department of Social Services has used said proposed regulation to extrapolate money damages against providers.

5. See attached data regarding the use of Connecticut General Statutes §17b-99, prior to it being approved.

6. The previously referenced notice published on October 16, 2012, failed to give any notice that the Department of Social Services was planning to use said Section during the time the proposed regulation was making its way through the approval process and being approved.

7. Providers were thus not given proper notice as to any potential consequences for any claimed non-compliance.

C. **As to Connecticut General Statutes §17b-10(b)**

1. The text of Connecticut General Statutes §17b-10(b) is attached as Exhibit 5.

2. The ABI Medicaid Waiver Program is intended to provide medical assistance to qualified individuals.

3. There is no authority to use Connecticut General Statutes §17b-10(b) to implement new proposed regulations while they are in the process of adoption.

4. The Agency itself, in an exchange of correspondence dated March 6, 2013 and March 7, 2013, questioned the authority to use the ABI Waiver regulation as a 17-10 regulation. (See Exhibit 6.)

2. **Statement of Facts**: The proposed regulations will require a detail of services and billing which has not been required before. Such detail has not been adequately publicized to the providers of services under the ABI Medicare Waiver Program, but under Connecticut General Statutes §17-99, providers are exposed to damages.

Providers signed "Provider Agreements" similar to the one the undersigned signed. (See Exhibit 3.) In paragraph 9 of said Provider Agreement, it states that "I will maintain records that fully disclose services and goods rendered and/or delivered to ABI Waiver Participants. These records will be made available to authorized representatives of the Department upon request.".

Once signed and services begun, no document, instruction, proposed invoice, training session, manual or the like were ever provided by the Agency to the providers so that they would know what is expected.

In fact, six (6) Town Halls (Windsor Locks - the petitioner's Town, Enfield, Wilton, Norwalk, Thomaston and Westport) never received any policy manuals. (See Exhibit 4a-f.)

The undersigned was audited and was advised that for any services provided after April 1, 2013, he would be held to the standards set forth in 17b-260a-16a of the regulations. (See letter dated May 20, 2014, from Attorney Joseph A. Smiga, Staff Attorney, DSS, attached hereto.)

As to Connecticut General Statutes §17b-10(b), the undersigned submits that it can't be applied to the ABI Waiver Program since there is no authority to use this regulation nor any requirement under the Federal Statute to adopt this regulation.

3. **Practitioner's Statement of Position**: The undersigned contends that said regulations are invalid due to the adoption deficiencies previously noted; and that there is no authority for Connecticut General Statutes §17b-10(b)

4. **Reasons Relied Upon for Petitioner's Position:** The undersigned incorporates herein his previous arguments in paragraphs 1A, 1B and 1C of this Petition.

5. **Petitioner and Legal Representative:**

Dated this 9th day of December, 2014.

NeuroStrategies, Inc.

By _____
Tariq Abdulaziz,, Ph.D., M.S., MBA
Its President Duly Authorized
23 Kate Way
Windsor Locks, CT 06096
PH: (860)377-0641

_____
Tariq Abdulaziz,, Ph.D., M.S., MBA,
Individually

Marder & DeFelice Law Offices, LLC

By _____
I. David Marder
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abdulazizpetdeclaratoryruling.misc.mb

ADMINISTRATIVE REGULATIONS

Regulations and notices published herein, pursuant to General Statutes Sections 4-168 and 4-173, are printed exactly as submitted by the forwarding agencies. These, being official documents submitted by the responsible agencies, are consequently not subject to editing by the Commission on Official Legal Publications.

A cumulative list of effective amendments to the Regulations of Connecticut State Agencies may be found in the Connecticut Law Journal dated March 5, 2013.

DEPARTMENT OF SOCIAL SERVICES

Notice of Intent to Adopt Regulations

In accordance with the provisions of subsection (a) of section 4-168 of the Connecticut General Statutes, notice is hereby given that the Commissioner of Social Services, under section 17b-260b of the Connecticut General Statutes, proposes to establish in regulation, the policies for the administration of the Acquired Brain Injury (ABI) waiver program. The Department, in accordance with 17b-10 of the Connecticut General Statutes, will implement and operate under the proposed regulation effective April 1, 2013.

Statement of purpose: (A) The purpose of the regulation is to set forth in regulation the policies regarding the administration of the ABI waiver program. The ABI waiver program is currently administered through policy set forth in the waiver application. The effect of the proposed regulation would be to formally establish the policies of the ABI waiver program in regulation format. (B) The main provisions of the regulation include: (1) A description of the purpose and scope of the ABI waiver program; (2) definitions of necessary terms; (3) eligibility requirements and determination of need; (4) a description of the home and community-based services available under the ABI Waiver program; (5) assessment and development of a cost-effective service plan; (6) the responsibilities of the individual, the Department and ABI waiver providers; and (7) provider participation requirements and procedures

(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 set forth the policies for administration of the ABI waiver program.

A copy of the complete text of this regulation is available, at no cost, upon request from the Office of Legal Counsel, Regulations and Administrative Hearings, Department of Social Services, 25 Sigourney Street, Hartford, Connecticut 06106; email: lara.stauning@ct.gov.

All written comments, questions, and concerns regarding this regulation may be submitted within 30 days of the publication of this notice to the Department of Social Services, Office of Legal Counsel, Regulations & Administrative Hearings, 25 Sigourney Street, Hartford, Connecticut, 06106. Attention: Brenda Parrella, Director. A hearing will be scheduled on the proposed regulation if requested by fifteen persons, by a governmental subdivision of an agency or by an association having

not less than fifteen members, if notice of the request is received by the Department within fourteen days after the date of publication of this notice.

When submitting correspondence, please refer to Regulation Control Number 08-07/DL.

CONNECTICUT HEALTH INSURANCE EXCHANGE
d/b/a Access Health CT

Notice of Intent to Adopt Policy

In accordance with Section 1-121(a) of the Connecticut General Statutes, notice is hereby given that the Connecticut Health Insurance Exchange (the Exchange) is proposing to adopt the "Policy: Acquiring Operating Funding" for the purpose of operating the Exchange pursuant to Chapter 706c, Connecticut Health Insurance Exchange, Section 38a-1080 et. seq. of the Connecticut General Statutes.

Interested persons wishing to present their views on this policy are invited to do so in writing within thirty (30) days following publication of this notice. Comments can be submitted electronically to Margo Lachowicz at Margo.Lachowicz@ct.gov (subject line should read: Public Comment). Comments can also be mailed to Margo Lachowicz, Access Health CT/Connecticut Health Insurance Exchange, 280 Trumbull Street, 15th Floor, Hartford, CT 06103.

The proposed policy is available at http://www.ct.gov/hix or via email to Margo Lachowicz at Margo.Lachowicz@ct.gov.

DEPARTMENT OF TRANSPORTATION

Notice of Intent to Amend Regulations

Specific Information Signs and Business Signs on Limited Access Highway

The Commissioner of Transportation, pursuant to Sections 4-168 and 13a-124a of the Connecticut General Statutes, hereby gives notice of his intent to amend regulations regarding *"Specific Information Signs and Business Signs on Limited Access Highways"*.

The purpose of the proposed amendments is to implement a series of changes in policies and practices that updates and allows more latitude in signing for general motorist services and tourist information facilities.

All interested persons are invited to submit written views and arguments in connection with the proposed action within thirty (30) days following the publication of this notice to Pamela Sucato, Legislative Program Manager, Department of Transportation, 2800 Berlin Turnpike, Newington, CT 06131 or through e-mail at pamela.sucato@ct.gov.

EXHIBIT 1

R-39 REV. 04/04
IMPORTANT: Read instructions on bottom of 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

Subject Matter of Regulation

Acquired Brain Injury Waiver Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

An individual shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

aggression toward others;

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

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

(A) The individual's:

(i) Mental capacity;

(ii) behaviors;

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

(iv) illegal or criminal activity;

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

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

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

(i) Illegal or criminal activity;

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

(iii) poor sanitation; or

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

(C) provider issues, such as:

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

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

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

(i) Illegal or criminal activity;

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

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

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

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

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

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

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

(a) General Principles

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

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

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

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

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

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

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

18

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Chore services shall not be covered if:

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

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

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

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

(A) A comprehensive assessment of cognition and behaviors;

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

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

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

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

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

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

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

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

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

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

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

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

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

independence.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) **Independent Living Skills Training**

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

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

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

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

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

(12) **Personal Care Assistance**

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

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

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

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

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

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

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

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

(14) **Respite Care**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(18) **Transportation Services**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

department, minus the average applied income;

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

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

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

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

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

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

(b) Individual and Aggregate Caps

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

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

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

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

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

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

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

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

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

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

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

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

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

The department shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) General Provider Responsibilities

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

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

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

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

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

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

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

(b) Agency Providers

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

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

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

(A) Person-centered provision of services;

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

(C) neglect, abuse and harassment of participants;

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

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

(F) critical incident reporting requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) For purposes of this section

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

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

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

(1) Billing for services not rendered;

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

(3) billing for services not medically necessary;

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

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

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

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

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

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

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

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

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

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

(2) provider's name and signature;

(3) dates of service;

(4) start time for each visit;

(5) end time for each visit; and

(6) a brief description of duties performed.

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

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

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

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

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

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

EXHIBIT 3

PROVIDER AGREEMENT

1. ALL OF THE STATEMENTS MADE BY ME ON THIS APPLICATION AND ALL INFORMATION CONTAINED IN MY SUPPORTING PROVIDER QUALIFICATION DOCUMENTATION IS TRUE AND CORRECT.

2. I ACKNOWLEDGE THAT I CAN PERFORM ALL STANDARDS AND DUTIES FOR THE SERVICES I AM APPLYING FOR, AS STATED IN THE PROVIDER MANUAL.

3. I WILL IMMEDIATELY NOTIFY THE DEPARTMENT IF ANY INFORMATION PROVIDED BY ME ON THIS APPLICATION CHANGES.

4. I WILL MAINTAIN CURRENT STANDING WITH RESPECT TO ANY LICENSE AND/OR CERTIFICATION REQUIREMENTS ESTABLISHED BY THE DEPARTMENT FOR MY ABI PROVIDER TYPE AND SERVICE SPECIALTY.

5. I WILL IMMEDIATELY NOTIFY THE DEPARTMENT IF SUCH LICENSES AND/OR CERTIFICATIONS EXPIRE, ARE REVOKED, SUSPENDED OR OTHERWISE TERMINATED FOR ANY REASON.

6. I WILL PROVIDE ALL SERVICES IN ACCORDANCE WITH THE TERMS OF THE ABI WAIVER PARTICIPANT'S APPROVED SERVICE PLAN.

7. THE RATE PAID BY THE DEPARTMENT FOR THE PERFORMANCE OF ABI WAIVER SERVICES IS THE COMPLETE PAYMENT IN FULL FOR ALL SERVICE(S), GOODS OR PRODUCTS DELIVERED TO ELIGIBLE ABI WAIVER PARTICIPANTS.

8. EXCEPT FOR AUTHORIZED CO-PAYMENTS MADE BY ELIGIBLE WAIVER PARTICIPANTS, THE DEPARTMENT'S PAYMENTS TO ME FOR THE PERFORMANCE OF ABI SERVICES CONSTITUTE SOLE AND COMPLETE PAYMENT IN FULL.

9. I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES AND GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTAITVES OF THE DEPARTMENT UPON REQUEST.

10. I ACKNOWLEDGE THAT I MAY BE SUSPENDED OR TERMINATED FROM THE ABI PROVIDER REGISTRY IF I AM FOUND BY THE DEPARTMENT TO HAVE ENGAGED IN FRAUDULENT OR ABUSIVE PROGRAM SERVICES.

11. I AGREE TO NOT USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) OTHER THAN AS PERMITTED OR AS REQUIRED BY LAW AND TO USE APPROPRIATE SAFEGUARDS TO PREVENT IMPROPER USE OR DISCLOSURE OF PHI.

12. I AM OVER 18 YEARS OF AGE.

Tariq M. Abdulaziz
PROVIDER NAME (please print individual or agency name)

[signature] 01/15/04
AUTHORIZED SIGNATURE (individual or agency rep.) DATE

ALL PAPERWORK MUST BE SUBMITTED PRIOR TO ATTENDING THE TRAINING

MARDER & DEFELICE LAW OFFICES, LLC
ATTORNEYS AT LAW
76 SOUTH FRONTAGE ROAD
VERNON, CONNECTICUT 06066-5518

I. DAVID MARDER
JOEL A. DEFELICE

TELEPHONE
(860) 871-8000
FACSIMILE -
(860) 871-8307
E-MAIL
office@marder-law.com

May 22, 2014

Joseph A. Smiga, Staff Attorney
CT Dept. of Social Services
Office of Legal Counsel, Regulations
and Administrative Hearings
25 Sigourney Street, 12th Floor
Hartford, CT 06106

RE: Tariq Abdulaziz, PhD MS MBA
Your Letter Dated May 20, 2014

Dear Attorney Smiga:

In your letter to me dated May 20, 2014, you cite item 9 of the provider agreement dated January 15, 2004, which we don't contest. Our issue is that item 9 does not set out as of January 15, 2004, what standards will be used in the review.

Your May 20, 2014, letter goes on to cite Section 17b-260a-16 of the Regulations of Connecticut State Agencies, noticed on March 26, 2013, and effective on April 1, 2013.

My research of your citation developed the following:

1. The Connecticut Law Journal Notice of Intent published on March 26, 2013, makes reference to Section 17b-260b not 17b-260a;

2. The publication as to Section 17b-260b was not made within 20 days after their adoption;

3. More than 15 persons commented upon the proposed regulations but no public hearing has been held;

4. In the DSS responses to public comments regarding "ABI Waiver Program" dated October 4, 2013, the following comment and response was made:

"5. Effective date of April 1, 2013

Comment: The Commentator also voiced concerns regarding the April 1, 2013 effective date of the policy/proposed regulation and the ability of providers to comply with some of the provisions on short notice.

Response: As previously stated above, there are provisions of the proposed regulation that are still being developed. However, once the Department has had an opportunity to specify such details, providers will be notified and given a reasonable amount of time to comply with these requirements.".

Please confirm that to date all the specifics of the proposed regulations have not yet been developed; the providers have not been notified of any such details and given a reasonable amount of time to comply; and that Section 17b-260a has not been noticed in the Connecticut Law Journal.

Furthermore, please advise as to the following:

1. Are there any financial costs associated with the audit;

2. The guidelines you cite in your letter of May 20, 2014, relating to Section 17b-260a-16 are not applicable for reasons cited above.

If you will recall, in my initial letter of May 13, 2014, I raised concerns about authorizing regulations and standards of review. Your responses to the above would help clarify my concerns, and we can then discuss scheduling an audit.

Very truly yours,

I. David Marder

IDM/mb
cc: Tariq Abdulaziz, PhD MS MBA

STATE OF CONNECTICUT

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

May 20, 2014

I. David Marder, Esq.
Marder & DeFelice Law Office, LLC
76 South Frontage Road
Vernon, CT 06066-5518

Dear Attorney Marder,

The purpose of this letter is to respond to your letter, dated May 13, 2014, in which you seek information about the Department of Social Services' (the "Department") authority to review Tariq Abdulaziz's records.

As you know, on April 21, 2014, the Department notified Tariq Abdulaziz, that the Department would be conducting an on-site visit to review records supporting claims paid under the Acquired Brain Injury ("ABI") Medicaid Waiver Program. The Department and your client agreed that this review would take place on May 13, 2014. This date was postponed due to your request.

In its April 21, 2014 letter, the Department noted that its request to review your client's records was in accordance with item nine of the provider agreement your client signed on January 15, 2004. Item nine states that Tariq Abdulaziz "will maintain records that fully disclose services and goods rendered and/or delivered to ABI waiver participants. These records will be made available to authorized representatives of the Department upon request."

Additionally, section 17b-260a-16 of the Regulations of Connecticut State Agencies, which was noticed on March 26, 2013, and became effective on April 1, 2013, provides as follows:

> (a) Providers are required to retain records to document services submitted for Medicaid reimbursement for at least five years from the date the service or item was provided. Documentation shall include the following:
>
> (1) Individual's name and the signature of the individual or their legal representative;
> (2) provider's name and signature;
> (3) dates of service;
> (4) start time for each visit;
> (5) end time for each visit; and
> (6) a brief description of duties performed.

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

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

At this time, in accordance with the provider agreement your client signed and section 17b-260a-16 of the Regulations of Connecticut State Agencies, the Department is requesting immediate access to your client's records. The Department's Quality Assurance division will contact your client to schedule a time for the record review.

Regarding your client's requests for copies of service plans, it is my understanding that the Department has and will continue to be accommodating to your client's requests. Your client's requests for service plans, however, are not relevant to the records review authorized by the provider agreement and section 17b-260a-16 of the Regulations of Connecticut State Agencies and should not delay the records review.

Sincerely,

Joseph A. Smiga
Staff Attorney, DSS

Enc. ABI Regulations
Provider Agreement

PROVIDER AGREEMENT

1. ALL OF THE STATEMENTS MADE BY ME ON THIS APPLICATION AND ALL INFORMATION CONTAINED IN MY SUPPORTING PROVIDER QUALIFICATION DOCUMENTATION IS TRUE AND CORRECT.

2. I ACKNOWLEDGE THAT I CAN PERFORM ALL STANDARDS AND DUTIES FOR THE SERVICES I AM APPLYING FOR, AS STATED IN THE PROVIDER MANUAL.

3. I WILL IMMEDIATELY NOTIFY THE DEPARTMENT IF ANY INFORMATION PROVIDED BY ME ON THIS APPLICATION CHANGES.

4. I WILL MAINTAIN CURRENT STANDING WITH RESPECT TO ANY LICENSE AND/OR CERTIFICATION REQUIREMENTS ESTABLISHED BY THE DEPARTMENT FOR MY ABI PROVIDER TYPE AND SERVICE SPECIALTY.

5. I WILL IMMEDIATELY NOTIFY THE DEPARTMENT IF SUCH LICENSES AND/OR CERTIFICATIONS EXPIRE, ARE REVOKED, SUSPENDED OR OTHERWISE TERMINATED FOR ANY REASON.

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10. I ACKNOWLEDGE THAT I MAY BE SUSPENDED OR TERMINATED FROM THE ABI PROVIDER REGISTRY IF I AM FOUND BY THE DEPARTMENT TO HAVE ENGAGED IN FRAUDULENT OR ABUSIVE PROGRAM SERVICES.

11. I AGREE TO NOT USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) OTHER THAN AS PERMITTED OR AS REQUIRED BY LAW AND TO USE APPROPRIATE SAFEGUARDS TO PREVENT IMPROPER USE OR DISCLOSURE OF PHI.

12. I AM OVER 18 YEARS OF AGE.

TARIQ M. ABDULAZIZ
PROVIDER NAME (please print individual or agency name)

AUTHORIZED SIGNATURE (individual or agency rep.) 01/15/04 DATE

ALL PAPERWORK MUST BE SUBMITTED PRIOR TO ATTENDING THE TRAINING

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE • HARTFORD, CONNECTICUT 06105

August 22, 2014

I. David Marder, Esq.
Marder & DePelice Law Office, LLC
76 South Frontage Road
Vernon, CT 06066-5518

Re: NeuroStrategies, Inc. – Tariq Abdulaziz

Dear Attorney Marder,

The purpose of this letter is to respond to your correspondence to me, dated May 22, 2014 and August 6, 2014.

In your August 6, 2014 letter, you question social workers' requests for monthly reports for 2013. Such requests should not have been made.

Next, you want to know about the audit standards that apply to the Department's review of your client's records. It is not clear what you mean by this question. The Department conducted a records review in accordance with the Provider Agreement your client signed on January 15, 2004 and section 17b-260a-16(b) of the regulations, which states that, "[u]pon written request presented to the provider, the department...may be given immediate access to, and permitted to review and copy any and all records and documentation used to support claims billed to Medicaid." As mentioned in my letter to you, dated May 28, 2014, the purpose for this records review is to review the documentation that supports the services your client claimed to have provided, for which the Department paid.

By signing the Provider Agreement, your client has agreed to maintain records that fully disclose services and goods rendered and/or delivered to ABI Waiver participants. Your client will be held to that standard. Moreover, for services provided on or after April 1, 2013, your client will be held to the standards outlined in section 17b-260a-16(a) of the regulations. This section provides as follows:

> 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.

In your May 22, 2014 letter, you also ask for information about the adoption of the Department's ABI waiver regulations. These are new policies necessary to conform to the requirement of an approved federal waiver, and the statute is clear that the Department may operate under them until the time final regulations are effective. *See* Conn. Gen. Stat. § 17b-10(b). The Department published its Notice of its Intent to adopt the regulations on March 26, 2013, five days prior to the policy going into effect on April 1, 2013. The Department, therefore, complied fully with section 17b-10(b) of the Connecticut General Statutes.

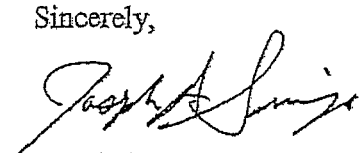
Moreover, contrary to the representation in your letter, the Department received only one set of comments to the proposed regulation, and did not get any requests for a hearing. Accordingly, pursuant to section 4-168(a) of the Connecticut General Statutes, there was no reason for the Department to hold a hearing on these proposed regulations.

You point out that there is a typographical error in the Notice of Intent ("NOI"), i.e., the NOI cites to section 17b-260b, rather than section 17b-260a, of the Connecticut General Statutes as the statutory authority for the proposed regulations. Nevertheless, it is clear that the NOI is announcing the Department's intent to adopt regulations for the ABI waiver program, as confirmed by multiple references to the ABI waiver program in the opening paragraph of the NOI and in the Statement of Purpose. There is no possibility that, despite the incorrect citation, anyone reading this NOI would misunderstand its meaning. The Department provided sufficient notice to the public of its intention to adopt regulations concerning the ABI waiver program, and that the implementation date for the proposed regulation was April 1, 2013.

Finally, you asked for confirmation that "the specifics of the proposed regulations have not yet been developed" indicating that "the providers have not been notified of any such details and given a reasonable amount of time to comply." Providers have been duly notified of the regulatory requirements and have been given ample time to comply; the regulations were noticed over a year ago.

As noted in the Department's response to comments, there are some aspects of the proposed regulation that are still being developed. As also noted, once the Department has specified such details, it will notify providers and give them a reasonable amount of time to comply with any new requirements.

Sincerely,



Joseph A. Smiga
Staff Attorney, DSS

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE • HARTFORD, CONNECTICUT 06105

September 12, 2014

I. David Marder, Esq.
Marder & DeFelice Law Office, LLC
76 South Frontage Road
Vernon, CT 06066-5518

Re: NeuroStrategies, Inc. – Tariq Abdulaziz

Dear Attorney Marder:

The purpose of this letter is to respond to your correspondence to me, dated September 3, 2014.

You continue to raise issues relating to the adoption of the ABI waiver regulations, 17b-269a-1 to 17b-269a-17, inclusive, of the Regulations of Connecticut State Agencies. I have already explained the legal basis for the Department's position that these proposed regulations were properly noticed and remain valid while the Department is in the process of finalizing them. I have addressed your concerns point-by-point in other correspondence; there is no need for me to repeat my explanations.

If the Department intends to take any adverse action against your client, your client will be notified.

Thank you for your cooperation.

Sincerely,

Joseph A. Smiga
Staff Attorney, DSS

EXHIBIT 6

Stauning, Lara

From: Hyman, Phyllis E.
Sent: Thursday, March 07, 2013 2:19 PM
To: Stauning, Lara
Subject: RE: ABI Waiver Regulation

The statute says we must adopt as a regulation any new policy necessary to conform to a requirement of an approved federal waiver application. To me, this means that we need to write regulations to implement the waiver program, and that we can operate under the policy while it's in the process of becoming a regulation, as provided. In other words, if the waiver requires us to provide certain benefits and have certain eligibility requirements, we need to write a regulation that conforms to this requirement, and we may do so and implement prior to its full promulgation.

Are you reading this to say that there must be a requirement in the federal waiver application to write regulations? I don't read it that way.

Let me know if you want to discuss this.

Thanks.

-Phyllis

Hyman, Phyllis E.
Phyllis.Hyman@ct.gov

DSS
25 Sigourney St.
Hartford, CT 06106
860-424-5266 Direct

www.ct.gov/dss

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From: Stauning, Lara
Sent: Wednesday, March 06, 2013 2:08 PM
To: Hyman, Phyllis E.
Subject: ABI Waiver Regulation

Hi Phyllis,

I am drafting up the NOI for the ABI regulation and I wanted to include the statutory authority for operating the regulation while in the process of adopting and provide an effective date. So far, I haven't been able to figure out the basis for treating the ABI waiver regulation as a 17b-10 regulation so I am not sure that we have the statutory authority to do so. For some reason I thought we had come up with an argument to support treating the regulation as a 17b-10, but there is no supporting language in the ABI waiver statute and I don't think it is covered by 17b-10 although waivers are mentioned in 17b-10(b).

The ABI waiver statute really provides no help:

"The Commissioner of Social Services shall seek a waiver from federal law to establish a Medicaid-financed, home and community-based program for individuals with acquired brain injury. Such waiver shall be submitted no later than October 1, 1995."

17b-10(b) provides,

> The department shall adopt as a regulation in accordance with the provisions of chapter 54, any new policy necessary to conform *to a requirement of an approved federal waiver application initiated in accordance with section 17b-8* and any new policy necessary to conform to a requirement of a federal or joint state and federal program administered by the department, including, but not limited to, the state supplement program to the Supplemental Security Income Program, but the department may operate under such policy while it is in the process of adopting the policy as a regulation, provided the Department of Social Services prints notice of intent to adopt the regulation in the Connecticut Law Journal within twenty days after adopting the policy. Such policy shall be valid until the time final regulations are effective.

Although the ABI waiver is a waiver initiated under 17b-8, neither the waiver application nor the federal statute (Sec.1915(c)) requires that the state adopt regulations. Maybe I am reading it too literally, but I don't think we have the authority to begin operating when the NOI is published as we had initially hoped. Please let me know what you think, maybe I am missing something?

Thanks! Lara

Lara K. Stauning, Staff Attorney
Department of Social Services
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Lara.stauning@ct.gov

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Fax: 860-424-5403

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

Roderick L. Bremby
Commissioner

Telephone
(860) 424-5053
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(860) 424-5057
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1-800-842-4524
Email
Commis.dss@ct.gov

Declaratory Ruling

Re: Petition for Declaratory Ruling by Tariq Abdulaziz

The Department of Social Services (the "Department") issues this declaratory ruling pursuant to the authority granted to administrative agencies in section 4-176 of the Connecticut General Statutes and sections 17-311-44 to 17-311-46, inclusive, of the Regulations of Connecticut State Agencies.

Procedural History

On December 9, 2014, Tariq Abdulaziz (the "Petitioner") filed a Petition for Declaratory Ruling. *See* Exhibit A, Petition for Declaratory Ruling. The questions set forth in the Petition for Declaratory Ruling are as follows:

1. Whether the regulations proposed by said Agency pursuant to Connecticut General Statutes §4-168, and being §17b-260a and §17b-260b were properly adopted pursuant to the Connecticut Uniform Administrative Procedure Act

2. Whether the regulations proposed by said Agency, pursuant to Connecticut General Statutes §4-168 and being §17b-99, were properly adopted.

3. Whether 17b-10 can be applied to the ABI Medicaid Waiver Program.

On December 30, 2014, the Department agreed to issue a declaratory ruling by May 29, 2015 in accordance with sections 4-176(e)(3) and 4-176(i) of the Connecticut General Statutes. *See* Exhibit B, Agreement to Issue Declaratory Ruling.

On February 20, 2015, the Petitioner filed two notices of deposition with the Department, in which he sought to depose two of the Department's employees, Lara Stauning and Dorian Long, and requested that they produce certain documents contained in the Schedule A of the notices of deposition. *See* Exhibit C, Notices of Deposition.

On March 4, 2015, the Department issued an Order in which it stated that no discovery, including the taking of a deposition, was permitted in relation to the Petition for Declaratory Ruling. *See* Exhibit D, Order dated March 4, 2015. The Department explained to the Petitioner that the declaratory ruling would be issued without any type of proceeding, per section 4-176(e)(3) of the Connecticut General Statutes, and even if there were a proceeding, the Connecticut Supreme Court has ruled that absent an express statutory or regulatory provision, there is no right to discovery in administrative proceedings. *See Pet v. Dep't of Health Servs.*,

207 Conn. 346, 357, 542 A.2d 672 (1988). Neither statutes nor the Department's regulations grant a party the right to discovery, including the taking of a deposition, in an administrative proceeding or in relation to a petition for a declaratory ruling.

On March 31, 2015, the Petitioner filed what he called an "Amended Petition for Declaratory Ruling." *See* Exhibit E, Amended Petition for Declaratory Ruling. The following questions were presented, in addition to the original three questions presented on December 9, 2014:

4. Whether the Department of Social Services (DSS), despite the non-adoption of regulations governing the Acquired Brain Injury/Traumatic Brain Injury Waiver Program (ABI Waiver), developed and applied certain published regulations in 1999 (1999 Operation Policy) and certain Social Work Policies.

5. Whether the Department of Social Services (DSS), in developing and applying said 1999 non-adopted regulations, distributed them to Licensing Regulation and Review Committee, the Office of Attorney General or the Secretary of State.

6. Whether the Department of Social Services (DSS) in applying said 1999 non-adopted regulations, impacted providers record keeping requirements and defined who is responsible for determining how services are provided to customers, without ever going through the regulatory adoption process.

7 Whether the Department of Social Services (DSS) in promulgating proposed regulations Connecticut General Statutes §17b-260a-1 to §17b-260a-17, with a Notice of Intent (NOI) published on March 26, 2013, in the Connecticut Law Journal with an effective date of April 1, 2013, despite reference errors as herein referred, failed to include in said NOI any reference to previous and current policies in effect and governing the ABI Waiver Program.

8. Whether the Department of Social Services (DSS) applied policies developed and/or in use by the Department of Social Work since 2009, but failed to publicize them to the general public; distribute them to consumers, providers, Licensing Regulation and Review Committee, the Attorney General or Secretary of State.

Ruling

Question One: Whether the regulations proposed by said Agency pursuant to Connecticut General Statutes §4-168, and being §17b-260a and §17b-260b were properly adopted pursuant to the Connecticut Uniform Administrative Procedure Act.

Sections 17b-260a and 17b-260b are statutes, not regulations. It will be assumed that the Petitioner is asking whether sections 17b-260a-1 to 17b-260a-17, inclusive, of the Regulations of Connecticut State Agencies (the "ABI Waiver Regulations") were properly adopted pursuant to the Connecticut Uniform Administrative Procedure Act ("UAPA").

The Petitioner asserts that the ABI Waiver Regulations were not properly adopted for the following reasons: A) the Department did not comply with the requirement of Connecticut General Statute §17b-10(b) to publish notice of intent to adopt the ABI Waiver Regulations within twenty day after adopting the policy; B) the Department did not comply with the requirement of Connecticut General Statutes §4-168(a) to publish notice of intent at least thirty days prior to adopting the ABI Waiver Regulations; C) the ABI Waiver Regulations have not been properly noticed because of a typographical error citing to §17b-260b, rather than §17b-260a, in the Connecticut Law Journal; and D) the Department did not submit the ABI Waiver Regulations to the Legislative Regulation Review Committee ("LRRC") within one hundred eighty (180) days of the notice's publication in the Connecticut Law Journal

The ABI Waiver Regulations have been properly adopted as follows:

A) The Department is operating under the ABI Waiver Regulations as a policy, in accordance with section 17b-10(b) of the Connecticut General Statutes. *See* Exhibit F, §17b-10(b) of the Connecticut General Statutes, in effect until June 30, 2013.

Section 17b-10(b) of the Connecticut General Statutes enables the Department to operate under a policy while the Department is in the process of adopting the policy as a regulation. *Id.* Until June 30, 2013, it provided that the Department

> shall adopt as a regulation in accordance with the provisions of chapter 54, any new policy necessary to conform to a requirement of an approved federal waiver application initiated in accordance with section 17b-8... but the department may operate under such policy while it is in the process of adopting the policy as a regulation, provided the Department of Social Services prints notice of intent to adopt the regulation in the Connecticut Law Journal within twenty days after adopting the policy. Such policy shall be valid until the time final regulations are effective. *Id* [1]

The ABI Waiver Regulations were promulgated as new policies necessary to conform to the requirement of an approved federal waiver. The statute in effect at the time was clear that, as long as the Department printed notice of its intent to adopt the policy as a regulation in the Connecticut Law Journal within twenty days after adopting the policy, the Department could operate under such policy until the final regulations become effective. *Id.*

In fact, the Department gave more notice than it was required to give. The Notice of Intent to Adopt Regulations ("NOI") was published in the Connecticut Law Journal on March 26, 2013, five days before the policy went into effect on April 1, 2013. *See* Exhibit G, Notice of Intent to Adopt Regulations. The Department, therefore, complied fully with section 17b-10(b)

[1] This section is virtually identical to the current version of section 17b-10(b) of the Connecticut General Statutes. The only difference is that that the Department is now required to post the policy on the eRegulations System prior to adopting the policy, rather than printing notice in the Connecticut Law Journal within twenty days after adopting the policy.

of the Connecticut General Statutes, which requires that notice be published no later than 20 days after adopting the policy.

B) Again, because the ABI Waiver Regulations were a new policy "necessary to conform to a requirement" of the approved ABI Waiver, the Department issued an NOI in accordance with section 17b-10(b) of the Connecticut General Statutes in effect at the time. *See* Exhibit F. As described in the previous response, the Department complied with the notice requirement in section 17b-10(b) of the Connecticut General Statutes.

C) The ABI Regulations have been properly noticed, even though there is a typographical error in the NOI that was published in the Connecticut Law Journal on March 26, 2013. The NOI cites to section 17b-260b, rather than to section 17b-260a of the Connecticut General Statutes as the statutory authority for the proposed regulations. *See* Exhibit G. Nevertheless, there is no question that the NOI is announcing the Department's intent to adopt regulations for the ABI waiver program. There are multiple references to the ABI waiver program in the opening paragraph of the NOI and in the Statement of Purpose. *Id.* Even with the incorrect statutory citation, therefore, there can be no confusion about the NOI's purpose. The Department provided sufficient notice to the public of its intention to adopt regulations concerning the ABI waiver program, and that the implementation date for the policy was April 1, 2013. *Id.* The typographical error, therefore, does not invalidate the policy under which the Department is operating.

D) The Department acknowledges that it did not submit the ABI Waiver Regulations to the LRRC within 180 days after publication of the NOI, nor did it notify the LRRC of the reasons for its noncompliance and the date by which it would submit the proposed regulations *See* Exhibit F The Department's failure to comply with this provision, however, is not a basis upon which to invalidate the policy under which the Department is operating.

The Connecticut Supreme Court has provided guidance concerning whether the time frame in a statute is mandatory in which case the failure to comply with it invalidates an agency's action:

> The test to be applied in determining whether a statute is mandatory or directory is whether the prescribed mode of action is the essence of the thing to be accomplished, or in other words, whether it relates to a matter of substance or a matter of convenience.... If it is a matter of substance, the statutory provision is mandatory. If, however, the legislative provision is designed to secure order, system and dispatch in the proceedings, it is generally held to be directory, especially where the requirement is stated in affirmative terms unaccompanied by negative words... Such a statutory provision is one which prescribes what shall be done but does not invalidate action upon a failure to comply." (Citations omitted; internal quotation marks omitted.) *Jones v Mansfield Training School,* 220 Conn. 721, 727, 601 A.2d 507 (1992). A reliable guide in determining whether a statutory provision is directory or mandatory is whether the provision is accompanied by language that expressly invalidates any action taken after noncompliance with the

provision. *Leo Fedus & Sons Construction Co. v. Zoning Board of Appeals,* 225 Conn. 432, 440, 623 A.2d 1007 (1993).

Katz v. Comm'r of Revenue Servs., 234 Conn. 614, 617, 662 A.2d 762, 764 (1995). There is nothing in section 17b-10 of the Connecticut General Statutes indicating that, if the Department failed to comply with the 180-day period, its regulation would become invalid. Accordingly, although the legislature may have intended for these matters to proceed expeditiously, there is nothing in the statute to indicate that it intended the draconian remedy of invalidating the operational policy, which has the effect of a regulation.

For all of the reasons set forth above, the ABI Waiver Regulations have been properly noticed and are in effect while the Department is in the process of final adoption.

Question Two: Whether the regulations proposed by said Agency, pursuant to Connecticut General Statutes §4-168 and being §17b-99, were properly adopted.

Section 17b-99 is a statute, not a regulation. It will be assumed that the Petitioner is asking whether proposed sections 17b-99(d)-1 to 17b-99(d)-6, inclusive, were properly adopted.

There are currently no regulations in effect for section 17b-99 of the Connecticut General Statutes. Although the Department has presented a proposed regulation to implement this section to the LRRC, the LRRC rejected it without prejudice, despite the Legislative Commissioner's Office's recommendation for approval. Accordingly, a declaratory ruling cannot be issued on the validity of a regulation that has not yet been adopted.

Contrary to the Petitioner's claim, the Department does not rely on regulations to extrapolate findings of overpayments against providers. Rather, section 17b-99(d) (3) of the Connecticut General Statutes authorizes the Department to extrapolate findings of overpayment under certain circumstances The Department acts in accordance with the statute when it extrapolates overpayments. *See* Conn. Gen. Stat. §17b-99.

Question Three: Whether 17b-10 can be applied to the ABI Medicaid Waiver Program.

Yes, section 17b-10(b) of the Connecticut General Statutes is applicable to the promulgation of regulations under the ABI Waiver Program. As stated above, section 17b-10(b) of the Connecticut General Statutes provides that the Department shall adopt as a regulation, in accordance with the provisions of chapter 54, any new policy necessary to conform to a requirement of an approved federal waiver application initiated in accordance with section 17b-8. *See* Exhibit F.

The ABI Waiver Program operates under an approved federal waiver which was initiated in accordance with section 17b-8 of the Connecticut General Statutes. The ABI Waiver Regulations were promulgated as new policies necessary to conform to the requirements of that waiver. Section 17b-10(b) of the Connecticut General Statutes, therefore, is applicable to regulations promulgated pursuant to the ABI Waiver.

Questions Four – Eight:

The Department has determined that questions four through eight do not constitute questions that meet the standard for questions that are properly answered through issuance of a declaratory ruling.

Section 4-176(a) of the Connecticut General Statutes provides that any person may petition a state agency for a declaratory ruling "as to the validity of any regulation, or the applicability to specified circumstances of a provision of the general statutes, a regulation, or a final decision on a matter within the jurisdiction of the agency." *See* Conn. Gen. Stat. §4-176(a). These are the "ground rules" or standards that a petitioner must meet for bringing a petition for a declaratory ruling before a state agency. *Peruta v Comm'r of Pub. Safety*, 128 Conn. App. 777, 785, *cert denied*, 302 Conn. 919 (2011).

In Peruta, the Appellate Court reviewed the trial court's granting of the Department of Public Safety's motion to dismiss the plaintiff's action for declaratory judgment for lack of subject matter jurisdiction. The plaintiff in that case emailed nine questions to the Department of Public Safety, and later delivered a document with the same questions.[2] The Department of Public Safety's legal affairs unit sent the plaintiff a letter stating that it was "unable to provide answers to his questions" and suggested that he seek the advice of an attorney. The plaintiff then filed the declaratory judgment action.

The Superior Court had granted the Department of Public Safety's motion to dismiss, finding that the Plaintiff had failed to exhaust his administrative remedies by not first requesting a declaratory ruling from the Department of Public Safety. *Id* at 779. It ruled that the email the Plaintiff sent to the Department of Public Safety with nine questions regarding the carrying of a firearm was not a valid petition for a declaratory ruling. *Id.*

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[2] In his e-mail, the plaintiff asked the following questions (1) "What state statute(s), regulation(s), policies or case law(s) mandates concealment of a firearm while being carried by an individual in possession of a valid license to carry same?"; (2) "What state statute(s), regulation(s), policies or case law(s) prevents the wearing of an exposed firearm while being carried by an individual in possession of a valid license to carry same?"; (3) "What state statute(s), regulation(s), policies or case law(s) establish the standards for concealment of a firearm while being carried by an individual in possession of a valid license to carry same?"; (4) "What state statute(s), regulation(s), policies or case law(s) establishes the simple act of carrying of a holstered firearm, by an individual in possession of a valid permit/license to carry same, into a restaurant as an element of a crime?" (5) "What state statute(s), regulation(s), policies or case law(s) establishes the simple act of carrying of a holstered firearm, by an individual in possession of a valid permit/license to carry same, into an establishment that serves alcoholic beverages, (such as a bar or restaurant), as an element of a crime?"; (6) "Is there any existing criminal case law where the simple act of carrying of a concealed holstered firearm, (by an individual in possession of a valid permit/license to carry same), into a restaurant meets the necessary elements contained in [General Statutes §] 53a–181—Breach of peace in the second degree?"; (7) "Is there any existing criminal case law on the simple act of carrying of an exposed, holstered firearm, (by an individual in possession of a valid permit/license to carry same), into a restaurant meets the necessary elements contained in [§] 53a–181—Breach of the peace in the second degree?", (8) "What state statute(s), regulation(s), policies, case law(s) or situations grant or provide the authority to a local police officer or department to seize and/or confiscate a pistol permit from the holder of same?"; (9) "What state statute(s), regulation(s), policies, case law(s) or situations grant or provide the authority to a local police officer to determine 'MATURE JUDGMENT' as the phrase pertains to carrying a firearm by a person permitted or licensed to do so?"

The Appellate Court affirmed the trial court's decision, ruling that the Plaintiff's email was not a petition for a declaratory ruling -- it needed to "set forth specific circumstances and seek to have the department apply a regulation, statute or final decision on a matter in its jurisdiction to those specific circumstances," and it failed to do that. *Id.* at 785- 786.

The Court stated:

> [T]hrough a series of nine questions, the plaintiff asked the department to *identify* and to provide the source of legal authority preventing, in whole or in part, a valid permit holder from carrying a firearm in the state, openly or exposed, and from doing so in a 'restaurant' or 'an establishment that services alcoholic beverages....' The plaintiff did not seek to have the department apply or examine a regulation or statute with respect to a specified set of circumstances."

Id. at 785-86 (emphasis in original).

Similar to the questions at issue in Peruta, questions four through eight posed by the Petitioner in his Amended Petition for Declaratory Ruling simply ask for information. They do not question the validity of a regulation nor do they seek to have the Department apply or examine a regulation or statute with respect to a specified set of circumstances. Accordingly, the Department is deciding not to issue a declaratory ruling on questions four through eight because these questions do not constitute a petition for a declaratory ruling. *See* Conn. Gen. Stat. 4-176(e)(5).

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

Roderick L. Bremby
Commissioner of Social Services

May 28, 2015

Certificate of Mailing Form

Declaratory Ruling – Tariq Abdulaziz

I certify that a copy of the above referenced Declaratory Ruling was sent to the following person(s) on:

May 29, 2015.

[ ] Hand Delivered
[X] Mailed
[ ] Other (specify)

Petitioner:

Tariq Abdulaziz
23 Kate Way
Windsor Locks, CT 06096

Petitioner's Attorney:

I. David Marder
76 South Frontage Road
Vernon, CT 06066

Joseph A. Smiga

5/29/15
Date

DOCKET NO: HHBCV156029943S

SUPERIOR COURT

NEUROSTRATEGIES, INC. Et Al
V.
CT DEPARTMENT OF SOCIAL SERVICES
Et Al

JUDICIAL DISTRICT OF NEW BRITAIN
AT NEW BRITAIN

11/25/2015

ORDER

ORDER REGARDING:
08/26/2015 107.00 MOTION TO DISMISS PB 10-30

All Counsel Present.

The foregoing, having been heard by the Court, is hereby:

ORDER: GRANTED

Granted for the reasons stated in court.

414999

Judge: CARL J SCHUMAN

77

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Attorney/Firm: AAG HUGH BARBER (085484) E-Mail: hugh.barber@ct.gov Logout

HHB-CV16-6034437-S NEUROSTRTAEGIES, INC. Et Al v. CT DEPARTMENT OF SOCIAL SERVICES Et Al

Prefix/Suffix: [none] **Case Type:** A90 **File Date:** 08/08/2016 **Return Date:** 08/23/2016

Case Detail Notices History Processing Scheduled Court Dates Help Manual

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Information updated as of: 09/14/2016

Case Information

Case Type: A90 - Appeals - All other
Court Location: New Britain JD
List Type: ADMINISTRATIVE APPEALS (AA)
Trial List Claim: 08/09/2016
Last Action Date: 09/14/2016 (The "last action date" is the date the information was entered in the system)

Disposition Information

Disposition Date:
Disposition:
Judge or Magistrate:

Party & Appearance Information

Party			No Fee Party	Category
P-01	NEUROSTRTAEGIES, INC			Plaintiff
	Attorney: MICHAEL T KOGUT (419933) 75 MARKET PLACE SPRINGFIELD, MA 01103	File Date 08/08/2016		
P-02	TARIQ ABDULAZIZ, PH.D., M.S., M.S., MBA			Plaintiff
	Attorney: MICHAEL T KOGUT (419933) 75 MARKET PLACE SPRINGFIELD, MA 01103	File Date 08/08/2016		
D-01	CT DEPARTMENT OF SOCIAL SERVICES			Defendant
	Attorney: AAG HUGH BARBER (085484) ATTY GEN-HEALTH PO BOX 120 HARTFORD, CT 06141	File Date 08/30/2016		
D-02	RODERICK L. BREMBY			Defendant
	Attorney: AAG HUGH BARBER (085484) ATTY GEN-HEALTH PO BOX 120 HARTFORD, CT 06141	File Date 08/30/2016		

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78

case by choosing the link next to the order or selecting "Notices" from the tab at the top of this page and choosing the link to the notice on this website Pleadings and other documents that are paperless can be viewed during normal business hours at any Judicial District courthouse and at many geographical area courthouses Any pleadings or documents that are ***not paperless*** can be viewed during normal business hours at the Clerk's Office in the Judicial District where the case is Some pleadings, orders and other documents are protected by court order and can be seen at the Clerk's Office in the Judicial District where the case is only by attorneys or parties on the case

Motions / Pleadings / Documents / Case Status

Entry No	File Date	Filed By	Description	Arguable
	08/30/2016	D	APPEARANCE Appearance	
100 30	08/08/2016	P	SUMMONS AND COMPLAINT	No
101 61	08/09/2016	C	CERTIFICATE OF CLOSED PLEADINGS AND CLAIM FOR TRIAL LIST	No
102 00	09/08/2016	D	CERTIFIED LIST OF PAPERS IN THE RECORD PB 14-7B(b) NEW	No
103 00	09/08/2016	D	NOTICE NEW OF SUBMISSION OF THE RECORD	No
104 00	09/08/2016	D	RECORD IN ADMINISTRATIVE APPEALS NEW	No
105 00	09/14/2016	D	RECORD IN ADMINISTRATIVE APPEALS NEW Record Pages 501-1959	No

Scheduled Court Dates as of 09/13/2016

HHB-CV16-6034437-S - NEUROSTRTAEGIES, INC. Et Al v. CT DEPARTMENT OF SOCIAL SERVICES Et Al

#	Date	Time	Event Description	Status
1	09/22/2016	3 30PM	Pretrial Conference	Proceeding

Judicial ADR events may be heard in a court that is different from the court where the case is filed To check location information about an ADR event, select the **Notices** tab on the top of the case detail page

Matters that appear on the Short Calendar and Family Support Magistrate Calendar are shown as scheduled court events on this page The date displayed on this page is the date of the calendar

All matters on a family support magistrate calendar are presumed ready to go forward

The status of a Short Calendar matter is not displayed because it is determined by markings made by the parties as required by the calendar notices and the civil or family standing orders Markings made electronically can be viewed by those who have electronic access through the Markings History link on the Civil/Family Menu in E-Services Markings made by telephone can only be obtained through the clerk's office If more than one motion is on a single short calendar, the calendar will be listed once on this page You can see more information on matters appearing on Short Calendars and Family Support Magistrate Calendars by going to the Civil/Family Case Look-Up page and Short Calendars By Juris Number or By Court Location

Periodic changes to terminology that do not affect the status of the case may be made.
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79

information will be displayed for the shorter period Under the Federal Violence Against Women Act of 2005, cases for relief from physical abuse, foreign protective orders, and motions that would be likely to publicly reveal the identity or location of a protected party may not be displayed and may be available only at the courts

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80

RETURN DATE: AUGUST 23, 2016	:	SUPERIOR COURT
NEUROSTRATEGIES, INC. AND TARIQ ABDULAZIZ, Ph.D., M.S., M.S., MBA	:	J. D. OF NEW BRITAIN
VS	:	AT NEW BRITAIN
CT DEPARTMENT OF SOCIAL SERVICES; RODERICK L. BREMBY, COMMISSIONER DEPARTMENT OF SOCIAL SERVICES	:	AUGUST 8, 2016

ADMINISTRATIVE APPEAL

Pursuant to Section 4-183(a) of the Connecticut General Statutes, plaintiffs/appellants NeuroStrategies, Inc. and Tariq Abdulaziz, Ph.D , M.S., M.S., MBA (hereinafter referred to collectively as "Plaintiffs"), as aggrieved parties to a Connecticut agency decision, hereby appeal the final decision of the defendant/appellee, Department of Social Services made through its designee Roderick L. Bremby, Commissioner of the Department of Social Services all collectively referred to as the "Department" as set forth in its Declaratory Ruling date June 24, 2016 [1]

1. In its declaratory ruling, DSS stated that effective July 1, 2016 a provider signature only needs to be obtained once. Plaintiffs appeal this declaratory ruling relative to the Department's interpretation of its regulations adopted April 1, 2013. The Department's regulation, 17b-260a-16(a)(1). at best, is vague. Plaintiffs have spent a tremendous amount of time attempting to obtain signatures on an ongoing basis. Plaintiff, Tariq Abdulaziz, Ph.D., M.S , M.S., MBA has spent a tremendous amount of time and money in an attempt to obtain signatures as vaguely described and acknowledged by DSS in its ruling (See 17b-260a-16(a)(1) below):

Sec. 17b-260a-16. Client Documentation and Provider Reporting

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

[1] All references contained in this administrative appeal refer and relate to the Department's "Declaratory Ruling" signed by Commissioner Roderick L Bremby, dated June 22, 2016 and post marked by the United States Postal Service on June 24, 2016.

81

(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.

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

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

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

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

2. The Department in its declaratory ruling erroneously determined that the regulations adopted on April 1, 2013 were properly adopted which required the plaintiffs to document information that the plaintiffs were never required to document according to the plaintiffs' provider agreement. The provider agreement signed January 2004 required the following;

I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE GOODS AND SERVICES RENDERED AND I WILL MAKE RECORDS AVAILABLE TO REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST

The April 1, 2013 policies required the following documentation

(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.

The plaintiffs were never required to document these items and spent tremendous time and money documenting the information outlined in the April 1, 2013 regulations.

3 The January 2004 regulations did not require the plaintiffs to provide monthly reports and written updates. The April 1, 2013 regulations required written updates and monthly reports and providers were not allowed to invoice for the reports. In addition, plaintiffs have been informed that they will be terminated from the program if they do not provide written updates and reports

4. The department misled the Center for Medicaid and Medicare Services ("CMS"), the federal agency granting such waiver, the plaintiffs, and the superior court in the original administrative appeal when it indicated that it conducts audits. The question from CMS was in the ABI Waiver application. It was not a general question about other waiver programs or any other DSS program but was very specific to the ABI Waiver program. The plaintiffs had an "ad hoc" review or records review which was conducted by DSS. Which explained as follows:

These audits include ad hoc reviews when the Department's fiscal intermediary or DSS Social Work Services staff alert QA to potential issues.
(ABI I Renewal Application, October 6, 2006, Petitioner's Exhibit 51)[2]

John McCormick, Director of the department's Office of Quality Assurance, ("QA") in a deposition held July 20, 2016 at the Office of the Connecticut Attorney General, testified under oath, that the records review conducted of the plaintiffs on June 16, 2014 was conducted in response to a report from the fiscal intermediary of a high frequency of billing. In November 2015 the New Britain District of the Superior Court ruled that this was a "records review" and not an audit.

These audits include ad hoc reviews when the Department's fiscal intermediary or DSS Social Work Services staff alert QA to potential issues.
(ABI I Renewal Application, October 6, 2006, Petitioner's Exhibit 51)

The plaintiffs properly acted based on the information in the department's application for the ABI Waiver. In addition, despite the departments' claim that it does not have audit regulations, the department conducted audits of providers on the ABI Waiver (Exhibits 65A-65H). In addition, DSS employed CGS 17b-99 and used extrapolation against these providers and exacted fines

[2] References to Exhibits refer to those on file in Administrative Appeal Docket No. HHB-CV15-6029943-S in New Britain Superior Court.

The plaintiffs reasonably believed that the records review as indicated by the department were audits as in their words "audits" include "ad hoc" reviews or so-called "record reviews."

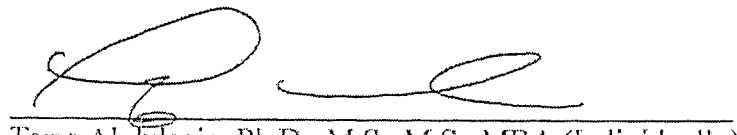
The plaintiffs, herein, were aggrieved and continue to be aggrieved by the arbitrary and capricious actions against them and as petitioners to this court, have been aggrieved as follows:

1. The department, by adopting new regulations which changed the documentation requirements in item number nine of the new provider agreement within the regulations, without proper notice and without a hearing in violation of state and federal law;

2. The department, by requiring these plaintiffs to pursue signatures that were not required prior to the illegal and unlawful adoption of the new regulations in violation of state and federal law;

3 The department, by unlawfully and arbitrarily requiring the documentation of "time in and out" which had never been required previous to the promulgation of the newly and unlawfully adopted regulations;

4. The department, by requiring completion of monthly reports and written updates which, again, had never been required previous to the promulgation of the newly and unlawfully adopted regulations,.



Tariq Abdulaziz, Ph D., M S., M.S., MBA (Individually)

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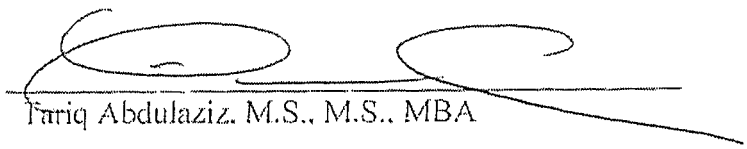


Tariq Abdulaziz, Ph.D., M.S , M.S , MBA
Duly appointed representative of NeuroStrategies, Inc.

NeuroStrategies, Inc.
Second Floor, Suite 8
91 Schraffts Drive
Waterbury, Connecticut 06705
(860) 377-0641 Voice/(860) 831-1044 Fax
tariqabdulaziz@neurostrategies info

CERTIFICATION

I, Tariq Abdulaziz, Ph.D., M.S., M.S., MBA hereby certify that, individually and as duly appointed representative of NeuroStrategies, Inc., caused this appeal of a final agency decision/declaratory ruling to be served upon the parties in this action by certified mail, return receipt requested, postage prepaid with the United States Postal Service in accordance with C G S Sec 4-183(c) on August 7, 2016



Tariq Abdulaziz, M.S., M.S., MBA

81 d

DOCKET NO. HHB-CV16-6034437-S	:	SUPERIOR COURT
NEUROSTRATEGIES, INC., Et Al	:	JUDICIAL DISTRICT OF NEW BRITAIN
v.	:	
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES, ET AL	:	SEPTEMBER 7, 2016

INDEX TO ADMINISTRATIVE RECORD

Pursuant to Conn. Gen. Stat. § 4-183(g), the defendants, Connecticut Department of Social Services and Roderick L. Bremby, Commissioner, submit the following documents as constituting the entire record of the proceedings before the Department in this matter.

	PAGES
1. Request for Declaratory Ruling, dated 12/28/2015	**1 - 201**
2. Attachments to Request for Declaratory Ruling, dated 12/28/2015	**202 – 1,853**
3. Emails Submitted for Inclusion in Record, dated 1/6/2016-1/31/2016	**1,854 – 1,896**
4. Agreement to Issue Declaratory Ruling, dated 2/23/2016	**1,897**
5. Declaratory Ruling, dated 6/22/2016	**1,898 - 1959**

The above and foregoing is hereby certified by the undersigned as constituting the entire record of proceedings for Neurostrategies Inc., Et. al., v. Connecticut Department of Social Services, Et Al.

Michael Slitt
Staff Attorney
Connecticut Department of Social Services

9/6/16
Date

82

REQUEST FOR DECLARATORY RULING

The undersigned petitions the Commissioner of Social Services for a Declaratory Ruling pursuant to Connecticut General Statutes 4-176 as amended.

The undersigned challenges the validity and applicability of each of the following regulations as they relate to the undersigned;

Connecticut General Statues 17b-260a-5(3)(B),
Connecticut General Statutes 17b-260a-16(a)(1),
Connecticut General Statutes 17b-260a-16(a)(4),
Connecticut General Statutes 17b-260a-16(a)(5),
Connecticut General Statutes 17b-260a-16(a)(6),
Connecticut General Statutes 17b-260a-16(b),
Connecticut General Statutes 17b-260a-16(c),
Connecticut General Statutes 17b-260a-16(d), and
Connecticut General Statutes 17b-260a-16(e)
Connecticut General Statutes 17b-260a-17

The undersigned petitions the Commissioner of Social Services for a Declaratory Ruling pursuant to Connecticut General Statutes 4-176 as amended. The undersigned challenges the validity and applicability of re-credential policies "audit protocols" adopted and implemented by Department of Social Services against the Petitioner's on October 31, 2015 without legislative approval pursuant to Connecticut General Statutes 17b-99.

The undersigned petitions the Commissioner of Social Services for a Declaratory Ruling pursuant to Connecticut General Statutes 4-176 as amended. The Petitioner's challenge the validity and applicability of policies adopted December 1, 2015 as they apply to Cognitive Behavioral Programs, a service provided by the Petitioner's.

83

QUESTIONS

1. Did Department of Social Services print more than one notice in Connecticut Law Journal regarding the adoption of

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

   as required by Connecticut General Statues 17b-10(b) prior to July 1, 2013, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

2. Given that Department of Social Services adopted the following regulations on April 1, 2013,

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

   did Department of Social Services print a Notice in Connecticut Law Journal regarding said regulations on either April, 2, 2013, April 9, 2013 or April 16, 2013, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

3. Given that Department of Social Services adopted the following regulations on April 1, 2013,

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);
Connecticut General Statutes 17b-260a-16(a)(b);
Connecticut General Statutes 17b-260a-16(a)(c);
Connecticut General Statutes 17b-260a-16(a)(d); and
Connecticut General Statutes 17b-260a-16(a)(e);

did Department of Social Services print a Notice in Connecticut Law Journal regarding said regulations on February 26, 2013 or prior to February 26, 2013, as required by Connecticut General Statutes 4-168, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

4. Given that a printing of a Notice of Intent, 30 days prior to adoption of a regulation is required by Connecticut General Statutes 4-168, including

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);
Connecticut General Statutes 17b-260a-16(a)(b);
Connecticut General Statutes 17b-260a-16(a)(c);
Connecticut General Statutes 17b-260a-16(a)(d); and
Connecticut General Statutes 17b-260a-16(a)(e);

did Department of Social Services print a Notice in Connecticut Law Journal, for said regulations, on or prior to March 2, 2013, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

5. Given that a printing of a Notice, 20 days after adoption is required by Connecticut General Statutes 17b-10(b), prior to July 1, 2013, including

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);

Connecticut General Statutes 17b-260a-16(a)(b);
Connecticut General Statutes 17b-260a-16(a)(c);
Connecticut General Statutes 17b-260a-16(a)(d); and
Connecticut General Statutes 17b-260a-16(a)(e);

did Department of Social Services print a Notice in Connecticut Law Journal, for said regulations, after April 1, 2013 but not later than April 21, 2013, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

6. In its Notice of Intent printed on March 26, 2013, did Department of Social Services, disclose that "1999 non-promulgated policies" existed and were used to administer the Acquired Brain Injury/Traumatic Brain injury Waiver Program prior to adoption of regulations, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);
Connecticut General Statutes 17b-260a-16(a)(b);
Connecticut General Statutes 17b-260a-16(a)(c);
Connecticut General Statutes 17b-260a-16(a)(d); and
Connecticut General Statutes 17b-260a-16(a)(e);

7. Given that referencing the correct statutory authority, in a Notice of Intent, is required by Connecticut General Statutes 4-168, prior to July 1, 2013 including,

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);
Connecticut General Statutes 17b-260a-16(a)(b);
Connecticut General Statutes 17b-260a-16(a)(c);
Connecticut General Statutes 17b-260a-16(a)(d); and
Connecticut General Statutes 17b-260a-16(a)(e);

EG

did Department of Social Services, reference the correct statutory authority in the notice printed on March 26, 2013 for said regulations, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

8. Given that Connecticut General Statutes 17b-10(b) requires a federal conforming requirement to use said statute in adoption of

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

   did Department of Social Services provide a reference to the federal conforming requirement in its Notice of Intent printed on March 26, 2013, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

9. Given that Connecticut General Statutes 17b-10(b) requires, Department of Social Services to forward,

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

   to the Licensing Regulation and Review Committee (LRRC) within 180 days of adoption, did Department of Social Services forward said regulations by October 1, 2013, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

10. Given that Connecticut General Statutes 17b-10(b) requires, Department of Social Services to forward,

    Connecticut General Statutes 17b-260a-16(a)(1);
    Connecticut General Statutes 17b-260a-16(a)(4);
    Connecticut General Statutes 17b-260a-16(a)(5);
    Connecticut General Statutes 17b-260a-16(a)(6);
    Connecticut General Statutes 17b-260a-16(a)(b);
    Connecticut General Statutes 17b-260a-16(a)(c);
    Connecticut General Statutes 17b-260a-16(a)(d); and
    Connecticut General Statutes 17b-260a-16(a)(e);

    to the Licensing Regulation and Review Committee within 180 days of adoption, did Department of Social Services forward said regulations by October 1, 2014, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

11. Given that Connecticut General Statutes 17b-10(b) requires, Department of Social Services to forward,

    Connecticut General Statutes 17b-260a-16(a)(1);
    Connecticut General Statutes 17b-260a-16(a)(4);
    Connecticut General Statutes 17b-260a-16(a)(5);
    Connecticut General Statutes 17b-260a-16(a)(6);
    Connecticut General Statutes 17b-260a-16(a)(b);
    Connecticut General Statutes 17b-260a-16(a)(c);
    Connecticut General Statutes 17b-260a-16(a)(d); and
    Connecticut General Statutes 17b-260a-16(a)(e);

    to the Licensing Regulation and Review Committee within 180 days of adoption, did Department of Social Services forward said regulations by October 1, 2015, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

12. Did Petitioner's enter into a Provider Agreement, dated January 15, 2004 with Department of Social Services prior to adoption of the following regulations;

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);
Connecticut General Statutes 17b-260a-16(a)(b);
Connecticut General Statutes 17b-260a-16(a)(c);
Connecticut General Statutes 17b-260a-16(a)(d); and
Connecticut General Statutes 17b-260a-16(a)(e);

given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

and did the Petitioner's operate under the Provider Agreement until adoption of said regulations, on April 1, 2013

and did the Petitioner's have their Provider Agreement terminated upon adoption of Connecticut General Statutes 17b-260a-16 on April 1, 2013, but Petitioner's signed a new Provider Agreement on October 23, 2014

and did the Petitioner's operate under said Provider Agreement until signing a subsequent agreement on October 28, 2015, and were the 2014 and 2015 Provider Agreements violated by DSS upon adoption of December 1, 2015 policies that violate "Item 4" of each Agreement (2014 and 2015)

and are "documentation requirements", detailed in the January 15, 2004 Provider Agreement and October 23, 2014 and October 28, 2015 Provider Agreements, essentially identical with the October 23, 2014 and October 28, 2015 "documentation requirements" being exactly identical as outlined below on January 15, 2004,

> I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES/GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST

and in 2014 and 2015,

THE AGENCY WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES/GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST

13. Did Department of Social Services, in its Notice of Intent printed on March 26, 2013, or in regulations adopted on April 1, 2013, or in any communication distributed to the Petitioner's, make reference to the Petitioner's Provider Agreements signed on January 15, 2004; October 23, 2014; or October 28, 2015, and did Department of Social Services, disclose that said Provider Agreements are contingent upon any of the regulations adopted on April 1, 2013, with specific emphasis on the following regulations including

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);
Connecticut General Statutes 17b-260a-16(a)(b);
Connecticut General Statutes 17b-260a-16(a)(c);
Connecticut General Statutes 17b-260a-16(a)(d); and
Connecticut General Statutes 17b-260a-16(a)(e);

and did Department of Social Services indicate that either the 2004, 2014, or 2015 Provider Agreement(s) were modified, altered, terminated or dependent upon, future or previous adoption of said regulations adopted on April 1, 2013, and is their any explicit reference to the said regulations in any of the previously signed Provider Agreements or any reference in the 2013 Regulations adopted on April 1, 2013 to the previously signed Provider Agreements.

14. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement in which Item 9 of said Agreement, details documentation requirements as follows;

9d

I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES/GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST

and having provided CBP services on an ongoing basis both prior to April 1, 2013 and subsequent to April 1, 2013, are Petitioner's required to retain records (signature of the individual or their legal representative, start time for each visit, end time for each visit, a brief description of duties performed, and monthly reports and written updates) that were not required to be maintained, prior to adoption of regulation Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); and Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(d) adopted on April 1, 2013, are Petitioner's required to adhere to said regulations.

15. Are the Petitioners', as providers of Cognitive Behavior Programs (CBP), on the ABI/TBI Medicaid Waiver, having signed a Provider Agreement on January 15, 2004, and having provided CBP services on an ongoing basis prior and subsequent to April 1, 2013, required to provide

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

"immediate access", that was not required to be provided prior to adoption of regulation Connecticut General Statutes 17b-260a-16(b), on April 1, 2013 and said requirement is not included in the previously signed Provider Agreement. In addition, the authority to "review and copy any and all records and

documentation used to support claims billed to Medicaid" is not a condition of the Petitioner's previously signed provider agreement dated January 15, 2004.

16. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI/TBI Medicaid Waiver, having signed a Provider Agreement on January 15, 2004, and having provided CBP services on an ongoing basis prior and subsequent to April 1, 2013, required to provide

    "immediate access" to records at the time the written request is presented to the provider

    and given that "immediate access" to records at the time the written request is presented to the provider" was not required prior to adoption of regulation Connecticut General Statutes 17b-260a-16(c), on April 1, 2013, and is not included in the previously signed Provider Agreement.

17. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI/TBI Medicaid Waiver, having signed a Provider Agreement on January 15, 2004, and having provided CBP services on an ongoing basis prior and subsequent to April 1, 2013, required to provide

    monthly reports and written updates on the individual's progress in a form set forth by the department,

    and given that monthly reports and written updates on the individual's progress in a form set forth by the department, were not required prior to adoption of proposed regulation Connecticut General Statutes 17b-260a-16(d), on April 1, 2013, and is not included in the previously signed Provider Agreement (January 15, 2004)

18. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI/TBI Medicaid Waiver Program and having signed a Provider Agreement on January 15, 2004, and having provided CBP services on an ongoing basis prior and subsequent to April 1, 2013, subject to penalties

    suspension of payment for failure to provide monthly reports and written updates,

    as detailed in Connecticut General Statutes 17b-260a-16(e) adopted on April 1, 2013, given that suspension of payment for failure to comply with Connecticut General Statutes 17b-260a-16(a)(1) Connecticut General Statutes 17b-260a-16(a)(2) Connecticut General Statutes 17b-260a-16(a)(3) Connecticut General Statutes 17b-260a-16(a)(4) Connecticut General Statutes 17b-260a-16(a)(5) Connecticut General Statutes 17b-260a-16(a)(6) Connecticut General Statutes 17b-260a-16(b) Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); was not a consequence prior to adoption of Connecticut General Statutes 17b-260a-16(e) on April 1, 2013, and is not included in the previously signed Provider Agreement.

19. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes, 17b-260a-16(a)(1) on April 1, 2013, required to comply with Connecticut General Statutes 17b-260a-16(a)(1) if a participant chooses not to provide a signature for services submitted for Medicaid reimbursement, given that said regulatory requirement did not exist prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

20. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15 2004, a Provider Agreement that does not require a signature to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, required to comply with Connecticut General Statutes 17b-260a-16(a)(1) if a participant is physically unable to provide a signature for services submitted for Medicaid reimbursement, given that said regulatory requirement did not exist prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

21. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, required to comply with Connecticut General Statutes 17b-260a-16(a)(1), if a participant is conserved of person and is legally not permitted to provide a signature for services submitted for Medicaid reimbursement, given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

22. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, required to comply with Connecticut General Statutes 17b-260a-16(a)(1) if the participant is conserved of estate and is legally not allowed to provide a signature for services submitted for Medicaid reimbursement, given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

23. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15 2004, a Provider Agreement that does not require a signature of the individual

or their legal representative to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, required to comply with Connecticut General Statutes 17b-260a-16(a)(1) if the legal representative of the participant is not present to provide a signature for services submitted for Medicaid reimbursement, given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

24. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature of the individual or their legal representative to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, required to comply with Connecticut General Statutes 17b-260a-16(a)(1) if a participant is conserved of person and/or conserved of estate and their legal representative was not present during the time services were provided, given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

25. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature of the individual or their legal representative to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013 required to comply with Connecticut General Statutes 17b-260a-16(a)(1) if a participant may be conserved of person and/or conserved of estate and the legal representative is denied access during service delivery due to a request for privacy during service delivery, given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013

26. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15 2004, a Provider Agreement that does not require a signature of the individual or their legal representative to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-

16(a)(1) on April 1, 2013, required to spend time, resources, and incur financial losses in pursuit of a signature as is required in Connecticut General Statutes 17b-260a-16(a)(1), given said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

27. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature of the individual or their legal representative to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, allowed to submit a bill for reimbursement for time spent, resources expended, and any financial losses incurred in pursuit of the signature required in Connecticut General Statutes 17b-260a-16(a)(1) given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

28. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature of the individual to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, granted legal authority to compel individuals and/or their legal representative to provide a signature for services rendered, given that no such authority existed prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

29. Are the Petitioners', as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require "visit" required to determine to the best of their ability the definition of the term "visit" after adoption of Connecticut General Statutes 17b-260a-16(a)(4) and 17b-260a-16(a)(5) on April 1, 2013, given that the term "visit" as adopted in Connecticut General Statutes 17b-260a-16(a)(4) and 17b-260a-16 (a)(5) is not defined within Connecticut General Statutes 17b-260a-1 to Connecticut General Statutes 17b-260a-17, given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes 17b-260a-16(a)(5) on April 1, 2013.

30. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that references but does not specify "duties," either in the Provider Agreement or ABI/TBI Medicaid Provider Manual, required to determine to the best of their ability the definition of the term "duties" after adoption of Connecticut General Statutes 17b-260a-16(6) on April 1, 2013, given that the term "duties" as adopted in Connecticut General Statutes 17b-260a-16(a)(5) and Connecticut General Statutes 17b-260a-16 (a)(6) has not been defined, given that said requirement, did not exist prior to adoption of Connecticut General Statutes 17b-260a-16(a)(6).

31. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that references, but does not specify "duties," either in the Provider Agreement or ABI/TBI Medicaid Provider Manual, required to determine "to the best of their ability" the definition of the term "duties" after adoption of Connecticut General Statutes 17b-260a-16(6) on April 1, 2013, given that the term "duties" as adopted in Connecticut General Statutes 17b-260a-16(a)(5) and Connecticut General Statutes 17b-260a-16 (a)(6) is consistent with functions performed by employees and not independent contractors as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii), given that said requirement to define "duties" was not required prior to adoption of Connecticut General Statutes 17b-260a-16(a)(6).

32. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require documentation of "start time for each visit" and "end time for each visit" determined to be employees of either the participant, their legal representative, and/or State of Connecticut after adoption of Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes 17b-260a-16(a)(5) on April 1, 2013, given that the phrases "start time for each visit" and "end time for each visit" exercises behavioral control over the Petitioner's who are either self-employed or employed by the Petitioner (NeuroStrategies, Inc) and such control is consistent with tasks performed by employees and not self-employed entities and private agencies, as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii) and as said requirement did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes 17b-260a-16(a)(5) on April 1, 2013.

33. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not specify "when" services are to be delivered, required to provide a service at a time (within 30 days) determined by Department of Social Services as required in Connecticut General Statutes 17b-260a-16-5(3)(B) after adoption of Connecticut General Statutes 17b-260a-16-5(3)(B) on April 1, 2013, given that determining "when" services are provided exercises behavioral control over Cognitive Behavioral Programs providers who are either self-employed or employees of an agency and such control is consistent with tasks performed by employees and self-employed or agency employed individuals, in this case NeuroStrategies, Inc. and not Department of Social Services, as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii) and was not required prior to adoption of Connecticut General Statutes 17b-260a-16-5(3)(B) on April 1, 2013.

34. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not, require the signature of the individual or their legal representative (Connecticut General Statutes 17b-260a-16(a)(1), required to comply with said regulations, given that said requirement for purposes of reimbursement, exercises behavioral control over Petitioner's, places unreasonable burden on petitioner's to spend time and resources to obtain a signature, at a cost to the petitioner since "signature seeking: is not listed as a service, and many of the individuals on the ABI/TBI Medicaid Waiver are physically unable to sign, unwilling to sign, conserved of person, conserved of estate, conserved of person and estate, legally not authorized to sign, and conservators or legal representatives are not present during service provision, and services can be offered through digital communication and telephone, therefore making obtaining a signature an unreasonable expectation and given that the petitioner's as CBP providers are either self-employed or employees of an agency and such control is consistent with tasks performed by employees and not self-employed or agency employed individuals, except by the employing agency which is NeuroStrategies, Inc. and not Department of Social Services, as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii) and was not required prior to adoption of said regulation on April 1, 2013.

35. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require "start time for each visit" and "end time for each visit" (Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes 17b-260a-16(a)(5)) required to comply with

said regulations, given that monitoring of "time in and time out" for purposes of reimbursement exercises behavioral control over Petitioner's who are either self-employed or employees of an agency and such control is consistent with tasks performed by employees and not self-employed or agency employed individuals, except by the employing agency which is NeuroStrategies, Inc. and not Department of Social Services, as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii) and was not required prior to adoption of Connecticut General Statutes 17b-260a-16-5(3)(B) on April 1, 2013.

36. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require "duties" (Connecticut General Statutes 17b-260a-16(a)(6)) required to comply with said regulations, given that duties, for purposes of reimbursement exercises behavioral control over Cognitive Behavioral Programs providers (CBP) who are either self-employed or employees of an agency and such control is consistent with tasks performed by employees and not self-employed or agency employed individuals, except by the employing agency which is NeuroStrategies, Inc. and not Department of Social Services, as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii) and was not required prior to adoption of Connecticut General Statutes 17b-260a-16-5(3)(B) on April 1, 2013.

37. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require "submission of monthly reports and written updates on the individual's progress in a form that is set forth by the department as detailed in Connecticut General Statutes 17b-260a-16(d), required to comply with said regulations, given that submission of monthly reports and written updates on the individual's progress in a form that is set forth by the department, exercises behavioral control over Petitioner's who are either self-employed or employees of an agency and such control is consistent with tasks performed by employees and not self-employed or agency employed individuals, except by the employing agency which is NeuroStrategies, Inc. and not Department of Social Services, as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii) and was not required prior to adoption of Connecticut General Statutes 17b-260a-16-5(3)(B) on April 1, 2013.

38. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January

15, 2004, a Provider Agreement that does not require said regulatory requirements, and having provided CBP services on an ongoing basis prior and subsequent to April 1, 2013, required to provide "monthly reports and written" updates on the individual's progress in a form set forth by the department," a form provided by the department, a form requiring submission of information determined by the department to be relevant (service goals, target date for achieving specific goals, strategies utilized, monthly progress toward each goal in measurable terms, and comments and/or concerns) as such a practice exercises behavioral control over Petitioner's who are either self-employed or employees of an agency and such control is consistent with tasks performed by employees and not self-employed or agency employed individuals, and having adopted proposed regulation 17b-260a-16(d), on April 1, 2013, despite said requirement not being required prior to adoption of 17b-260a-16(d) on April 1, 2013 and in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

39. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) required to comply with the terms of said regulations, adopted on April 1, 2013, if a Notice of Intent for said regulations, was not printed in the Connecticut Law Journal at least 30 days prior to adoption of said regulations on April 1, 2013, as required under Connecticut General Statutes 4-168(a) prior to July 1, 2013.

40. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) required to comply with the terms of said regulations, printed in the Connecticut Law Journal on March 26, 2013 and adopted on April 1, 2013, if a Notice for said regulations, was not printed in the Connecticut Law Journal after

April 1, 2013 and not later than April 21, 2013, indicating that the department will operate under the policy while it is being considered, provided that the department prints its Notice in the Connecticut Law Journal within 20 days after adoption as required under Connecticut General Statutes 17b-10(b) prior to July 1, 2013.

41. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statute 17b-260a-16(e), subjected to suspension of payment for services rendered if monthly reports and written updates are not provided as required in Connecticut General Statute 17b-260a-16(e) adopted on April 1, 2013, if a Notice of Intent for Connecticut General Statute 17b-260a-16(e) was not printed in the Connecticut Law Journal at least 30 days prior to adoption of Connecticut General Statute 17b-260a-16(e) on April 1, 2013 as required under Connecticut General Statutes 4-168(a) prior to July 1, 2013.

42. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statute 17b-260a-16(e), subjected to suspension of payment for services rendered if monthly reports and written updates are not provided as required in Connecticut General Statutes 17b-260a-16(e) adopted on April 1, 2013, if a Notice of Intent for Connecticut General Statutes 17b-260a-16(e) was not printed in the Connecticut Law Journal after April 1, 2013 and not later than April 21, 2013, indicating that the department will operate under the policy while it is being considered, provided that the department prints its Notice of Intent in the Connecticut Law Journal within 20 days after adoption as required under Connecticut General Statutes 17b-10(b) prior to July 1, 2013.

43. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut

General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to follow said regulations, given that the incorrect statutory authority is referenced in the Notice of Intent published on March 26, 2013 thereby rendering adoption of said regulations defective.

44. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations, given that the proposed regulations were not submitted to the Licensing Rules Regulation Committee (LRRC) within 180 days as required under Connecticut General Statutes 17b-10(b) and can the Department of Social Services be considered to have abandoned the promulgation of said regulations given the failure to follow Connecticut General Statutes 17b-10(b) is mandatory.

45. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations, given that the proposed regulations are not being considered by the legislature (LRRC) as "consideration" is a requirement to operate under the regulations while they are being developed during the 180 day period by Connecticut General Statutes 17b-10.

46. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes

17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations, given that the proposed regulations were not submitted to the Licensing Rules Regulation Committee (LRRC) in over 900 days and tolling, thereby exceeding the 180 day requirement under Connecticut General Statutes 17b-10(b) by five times the maximum time allowed for consideration and after more than 900 days of failure to submit said regulations, and not submitting notice to LRRC as to the departments' reason for failing to submit the regulations for consideration and Commissioner of Department of Social Services, not choosing to explain his decision not to forward said regulations to LRRC, by Connecticut General Statutes 17b-10(b) and Connecticut General Statutes 17b-10(c) respectively.

47. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations, given that there was no federal conforming requirement issued by Centers for Medicare and Medicaid Services (CMS) requiring adoption of said regulations, as required in Connecticut General Statutes 17b-10(b).

48. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations, given that there was no federal conforming requirement to adopt "documentation requirements" thereby misapplying, Connecticut General Statutes 17b-10(b).

49. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations, given that the application for the ABI/TBI Medicaid Waiver Program was submitted in January 2012, prior to adoption of said regulations, on April 1, 2013 and the department confirms that there were no changes to the ABI/TBI Medicaid Waiver Program application submitted in 2012

50. Given that Department of Social Services (DSS) submitted an application (Exhibit 51) to Centers for Medicare and Medicaid Services on October 6, 2006 and in said application, claimed in "Appendix I-1 Financial Accountability" that DSS (1) conducts audits of Medicaid providers and (2) the Office of Quality Assurance (QA) conducts financial audits of Medicaid providers and (3) all waiver providers are subject to audits performed by the QA, has Department of Social Services ever promulgated and received legally enforceable approved regulations, including but not limited to

    Connecticut General Statutes 17b-260a-16(a)(1);
    Connecticut General Statutes 17b-260a-16(a)(4);
    Connecticut General Statutes 17b-260a-16(a)(5); and
    Connecticut General Statutes 17b-260a-16(a)(6);

    as required by Connecticut General Statues 17b-99 (Exhibit 35), which may be used to audit the Petitioner's as it relates to the Petitioner's, as providers on the ABI/TBI Medicaid Waiver program since 1999

51. Given that the Department of Social Services submitted an application (Exhibit 52) to Centers for Medicare and Medicaid Services on October 1, 2012 and in said application, claimed in "Appendix I-1 Financial Accountability" that
    (1) DSS Office of Quality Assurance conducts financial audits of Medicaid providers and (2) all waiver providers are subject to audits performed by the QA, and (3) the auditor reviews supporting documentation maintained by the provider and claim information maintained by the department,
    has Department of Social Services ever promulgated and received legally

enforceable approved regulations, including but not limited to
Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

as required by Connecticut General Statues 17b-99, that may be used to audit the Petitioner's as it relates to the Petitioner's, as providers on the ABI/TBI Medicaid Waiver program

52. Given that the Department of Social Services (DSS) submitted an application to Centers for Medicare and Medicaid Services on October 6, 2006 and in said application (Exhibit 51), claimed in "Appendix I-1 Financial Accountability that" DSS
(1) conducts audits of Medicaid providers and (2) the Office of Quality Assurance (QA) conducts financial audits of Medicaid providers and (3) all waiver providers are subject to audits performed by the QA,
having never promulgated and received legally enforceable approval of "audit regulations" including but not limited to

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

as required under Connecticut General Statues 17b-99 to audit providers on the ABI/TBI Medicaid Waiver program since 1999, did Department of Social Services, submit a false claim in its application to CMS on October 6, 2006, and by doing so, did Department of Social Services mislead the Petitioner's regarding the potential for them to be audited under Connecticut General Statutes 17b-99

53. Given that the Department of Social Services submitted an application to Centers for Medicare and Medicaid Services on October 1, 2012 and in said application, claimed in "Appendix I-1 Financial Accountability" that
(1) DSS Office of Quality Assurance conducts financial audits of Medicaid providers and (2) all waiver providers are subject to audits performed by the QA, and (3) the auditor reviews supporting documentation maintained by the provider and claim information

maintained by the department,
having never promulgated and received legally enforceable approval of "audit regulations" including but not limited to

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

as required under Connecticut General Statues 17b-99 to audit providers on the ABI/TBI Medicaid Waiver program since 1999, did Department of Social Services, submit a false claim in its application to CMS on October 1, 2012, and by doing so, did Department of Social Services mislead the Petitioner's regarding the potential for them to be audited under Connecticut General Statutes 17b-99

54. Given that the Department of Social Services submitted an application to Centers for Medicare and Medicaid Services on October 1, 2012 and in said application, claimed in "Appendix I-1 Financial Accountability" that (1) DSS Office of Quality Assurance conducts financial audits of Medicaid providers and (2) all waiver providers are subject to audits performed by the QA, and (3) the auditor reviews supporting documentation maintained by the provider and claim information maintained by the department, having never promulgated and received legally enforceable approval of any "audit regulations" including but not limited to
Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

and having printed a Notice of Intent "sixteen days" later, in Connecticut Law Journal, in an attempt to adopt regulations to "audit providers," a regulation that has never been approved,

did Department of Social Services "falsify" its application to Centers for Medicare & Medicaid Services, to obtain federal funding for its ABI/TBI Medicaid Waiver program, and by doing so, did Department of Social Services violate federal law and mislead the Petitioner's

55. Given that the Department of Social Services is submitting or has submitted an application to Centers for Medicare and Medicaid Services for renewal of ABI/TBI Medicaid Waiver program effective January 1, 2016,
will Department of Social Services, claim in "Appendix I-1 Financial Accountability" that (1) DSS Office of Quality Assurance or Allied Community Resources (ACR) conducts financial audits of Medicaid providers and (2) all waiver providers are subject to audits performed by the QA, and (3) the auditor reviews supporting documentation maintained by the provider by,
Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6); and

having never promulgated and received legally enforceable approval of the aforementioned "documentation requirements" as "audit regulations" including but not limited to

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

as required under Connecticut General Statues 17b-99, to audit providers on the ABI/TBI Medicaid Waiver program since 1999,
will Department of Social Services, submit a false claim in its application to CMS for its ABI/TBI Medicaid Waiver due for renewal in January 2016, and mislead the Petitioner's

and will Department of Social Services harm the Petitioner's and other small business owners who provide services on the ABI Waiver, despite failing to legally adopt "audit protocols" by Connecticut General Statutes 17b-99

56. Given that Department of Social Services initiated "audit protocols" against Petitioner's, (Exhibit 58) consistent with requirements outlined in the "Appendix I-1" (Exhibit 9) of Centers for Medicare and Medicaid Services Manual for Home and Community Based Waivers,

has Department of Social Services, violated Connecticut General Statutes 17b-99 and Public Act 14-162, regarding Connecticut General Statutes 17b-99 (Exhibit 56), and its clarifications for fairness in the process of auditing provider's, including the Petitioner's, by initiating "audit protocols" without compliance with Connecticut General Statutes 17b-99, and harmed the Petitioner's by impairing their autonomy, dignity (release of financial information, securing various financial statements) and forcing the Petitioner's to assume additional costs (dishonesty bond, accounting fees, and development of other items found in Exhibit 58) for items that were not required prior to adoption of audit protocols (Exhibit 60) not governed by Connecticut General Statutes 17b-99

57. Given that the Department of Social Services maintains claims submitted for reimbursement for at least five years, and assuming that claims alone meet the requirements of the Provider Agreements signed by the Petitioner's on January 15, 2004 (Exhibit 1), October 23, 2014 (Exhibit 46), and October 28, 2015 (Exhibit 47), have not the Petitioner's complied with the documentation requirements in "Item 9" and "Item 7" of the respective Provider Agreements, and if Department of Social Services having never adopted "audit protocols" by Connecticut General Statutes 17b-99, and the Department of Social Services having no "documentation requirements" beyond the Provider Agreement prior to July 1,2013, with adoption of Connecticut General Statutes 17b-260a-16 on April 1, 2013, can it be concluded that, Department of Social Services is in possession of all "documentation" necessary for the Petitioner's to have met the "documentation requirements" in place prior to April 1, 2013,

and would possession of claims by DSS, apply similarly to previously audited entities (Exhibits 25-30), who were audited based on dates that preceded adoption of Connecticut General Statutes 17b-260a-16, on April 1, 2013, as is the case for the Petitioner's, given that the first quarter of 2013 records were copied and audited/reviewed by DSSQA on June 16 2004,

and having not informed Petitioner's and other providers that copies of invoices, serving as documentation, could be obtained through Allied Community Resources (ACR), did DSS take advantage of the Petitioner's due to the deception

in the 2006 and 2012 ABI Waiver applications,

and did Department of Social Services violate the rights of the Petitioner's by copying files with dates from January 1, 2013 to March 31, 2013, given that the Provider Agreement signed January 15, 2004, only provided Department of Social Services with access to files, not the ability to copy files, which did not exist until adoption of Connecticut General Statutes 17b-260a16(b) and Connecticut General Statutes 17b-260a16(c),

and did DSS commit a legal error by recouping monies from unsuspecting providers who were audited (Exhibits 25-30) and Exhibits 65-65H) and fined thousands of dollars despite the absence of "audit protocols" as were the Petitioner's similarly unaware,

and given that fines were levied by Department of Social Services, and negotiated for a settlement by member(s) of Department of Social Services Quality Assurance (DSSQA), in violation of Connecticut General Statutes 17b-99 and in anticipation by the Petitioner's, who have not received results of its "Records Review," disguised as an audit, can Petitioner's expect a similar outcome as those who were previously audited (Exhibits 25-30),

and is it not the case that Department of Social Services uses the term "Records Review" as a "gateway" to an illegal audit, whereby if the Petitioner's challenge the "Records Review" and go to Superior Court, the issue is addressed in court as a "Records Review"

and if the Petitioner's had not challenged the "Records Review" beyond the

Administrative level (Department of Social Services), would the Petitioner's have been assumed by DSS to be ignorant of the process which would allow Department of Social Services to take advantage of the Petitioner's and levy heavy fines against the Petitioner's as DSS did against previous providers (Exhibits 25-30),

and if the Petitioner's , had been ignorant of the process and had accepted a fine at the administrative level, would DSS have allowed the Petitioner's to negotiate a settlement with a representative of DSSQA, in violation of Connecticut General Statutes 17b-99,

and if the Petitioner's were to seek counsel and support from individuals who may have a relationship with the Director of DSSQA, might the Petitioner's, risk of an adverse finding have been reduced

58. Given that Department of Social Services (DSS) misled Petitioner's due to DSS' false claims in its 2006 and 2012 application to Centers for Medicare & Medicaid Services (CMS), regarding DSS having "audit protocols," and Department of Social Services, having conducted "audits" of ABI Waiver providers' (Exhibits 25-30) in the absence of "audit protocols" by Connecticut General Statutes 17b-99,
Has DSS harmed the Petitioner's by leading the Petitioner's to assume that what was termed a "Records Review," conducted against the Petitioner's on June 16, 2004, was in actuality an "audit," given that "Records Review" is not referenced in either the 2006 or the 2012 "falsified" ABI Waiver applications but Department of Social Services attests that it conducts "audits"

59. Do the following statutes,

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);
meet criteria to be considered "audit regulations" that may be used in the process of an audit of the Petitioner's by Connecticut General Statutes 17b-99, given that the Petitioner's are providers on the ABI Waiver Program and would be required to adhere to said regulations

60. Do the following statutes

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

meet criteria to be considered "documentation requirements" or "documentation regulations" that may be used in the process of conducting an audit of the Petitioner's by Connecticut General Statutes 17b-99

given that the Petitioner's are providers on the ABI Waiver Program and would be required to adhere to said regulations

61. Is the impending audit of the Petitioner's that will be conducted by Allied Community Resources (Exhibit 58) based on Connecticut General Statutes 17b-99

or an attempt to comply with Appendix I-1 Financial Accountability & Integrity

and is the attempt to comply with the aforementioned CMS Assurance done at the expense of the Petitioner's and in violation of Connecticut General Statutes 17b-99

62. Is the adoption of "audit protocols" that will be employed by Allied Community Resources, against the Petitioner's (Exhibit 58), an attempt to comply with "Appendix I-1 Financial Accountability & Integrity" with the Centers for Medicaid Technical Guidance Manual and Department of Social Services application/renewal of the ABI Medicaid Waiver for 2016, and have said "audit protocols" been adopted by Connecticut General Statutes 17b-99

63. Is the adoption of "audit protocols" that will be conducted by Allied Community Resources against the Petitioner's (Exhibit 58) an attempt to comply with "Appendix I-1 Financial Accountability & Integrity" with the Centers for Medicaid Technical Guidance Manual and Department of Social Services application/renewal of the ABI Medicaid Waiver for 2016, without approval of "audit protocols" as required by Connecticut General Statutes 17b-99, illegal

64. Did the Department of Social Services use the federal conforming requirement to adopt "audit protocols" as required by CMS (Exhibit 9, p.248-251) as a basis to adopt "documentation requirements"

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

when "audit protocols" are required, not "documentation requirements" and will DSS use Connecticut General Statutes 17b-260a-16 during audits conducted by Allied Community Resources (ACR) or Department of Social Services Quality Assurance and are "audits" to be implemented by Allied Community Resources used to satisfy the requirements of Appendix I-1 Financial Accountability & Integrity in the CMS application and will the audits be conducted despite never being developed by Connecticut General Statutes 17b-99 and will Connecticut General Statutes 17b-260a-16 and audits conducted by ACR be paired to conduct audits of providers despite the protocols not being Connecticut General Statutes 17b-99 protocols

and given that Department of Social Services could have chosen to provide a strategy for developing rules, policies, or regulations that govern the "Financial Accountability & Integrity Assurance, Exhibit 9, pp248-251) without adopting regulations,

is it the case that there was no requirement to adopt "documentation regulations" nor is failure to immediately "adopt audit protocols" required

and by applying Connecticut General Statutes 17b-10(b) to the adoption of regulations that do not meet the requirement CMS has demanded, has not the Department of Social Services committed at minimum, an error and at most, an illegal act by willfully betraying the Petitioner's and the public trust by purposely misapplying a statute (Connecticut General Statutes 17b-10(b) that Department of Social Services knows does not apply to the regulations adopted on April 1, 2013

65. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statute 17b-260a-16(a); Connecticut General Statute 17b-260a-16(b); Connecticut General Statute 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statute 17b-260a-16(e), required to comply with said regulations, given that the application for the ABI/TBI Medicaid Waiver Program requires renewal in January 2016, more than two years after adoption of said regulations, on April 1, 2013, and Dianne Kayala (Acting Senior Policy Analyst, Technical Guidance Director, Quality and Managed Care, DLTSS) for Centers for Medicare and Medicaid Services indicated on September 8, 2014 that there were no requirements issued by Centers for Medicare and Medicaid Services after January 1, 2012 that would demand that Connecticut conform to a federal requirement for the existing waiver program prior to its renewal in 2016, and Technical Guidance Manual for HCBS Waivers printed in January 2015 does not require states to adopt regulations to operate a waiver.

66. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(d), required to comply with said regulations given that said regulations were written in a manner that was described by the department as "intentionally vague" which is in direct violation of Connecticut General Statutes 17b-10(a) which requires that regulations be written in language that is "clear and concise".

67. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General

Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations given that said regulations were not distributed to workers in sub-regional offices as required under Connecticut General Statutes 17b-10(a).

68. Are the Petitioner's, having previously signed a Provider Agreement, under which the petitioner's operated continuously from January 15, 2004 through adoption of regulations

Connecticut General Statues 17b-260a-5(3)(B);
Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);
Connecticut General Statutes 17b-260a-16(b);
Connecticut General Statutes 17b-260a-16(c);
Connecticut General Statutes 17b-260a-16(d), and
Connecticut General Statutes 17b-260a-16(e)
Connecticut General Statutes 17b-260a-17

adopted on April 1, 2013, free from behavioral control in contract and "in fact" by Connecticut General Statutes 31-222(a)(1)(B)(ii) and do said regulations violate Connecticut General Statutes 31-222(a)(1)(B)(ii)

and given said regulations, adopted April 1, 2013, were adopted after petitioner's signed a Provider Agreement on January 15, 2014, are said regulations binding on petitioner's if they are designated as "self-employed"

and do said regulations violate the "ABC Test" (Connecticut General Statutes 31-222(a)(1)(B)(ii) , is the employer (Allied Community Resources and Department of Social Services) required to either refrain from behavioral control or reclassify the petitioner's as employee's

and do said regulations violate the "ABC Test" (Connecticut General Statutes 31-222(a)(1)(B)(ii) , is the employer (Allied Community Resources and Department of Social Services) required to pay unemployment compensation, workers compensation, health insurance, retirement benefits, and other entitlements afforded to state employee's

and do said regulations violate the "ABC Test" (Connecticut General Statutes 31-222(a)(1)(B)(ii) , is the employer (Allied Community Resources and Department of Social Services) required to repay previous years costs of the petitioner's for payment of unemployment compensation, workers compensation, health insurance, retirement benefits, other entitlements afforded to state employee's, as well as State and Federal taxes paid in excess of what would be required of an employee

and do said regulations violate the "ABC Test" (Connecticut General Statutes 31-222(a)(1)(B)(ii) , is the employer (Allied Community Resources and Department of Social Services) required to designate the petitioner as an employee of State of Connecticut

and do said regulations violate the "ABC Test" (Connecticut General Statutes 31-222(a)(1)(B)(ii) , is the employer (Allied Community Resources and Department of Social Services) having designated the

petitioner employee status required to grant the petitioner "Whistleblower Status" by Connecticut General Statutes 4-61dd

and given that said petitioner is granted employee status, and can provide supporting evidence that members of Department of Social Services Quality Assurance participated in the audit, recoupment of fines, and negotiation of a settlement of audits without audit protocols, in violation of Connecticut General Statutes 17b-99(d)(8) required to shield said employee from harm as required in Connecticut General Statutes 4-61dd

69. Are petitioner's having signed a Provider Agreement on January 15, 2004, and continuously operated under said Provider Agreement throughout 2013, prior to adoption of Connecticut General Statutes 17b-260a-17, subject to said regulation given that Connecticut General Statues 17b-260a-17 was adopted after the previously signed Provider Agreement and is not a condition of the Provider Agreement previously signed on January 15, 2004.

70. Are the Petitioner's, having signed a Provider Agreement on January 15, 2004, and having cooperated with Department of Social Services (DSS) Review of Records conducted on June 16, 2014, and DSS having communicated that all regulations printed on March 26, 2013 and adopted on April 1, 2013 (Connecticut General Statues 17b-260a-1 to Connecticut General Statutes 17b-260a-17) are in effect as of April 1, 2013, and having adopted new documentation requirements in conducting a Review of Records, as governed by

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);
Connecticut General Statutes 17b-260a-16(b);
Connecticut General Statutes 17b-260a-16(c);
Connecticut General Statutes 17b-260a-16(d), and

Connecticut General Statutes 17b-260a-16(e)
Connecticut General Statutes 17b-260a-17

and DSS having attested that the regulations cited above may be used as a measure of the petitioner's compliance

and DSS, having attested, that it would apply the following regulations to an evaluation of the new documentation requirements adopted April 1, 2013

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);

and despite the petitioner's signed Provider Agreement, signed January 15, 2004, prior to adoption of

Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6) on April 1, 2013

and the Petitioner's, having granted, Department of Social Services, immediate access to records to be reviewed due to threat of harm (Connecticut General Statutes 17b-260a-17) by Connecticut General Statues 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c)

and DSS having stated that they will apply said regulations as a measure of compliance with new documentation requirements

and DSS having employed Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c) as a basis for their demand for access that must be immediately provided

and Department of Social Services Quality Assurance (DSSQA) having requested monthly reports for the period of the Records Review (2013) on July 29, 2014, as authorized by

Connecticut General Statutes 17b-260a-16(d),

and DSS having adopted Connecticut General Statutes 17b-260a-16(e);

and Connecticut General Statutes 17b-260a-17, is it true that Department

of Social Services, "terminated" the Provider Agreement previously signed on January 15, 2004, without notice and without cause

and harmed the Petitioner's by conducting a Records Review based on a Provider Agreement that was "terminated," upon adoption of "new documentation requirements" on April 1, 2013, documentation requirements that did not exist prior to adoption and are not inclusive of the Provider Agreement signed January 15, 2004

and if Department of Social Services terminated said Provider Agreement dated January 15, 2004, has Department of Social Services, allowed Petitioner's to operate as providers with a terminated Provider Agreement in violation of Centers for Medicare and Medicaid Services (CMS) requirements without notifying CMS

and would Department of Social Services be considered to have harmed the Petitioner's by conducting a Records Review based on a Provider Agreement that was violated upon adoption of "new documentation requirements" on April 1, 2013, documentation requirements that did not exist prior to adoption and are not inclusive of the Provider Agreement signed January 15, 2004

and tortuously interfered with the Petitioner's business

71. Are the Petitioner's, having signed a Provider Agreement on January 15, 2004, and having been designated as self-employed, "misclassified" as self-employed, if a representative of the employer or an employee of a contracted agency working on behalf of the employer (DSS), provides

direction in the performance of the service, or

control in the performance of the service, or

work is performed as part of the employer's usual course of business, or

the worker's service is performed inside the employer's place of business,

can Department of Social Services be considered to have violated Connecticut General Statutes 31-222(a)(1)(B)(ii).

72. Are the Petitioner's, having signed a Provider Agreement on January 15, 2004, and having been designated as self-employed, "misclassified" as self-employed, if

a representative of the employer or an employee of a contracted agency working on behalf of the employer (DSS), provides materials such as (monthly report forms, billing invoices, and other materials) that must be used in the performance of the service, or

establishes hourly wages, or

determines the number of hours performed per client, per day, or

employer establishes the level of payment for the services provided,

can Department of Social Services be considered to have violated Connecticut General Statutes 31-222(a)(1)(B)(ii).

73. Given that the Petitioner's signed a Provider Agreement (signed January 15, 2004) that contained documentation requirements;

> I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES AND GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST.
>
> and Department of Social Services (DSS) having adopted new documentation requirements Connecticut General Statutes 17b-260a-16, is the Provider Agreement signed January 15, 2004 "terminated" upon adoption of Connecticut General Statutes 17b-260a-16,

and if having terminated said Provider Agreement, did DSS relinquish its rights to review records upon adoption of Connecticut General Statutes 17b-260a-16,

and if having terminated said Provider Agreement, did DSS relinquish its authority assigned within the Provider Agreement signed January 15, 2004,

and the Petitioner's having signed a subsequent Provider Agreement (Exhibit 45) on October 23, 2014, that similarly details documentation requirements in Item "7" as follows;

THE AGENCY WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES AND GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF DSS UPON REQUEST

and Petitioner's, having argued that DSS did not properly adopt Connecticut General Statutes 17b-260a-16 on April 1, 2013 due to multiple errors including but not limited to, a citation of the incorrect statutory authority in its Notice of Intent dated March 26, 2013, and a failure to provide 30 days notice prior to adoption of Connecticut General Statutes 17b-260a-16, and failure to print a notice in the Connecticut Law Journal after April 1, 2013 and not later than April 21, 2013 as required by Connecticut General Statutes 17b-10(b), and having suppressed public comment which may have resulted in a lack of response necessary to hold a public hearing, and having written Connecticut General Statutes 17b-260a-16 in a manner that was "intentionally vague" in violation of Connecticut General Statutes 17b-10, and having failed to reveal the existence of non-promulgated regulations in the Notice of Intent printed on March 26, 2013 and having used non-promulgated regulations in legal decision making from 1999 through adoption of Connecticut General Statutes 17b-260a-16 on April 1, 2013 and as late as 2015 (Exhibit 31) despite asserting that Connecticut General Statutes 17b-260a-16 was in place and "operating" and having failed to reveal a federal conforming requirement, and the Petitioner's having presented lines of evidence that no federal conforming requirement exists as no federal conforming requirement can be found in the Technical Guidance Manual for Home and Community Based Waivers, and Department of Social Services (DSS) having asserted that DSS provided all communications between DSS and Centers for Medicare and Medicaid Services (CMS) between circa 2009 and circa 2014 and no federal conforming requirement can be found in DSS' documents and a CMS representative responsible for "Technical Guidance" indicates that no federal conforming requirement exists, and despite repeated requests to reveal the federal conforming requirement, can it be concluded that no federal conforming requirement exists and having failed to forward Connecticut General Statutes 17b-260a-16 to the

Licensing Regulation Review Committee (LRRC) within 180 days as required by Connecticut General Statutes 17b-10 and having still failed to do so more than 900 days after printing on March 26, 2013, can DSS be considered to have improperly adopted Connecticut General Statues 17b-260a-16 and having had no regulations in place upon the Petitioner's signing of a Provider Agreement on October 23, 2014, can the Petitioner's be considered to have not been governed by a Provider Agreement nor Connecticut General Statutes 17b-260a-12(a)(1) or Connecticut General Statutes 17b-260a-1 to Connecticut General Statutes 17b-260a-17, on April 1, 2013

and have the Petitioner's operated without a Provider Agreement from April 1, 2013 until signing of a Provider Agreement on October 23, 2014, after adoption of Connecticut General Statutes 17b-260a-12(a)(1) on April 1, 2013

and has Department of Social Services determined that the Provider Agreement signed October 23, 2014 was the sole requirement regarding documentation from its signing on October 23, 2014 until the signing of a final Provider Agreement on October 28, 2015, which details documentation requirements in Item "7";

THE AGENCY WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES AND GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF DSS UPON REQUEST

and given that the Petitioner's Provider Agreement signed October 28, 2015 is being reviewed as of December 5, 2015, can it be concluded that the Petitioner's are operating under the October 23, 2014 Provider Agreement as of submission of this "Request for Declaratory Ruling" but the position of the Petitioner's is unchanged after review of Provider Agreement signed October 28, 2015, as the documentation requirements in the October 23, 2014 and October 28, 2015 Provider Agreements are identical

and

is it true that the Petitioner's under said circumstances, have as their sole requirement for documentation, Item "7" of the October 23, 2014 and October 28, 2015, Provider Agreement and not Connecticut General Statutes 17b-260a-16 for purposes of documentation requirements

and

is it true that the Petitioner's under said circumstances have as their sole requirement, for any and all requirements governing the Petitioner's activities on the ABI/TBI Medicaid Waiver Program, the Provider Agreement signed on October 23, 2014 and not any of the regulations adopted on April 1, 2013 (Connecticut General Statutes 17b-260a-1 to Connecticut General Statutes 17b-260a-17

and until the Provider Agreement signed on October 28, 2015 is confirmed to have been reviewed, that the Petitioner's have as their sole requirement, regarding activities on the ABI/TBI Medicaid Waiver, the Provider Agreement signed October 23, 2014, given that Connecticut General Statues 17b-260a-12(a)(5) was not properly adopted

and the Petitioner's having signed the October 23, 2014 and October 28, 2015 Provider Agreements which require in Item "4" of each agreement respectively, a requirement regarding billing that requires adherence to the Provider Agreement "Item 4" given that Connecticut General Statues 17b-260a-12(a)(5) was not properly adopted

THE AGENCY WILL ADHERE TO THE UNITS AND SERVICES ASSIGNED IN ACCORDANCE WITH THE ABI WAIVER PARTICIPANT'S SERVICE PLAN TO WHICH THE AGENCY IS NAMED AS A SERVICE PROVIDER

are Petitioner's allowed to violate the terms of said agreement (Item 4) without mutual agreement between Petitioner's and Department of Social Services, given that Connecticut General Statues 17b-260a-12(a)(5) was not properly adopted

and are Petitioner's allowed to violate the terms of said agreement (Item 4) without mutual agreement among Petitioner's, Department of Social

Services, and Participant (the participant has a signed service plan agreement with DSS regarding billing and units) given that Connecticut General Statues 17b-260a-12(a)(5) was not properly adopted

and are the Petitioner's required to forego access to any residual budget amounts available to the client based upon their approved service plan, regardless of the units assigned in the plan, given that Connecticut General Statues 17b-260a-12(a)(5) was not properly adopted

and is the Provider Agreement signed October 23, 2014 terminated due to adoption of December 1, 2015 policies which violate "Item 4" of the Provider Agreement by creation of a Procedure Code (1448P) and associating "units" with a Procedure Code (1448P) and thereby violating "Item 4" by having Petitioner's bill for service units (1448P) that are not included in the participants' service plan

and is the Provider Agreement signed October 28, 2015 terminated due to adoption of December 1, 2015 policies which violate "Item 4" of the Provider Agreement by creation of a Procedure Code (1448P) and associating "units" with a Procedure Code (1448P) and thereby violating "Item 4" by having Petitioner's bill for service units (1448P) that are not included in the participants' service plan

74. Were the Petitioner's under Provider Agreement signed January 15, 2004, (PA1) required to bill for units as the units appeared in the participants' service plan based on the Provider Agreement in place after January 15, 2004 , and prior to adoption of Connecticut General Statutes 17b-260a-16 on April 1, 2013

and were Petitioner's required to bill in whole hour units as detailed in the Provider Manual (Exhibit 12) while operating under PA1 and Provider Agreement 2 (PA2) signed on October 23, 2014 before and after adoption of Connecticut General Statutes 17b-260a-12(a)(5) on April 1, 2013

and as provided in "Item 4" of the Provider Agreement signed on October 23, 2014 (PA2) were Petitioner's required to bill in whole hour units according to "Item 4" of said Provider Agreement prior to and after adoption of Connecticut General Statutes 17b-260a-12(a)(5)

and as provided in "Item 4" of the PA2, signed on October 23, 2014, were the Petitioner's required to bill in whole hour units according to "Item 4" of the Provider Agreement and adoption of Connecticut General Statues 17b-260a-12(a)(5) on April 1, 2013

and as provided in "Item 4" of the PA2, signed on October 23, 2014, were the Petitioner's required to bill in whole hour units according to "Item 4" of the Provider Agreement on December 1, 2015, after adoption of Connecticut General Statutes 17b-260a-12(a)(5) on April 1, 2013

and as provided in "Item 4" of the PA2, signed on October 23, 2014, did the Petitioner's sign any agreement to modify or change "Item 4" of the Provider Agreement effective December 1, 2015, or amend Connecticut General Statutes 17b-260a-12(a)(5), adopted on April 1, 2013

and are the Petitioner's listed as a provider of services for the participant identified (Exhibit 50) on March 26, 2014 after adoption of Connecticut General Statues 17b-260a-12(a)(5) on April 1, 2013

and are the Petitioner's listed on the service plan that is signed by the participant and Department of Social Services on March 26, 2015 and effective until March 26, 2016, after adoption of Connecticut General Statutes 17b-260a-12(a)(5) on April 1, 2013, and if so with how many units and with what service code attached to said units for the Petitioner's to use

and are the Petitioner's required to bill units as required by Department of Social Services in its adoption of a "new" policy on December 1, 2015

(Exhibits 47 and 48) and after adoption of Connecticut General Statutes 17b-260a-12(a)(5) adopted on April 1, 2013

[redacted]

and are the Petitioner's shielded from liability if Petitioner's bill units in violation of the service plan dated March 26, 2013 and in violation of Connecticut General Statues 17b-260a12(a)(5), adopted on April 1, 2013

[redacted]

and is it the position of Department of Social Services that any and all legal action taken by a participant against Petitioner's will be assumed (financially) by Department of Social Services despite violation of Connecticut General Statutes 17b-260a-12(a)(5)

[redacted]

and is it the position of Department of Social Services that the Provider Agreement (PA2) signed October 28, 2013, is still in effect despite the Petitioner's having taken action that is in violation of the Provider Agreement "Item 4"and billed units in violation of the service plan (agreement) between the participant and Department of Social Services signed March 26, 2015 and after adoption of Connecticut General Statutes 17b-260a-12(a)(5)

[redacted]

and is it the position of Department of Social Services that the participants' have not been harmed by the Petitioner's action to increase rates and operate in violation of the Provider Agreement "Item 4" and the participants, signed service plan after adoption of Connecticut General Statutes 17b-260a-12(a)(5)

[redacted]

and has either Provider Agreement (PA2) or Provider Agreement (PA3) been violated due to the adoption of "new" policies and has either Provider Agreement been terminated or voided due to the adoption of "new" policies in contradiction to the signed Provider Agreement (PA2) being in effect at the time of adoption of December 1, 2015 policy changes and Provider Agreement (PA3) having been signed under the premise of a prior description of Cognitive Behavioral Programs (Exhibit 12), after adoption of Connecticut General Statutes 17b-260a-5(3)

[redacted]

75. The Petitioner's are identified as agency providers according to the Provider

Agreement signed on October 28, 2014 (Exhibit 60)

THE AGENCY WILL ADHERE TO THE UNITS AND SERVICES ASSIGNED IN ACCORDANCE WITH THE ABI WAIVER PARTICIPANT'S SERVICE PLAN TO WHICH THE AGENCY IS NAMED AS A SERVICE PROVIDER

is adoption and implementation of a change in units billed by adoption of new policies on December 1, 2015 (Exhibit 48) that are not contained in the Provider Agreements, a violation of the Provider Agreements signed on October 23, 2014 and October 28, 2015,

and were there units in the signed service plan for Cognitive Behavioral Programs with the Procedural code 1448P from March 26, 2015 to March 26, 2016, as required in Connecticut General Statutes 17b-260a-12(a)(5),

and did the Petitioner's submit an invoice for billing with the procedure code 1448P in December 2015, as required in Connecticut General Statutes 17b-260a-12(a)(5),

and is billing for "units" that are not in the participants' plan a violation of Connecticut General Statutes 17b-260a-12(a)(5),

and is billing for "units" that are not in the participants' plan a violation of Connecticut General Statutes 17b-260a-12(a)(5),

and is billing for "units" that are not in the participants' plan a violation of "Item 4" of the October 23, 2014 Provider Agreement and the October 28, 2015 Provider Agreement,

and did the Department of Social Services inform the Petitioner's that they were required to submit the billing and use procedure code 1448P for activities related to service provision under Cognitive Behavioral Programs effective December 1, 2015,

and are the activities identified in the December 1, 2015 edict issued by Department of Social Services "new requirements" meaning, they were not in effect prior to December 1, 2015,

and are the requirements effective December 1, 2015 optional for the Petitioner's or are they contained in Connecticut General Statutes 17b-260a-1 to Connecticut General Statutes 17b-260a-17 or a Provider Agreement signed by the Petitioner's or a service plan (agreement) signed by the participant,

and will the Petitioner's be reimbursed if they submit invoicing under billing requirements in effect on November 30, 2015, despite adoption of new billing requirements that do not appear in Connecticut General Statutes 17b-260a-17 or a Provider Agreement signed by the Petitioner's or a service plan (agreement) signed by the participant,

and are these changes legally enforceable on the Petitioner's, and what is the legal basis for adoption of policies that do not appear in Connecticut General Statutes 17b-260a-17 or a Provider Agreement signed by the Petitioner's or a service plan (agreement) signed by the participant,

and do the changes implemented on December 1, 2015, require the approval of the Licensing Regulation Review Committee (LRRC) and if they do not require approval from LRRC, please explain how adoption other than in Connecticut General Statutes 17b-260a-17 or a Provider Agreement signed by the Petitioner's or a service plan (agreement) signed by the participant is legally binding on the Petitioner's

and did Department of Social Services consider that the contract (Exhibit 31) between Department of Social Services and Allied Community Resources (ACR) requires the fiduciary (ACR) not to pay for services billed that are not in the service plan which is consistent with Connecticut General Statutes 17b-260a-12(a)(5),

and did Department of Social Services request that Allied Community Resources ignore the provision of their contractual obligation (below) despite Connecticut General Statutes 17b-260a-12(a)(5):

> "Review the invoice to determine whether the services described in the invoice and the amounts charged for such services, conform on their face to services and amounts authorized under the applicable Service Plan" (Exhibit 31)

in examining the service plan (Exhibit 50) is it reasonable to conclude that the Petitioner's could submit an invoice for either $105.00, or $78.00 or $19.50, or $39.00, or $58.50 and the invoice be consistent with the obligation outlined above and Connecticut General Statutes 17b-260a-12(a)(5)

and did Department of Social Services reimburse an invoice related to the clients' program in Exhibit 50 for $105.00 dated December 13, 2015 and is such payment consistent with Connecticut General Statutes 17b-260a-12(a)(5)

did Department of Social Services violate the terms of the current Provider Agreements of the Petitioner's by compelling the Petitioner's to submit billing that is not consistent with "units" as described in a legal contract (Allied Community Resources) with the fiduciary of the ABI/TBI Medicaid Waiver Program, in violation of Connecticut General Statutes 17b-260a-12(a)(5)

and did Department of Social Services require the Petitioner's to submit payments that are inconsistent with the contractual obligations of Allied Community Resources, and in violation of Connecticut General Statutes 17b-260a-12(a)(5)

76. Did the Department of Social Services conduct a review of records held by the Petitioner's on June 16, 2014 and were said records review based on the January 15, 2004 Provider Agreement, as well as Connecticut General Statutes 17b-260a-16(c) and Connecticut General Statutes 17b-260a-16(d)

and did Department of Social Services copy all files,

and is the copying of files allowed under the Provider Agreement signed January 15, 2004 , or are the Petitioner's solely responsible for making records available

and did Department of Social Services obtain approval prior to copying files from January 1, 2013 to March 31, 2013

77. Is the Department of Social Services in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii) by adoption of new policies on December 1, 2015 that require that Petitioner's to,

deliver services "face-to-face, thereby exercising behavioral control in violation

of Connecticut General Statutes 31-222(a)(1)(B)(ii) and

a requirement that Petitioner's provide

"A quarterly in person meeting with the waiver participant is required for this service"

in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii)

A requirement that Petitioner's use a particular product or service as a means of conducting video conferencing "Skype" in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii),

A requirement that Petitioner's

"Work in "concert" with a case manager"

in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii)

78. Are Petitioner's subject to an "audit" by Connecticut General Statutes 17b-99, for records prior to adoption of Connecticut General Statutes 17b-260a-16, on April 1, 2013, given that Department of Social Services failed to adopt regulations by Connecticut General Statutes 17b-99, and despite application of Connecticut General Statutes 17b-99 to "audits" conducted against ABI Waiver providers prior to April 1, 2013 (See Exhibits 65, 65A, 65B, 65C, 65D, 65E, 65F, 65G, 65H)

79. Are Petitioner's subject to application of "extrapolation" by Connecticut General Statutes 17b-99, for records prior to adoption of Connecticut General Statutes 17b-260a-16, on April 1, 2013, given that Department of Social Services failed to adopt regulations by Connecticut General Statutes 17b-99, and despite application of "extrapolation" by Connecticut General Statutes 17b-99 to "audits" conducted against ABI Waiver providers prior to April 1, 2013 (See Exhibits 65, 65A, 65B, 65C, 65D, 65E, 65F, 65G, 65H)

80. Are Petitioner's allowed to negotiate a settlement of a finding based on extrapolation, resulting from an audit conducted by Connecticut General Statutes 17b-99, for records prior to adoption of Connecticut General Statutes 17b-260a-16, on April 1, 2013, given that Department of Social Services failed to adopt regulations by Connecticut General Statutes 17b-99, and despite allowing a "negotiated settlement" by a Department of Social Services Quality Assurance (DSSQA) employee in violation of Connecticut General Statutes 17b-99 to "audits" conducted against ABI Waiver providers prior to April 1, 2013 (See Exhibits 65, 65A, 65B, 65C, 65D, 65E, 65F, 65G, 65H)

81. Are Petitioner's "documentation requirements" by Connecticut General Statutes 17b-99, for records prior to adoption of Connecticut General Statutes 17b-260a-16, on April 1, 2013, based on previously signed Provider Agreements, "Item 9" signed by the Petitioner's (Exhibit 1), which said requirement can be met by presentation of invoice submitted for reimbursement or are "documentation requirements" prior to April 1, 2013, based on "alternate criteria," such as "timesheets" and "monthly/daily schedule documents" (see Exhibit 65B), as required of providers "audited" prior to adoption of Connecticut General Statutes 17b-260a-16 on April 1, 2013

82. Are Petitioner's allowed to obtain "really good deals" from John McCormick or Director of Department of Social Services Quality Assurance (DSSQA) by Connecticut General Statutes 17b-99 (Exhibit 65E, 65F, 65G), if Petitioner's commit errors in the area of "documentation requirements" as required by a signed Provider Agreement (Exhibits 1, 46, 47, & 65) or Connecticut General Statutes 17b-260a-16

and are Petitioner's subject to financial penalties if errors are found due to "audits" executed by Allied Community Resources (ACR) on behalf of Department of Social Services (DSS), after adoption of "new" credentialing policies effective November 1, 2015 and "new" documentation requirements (Connecticut General Statutes 17b-260a-16), adopted on April 1, 2013.

83. Are Petitioner's allowed to consult with Roderick Bremby or Commissioner of Department of Social Services upon settlement of a finding after an "audit" by Connecticut General Statutes 17b-99, assuming that Commissioner of Department of Social Services, may have violated Connecticut General Statutes 17b-99 by appointing a member of Department of Social Services Quality Assurance to negotiate a settlement (Exhibits 65E, 65F, 65G) of audit findings in violation of Connecticut General Statutes 17b-99 prior to adoption of Connecticut General Statutes 17b-260a-16 and subsequent to signing of a Provider Agreement (Exhibit 1 and Exhibit 65) and "new" credentialing requirements effective November 1, 2015.

84. Are Connecticut General Statutes 17b-260a-16 considered to be "audit protocols" adopted in accordance with Connecticut General Statutes 17b-99, given that the Petitioner's are providers on ABI Waiver program since signing a Provider Agreement on January 15, 2004.

85. Are "credential policies" implemented October 31, 2015 (Exhibit 58) by Department of Social Services and its designee, Allied Community Resources (ACR) considered to be "audit protocols" adopted in accordance with Connecticut General Statutes 17b-99, given that the Petitioner's are providers on ABI Waiver program since signing a Provider Agreement on January 15, 2004.

86. Were "credential policies" implemented October 31, 2015 (Exhibit 58) by Department of Social Services and its designee, Allied Community Resources (ACR) considered to be "audit protocols" adopted in accordance with Connecticut General Statutes 4-168, given that the Petitioner's are providers on ABI Waiver program since signing a Provider Agreement on January 15, 2004.

87. Were "credential policies" implemented October 31, 2015 (Exhibit 58) by Department of Social Services and its designee, Allied Community Resources (ACR) considered to be "audit protocols" adopted in accordance with Connecticut General Statutes 17b-10(b), given that the Petitioner's are providers on ABI Waiver program since signing a Provider Agreement on January 15, 2004.

88. Are Record Reviews, as outlined in the Petitioner's Provider Agreements (Exhibits 1, 46, & 47) considered to be "audit protocols" adopted in accordance with Connecticut General Statutes 17b-99, given that the Petitioner's are providers on ABI Waiver program since signing a Provider Agreement on January 15, 2004.

89. Are Record Reviews, as outlined in the Petitioner's Provider Agreements (Exhibits 1, 46, & 47) considered to be "audit protocols" adopted in accordance with Connecticut General Statutes 4-168, given that the Petitioner's are providers on ABI Waiver program since signing a Provider Agreement on January 15, 2004.

90. Are Record Reviews, as outlined in the Petitioner's Provider Agreements (Exhibits 1, 46, & 47) considered to be "audit protocols" adopted in accordance with Connecticut General Statutes 17b-10(b), given that the Petitioner's are providers on ABI Waiver program since signing a Provider Agreement on January 15, 2004.

91. Given that Connecticut General Statutes 17b-260a-16, "credential policies" adopted October 31, 2015, Record Reviews, have either not been adopted by Connecticut General Statutes 4-168; Connecticut General Statutes 17b-10(b); Connecticut General Statutes 17b-99 or never promulgated in accordance with Connecticut General Statutes 4-168; Connecticut General Statutes 17b-10(b); Connecticut General Statutes 17b-99, do any of the policies, (Connecticut General

Statutes 17b-260a-16, "credential policies" adopted October 31, 2015, Record Review) carry the force of law

and do any of the policies carry the force of law in accordance with Connecticut General Statutes 17b-99

92. Given that Petitioner's signed a Provider Agreement on January 15, 2004, and continuously operated under said agreement until adoption of "documentation requirements" including

> Connecticut General Statutes 17b-260a-16(a)(1);
> Connecticut General Statutes 17b-260a-16(a)(4);
> Connecticut General Statutes 17b-260a-16(a)(5);
> Connecticut General Statutes 17b-260a-16(a)(6);

and given that said regulations contain requirements that did not exist prior to adoption of "documentation requirements" on April 1, 2013, and are different from the requirements found in "Item 9" of the Provider Agreement,

> I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES/GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST

did Department of Social Services terminate the Provider Agreement upon adoption of its "documentation requirements"

93. Given that Petitioner's signed a Provider Agreement on October 23, 2014, and continuously operated under said agreement until adoption of "reimbursement policies," on December 1, 2015, policies that require Cognitive Behavioral Program providers to use a Procedure Code "1448P" when submitting an invoice for reimbursement for services provided in a "non face-to-face" format, a Procedure Code "1448P" that has "units" associated with said Procedure Code but said "units" do not appear on the participants' service plan, in violation of "Item 4" of the Provider Agreement signed by the Petitioner's on October 23, 2014, has Department of Social Services compelled the Petitioner's to violate the Provider Agreement by adoption of December 1, 2015 policies

94. Given that Petitioner's signed a Provider Agreement on October 28, 2015, and continuously operated under said agreement until adoption of "reimbursement policies," on December 1, 2015, policies that require Cognitive Behavioral Program providers to use a Procedure Code "1448P" when submitting an invoice for reimbursement for services provided in a "non face-to-face" format, a Procedure Code "1448P" that has "units" associated with said Procedure Code but said "units" do not appear on the participants' service plan, in violation of "Item 4" of the Provider Agreement signed by the Petitioner's on October 28, 2015, has Department of Social Services voided the Petitioner's Provider Agreement by adoption of December 1, 2015 policies due to Procedure Code "1448P" not being associated with Cognitive Behavioral programs at the time the Provider Agreement was signed, therefore the Petitioner's could not have agreed to the terms of the policies adopted on December 1, 2015 as said policies were not policy at the time of the signing of the Provider Agreement on October 28, 2015

95. Given that Lara Stauning, as author of

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

was aware that there was no federal conforming requirement issued by CMS and knowingly used a requirement to "adopt audit protocols" as the basis for adoption of "documentation requirements," "documentation requirements" that Attorney Hugh Barber has confirmed are not "audit protocols" (Exhibit 36), has Lara Stauning and possibly other members of Department of Social Services committed willful and wanton misconduct by facilitating adoption of said regulations by Connecticut General Statutes 17b-10(b)

and did Lara Stauning et al. cause harm to the Petitioner's by leading the Petitioner's into activities in an attempt to comply with improperly adopted regulations with no basis for adoption by Connecticut General Statutes 17b-10(b)

96. If it is determined that Department of Social Services falsified its 2006 application to CMS regarding "Appendix I-1 Financial Accountability & Integrity" by attesting that "audit protocols" existed and were in effect for the ABI Waiver, despite Department of Social Services' repeated failures to adopt "audit protocols" by Connecticut General Statutes 17b-99,

    can Commissioner of Department of Social Services and those who signed the ABI Waiver application and those who were designated as contact persons for said waiver application, be considered to have committed Medicaid Fraud by deceiving CMS that "audit protocols" existed when they did not

    and can it be said that the actions of said individuals was malicious and reckless and was an attempt to secure federal funding for its ABI Waiver program by attempting to give the impression that an Assurance had been met when it had not

97. If it is determined that Department of Social Services falsified its 2012 application to CMS regarding "Appendix I-1 Financial Accountability & Integrity" by attesting that "audit protocols" exist and are in effect for the ABI Waiver, despite Department of Social Services' repeated failures to adopt "audit protocols" by Connecticut General Statutes 17b-99,

    can Commissioner of Department of Social Services (Roderick Bremby) and those who signed the ABI Waiver application and those who were designated as contact persons for said waiver application, be considered to have committed Medicaid Fraud by deceiving CMS that "audit protocols" existed when they did not

    and can it be said that the actions of said individuals was malicious and reckless and was an attempt to secure federal funding for its ABI Waiver program by attempting to give the impression that an Assurance had been met when it had not

98. If it is determined that Department of Social Services falsified its amended 2012 application to CMS regarding "Appendix I-1 Financial Accountability & Integrity" by attesting that "audit protocols" exist and are in effect for the ABI Waiver, despite Department of Social Services' repeated failures to adopt "audit protocols" by Connecticut General Statutes 17b-99,

    can Commissioner of Department of Social Services (Roderick Bremby) and those who signed the ABI Waiver application and those who were designated as contact persons for said waiver application, be considered to have committed Medicaid Fraud by deceiving CMS that "audit protocols" existed when they did not

    and can it be said that the actions of said individuals was malicious and reckless and was an attempt to secure federal funding for its ABI Waiver program by attempting to give the impression that an Assurance had been met when it had not

99. If it is determined that Department of Social Services falsified its 2014 ABI Waiver II application to CMS regarding "Appendix I-1 Financial Accountability & Integrity" by attesting that "audit protocols" exist and are in effect for the ABI Waiver, despite Department of Social Services' repeated failures to adopt "audit protocols" by Connecticut General Statutes 17b-99,

    can Commissioner of Department of Social Services (Roderick Bremby) and those who signed the ABI Waiver application and those who were designated as contact persons for said waiver application, be considered to have committed Medicaid Fraud by deceiving CMS that "audit protocols" existed when they did not

    and can it be said that the actions of said individuals was malicious and reckless and was an attempt to secure federal funding for its ABI Waiver program by attempting to give the impression that an Assurance had been met when it had not

100. If Department of Social Services falsifies its 2016 renewal application to CMS regarding "Appendix I-1 Financial Accountability & Integrity" by attesting that "audit protocols" exist and are in effect for the ABI Waiver, despite Department of Social Services' repeated failures to adopt "audit protocols" by Connecticut General Statutes 17b-99,

will Commissioner of Department of Social Services and those who will sign the ABI Waiver application and those who are designated as contact persons for said waiver application, be considered to have committed Medicaid Fraud by deceiving CMS that "audit protocols" exist when they do not,

and can it be said that the actions of said individuals are malicious and reckless and are an attempt to secure federal funding for its ABI Waiver program by attempting to give the impression that an Assurance (Financial Accountability & Integrity) has been met and is in accordance with Connecticut General Statutes 17b-99

and will Petitioner's have been harmed by such actions given that the Petitioner's will have submitted private information to the fiduciary for Department of Social Services including financial information and insurance accounts information and incurred significant costs that were not previously required when applying to be a provider on the ABI Waiver program

101. If it is determined that the Provider Agreements signed October 23, 2014 and October 28, 2014 have been terminated due to violation of "Item 4" in each Provider Agreement, does Department of Social Services retain any authority to conduct a Review of the Petitioner's records given that the Petitioner's attest that the Provider Agreement has been terminated by Department of Social Services and what is the legal authority that serves as the authority to compel Petitioner's to participate

102. Given that "documentation requirements" are not "audit protocols" as communicated by Attorney Hugh Barber (Exhibit 36) are Petitioner's required to participate in any "Records Review" or "audit" that requires adherence to the following regulations,

Connecticut General Statutes 17b-260a-16(a)(1)
Connecticut General Statutes 17b-260a-16(a)(4)

Connecticut General Statutes 17b-260a-16(a)(5)
Connecticut General Statutes 17b-260a-16(a)(6)

and given that "documentation requirements" were not adopted in accordance with Connecticut General Statutes 17b-99, are Petitioner's required to participate in a review of records or an audit, and please provide the legal authority that serves as the authority to compel Petitioner's to participate

and given that "documentation requirements" were not adopted in accordance with Connecticut General Statutes 4-168, are Petitioner's required to participate in a review of records or an audit, and please provide the legal authority that serves as the authority to compel Petitioner's to participate

103. Are Petitioner's required to forego protections outlined in Connecticut General Statutes 17b-99 including but not limited to (1) 30 days notice prior to complying with an audit (2) training related to record keeping and (3) requirements regarding evaluation of errors and (4) opportunities to resolve discrepancies related to findings resulting from an audit, given that the Petitioner's are providers on the ABI Waiver program

104. Given that Connecticut General Statutes 17b-260a-16(d) is not a "documentation requirement" and there was no federal conforming requirement to adopt a regulation that requires monthly reporting and monthly reporting was not required prior to the adoption of said requirement on April 1, 2013 and said requirement was not adopted in accordance with Connecticut General Statutes 4-168 and Connecticut General Statutes 17b-10(b), are Petitioner's required to submit monthly report

105. Given that audit protocols must be adopted in accordance with Connecticut General Statutes 17b-99 and Department of Social Services has adopted "audit protocols' without promulgating said protocols in accordance with Connecticut General Statues 4-168 and Connecticut General Statutes 17b-99 are the Petitioner's being providers on the ABI Waiver required to participate in said "audits" and what is the legal authority to require Petitioner's to participate

106. Given that Connecticut General Statutes 17b-260a-1 to Connecticut General Statutes 17b-260a-15 are not "audit protocols" and were not adopted in accordance with Connecticut General Statutes 4-168, are Petitioner's required to adhere to said regulations

and given that Connecticut General Statutes 17b-260a-1 to Connecticut General Statutes 17b-260a-15 are not "audit protocols" and the federal conforming requirement was to adopt "audit protocols"(Exhibit 9, pp.248-251) and Department of Social Services improperly applied Connecticut General Statutes 17b-10(b) to said regulations are Petitioner's required to adhere to said regulations

FACTS

1. The Petitioner signed a Provider Agreement with Department of Social Services on January 15, 2004.

   A. The Provider Agreement details the documentation requirements of the Petitioner as follows:

      I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES/GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST

   B. The Petitioner provided Cognitive Behavior Program services on the Acquired Brain Injury/Traumatic Brain Injury Medicaid Waiver Program (ABI/TBI Medicaid Waiver Program) under a Provider Agreement signed January 15, 2004 and continuously operated under said agreement throughout 2013.

   C. The Department of Social Services printed a Notice of Intent to adopt regulations, Connecticut General Statutes 17b-260a-16(5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes17b-260a-16(d); Connecticut General Statutes17b-260a-16(e), for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and adopted said regulations, on April 1, 2013, requirements that did not exist prior to the adoption of said regulations. The department operated under non-promulgated policies that DSS failed to acknowledge in its Notice of Intent, a Notice of Intent printed on March 26, 2013 and adopted on April 1, 2013.

      The Petitioner's are harmed by the failure of Department of Social Services to reveal the presence of non-promulgated policies due to a lack of fundamental fairness.

   D. The Department of Social Services, in its Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-16(5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-

16(c); Connecticut General Statutes17b-260a-16(d); Connecticut General Statutes17b-260a-16(e) for the ABI/TBI Medicaid Waiver Program, printed on March 26, 2013, included in the March 26, 2013 printing, an adoption date of April 1, 2013.

The Petitioner's are harmed by the inclusion of the adoption in the same Notice of Intent as the printing date. Prior to July 1, 2013 there was a requirement to submit two Notices to comply with both Connecticut General Statutes 4-168(a) and Connecticut General Statutes 17b-10.

Connecticut General Statutes 17b-10(b) requires adherence to Section 54. Section 54 includes Connecticut General Statutes 4-168(a), which requires that a Notice of Intent is published prior to adoption of regulations. There was no publication of said regulations 30 days prior to adoption.

In addition, Connecticut General Statutes 17b-10(b) requires printing of a Notice of Intent within 20 days after adoption. The Department of Social Services adopted on April 1, 2013. An additional notice was required after April 1, 2013 but not later than April 21, 2013.

E. The Department of Social Services, in its Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-16(5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes17b-260a-16(d); Connecticut General Statutes17b-260a-16(e) for the ABI/TBI Medicaid Waiver Program, printed on March 26, 2013, cited the incorrect statutory authority for the ABI/TBI Medicaid Waiver Program.

F. The Department of Social Services, in its Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-16(5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes17b-260a-16(d); Connecticut General Statutes17b-260a-16(e)), printed on March 26, 2013, incorrectly cited Connecticut General Statutes17b-260b as the ABI/TBI Medicaid Waiver Program.

G. The Department of Social Services, in its Notice of Intent, printed on March 26, 2013 to adopt regulations (Connecticut General Statutes 17b-260a-16(5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1);

Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes17b-260a-16(d); Connecticut General Statutes17b-260a-16(e), failed to provide a reference to the federal conforming requirement that provided authority for adopting regulations, whether in an application or through communication with the federal government, under Connecticut General Statutes 17b-10 prior to July 1, 2013.

H. The Department of Social Services, in its Notice of Intent, printed on March 26, 2013 to adopt regulations (Connecticut General Statutes (5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes17b-260a-16(d); Connecticut General Statutes17b-260a-16(e)), failed to disclose the existence of non-promulgated regulations in the Notice of Intent, adopted April 1, 2013, as prior policy used in legal decision-making, as required under Connecticut General Statutes 17b-10 prior to July 1, 2013.

I. The Department of Social Services, failed to print a Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-16(5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes17b-260a-16(d); Connecticut General Statutes17b-260a-16(e), 30 days prior to adopting said regulations on April 1, 2013 as required by Connecticut General Statutes 4-168 prior to July 1, 2013.

J. The Department of Social Services, failed to print a Notice of Intent to adopt regulations (Connecticut General Statutes (5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes17b-260a-16(d); Connecticut General Statutes17b-260a-16(e)), within 20 days after adopting said regulations adopted on April 1, 2013, as required by Connecticut General Statutes 17b-10 prior to July 1, 2013.

K. The Department of Social Services printed a Notice of Intent to adopt

regulations (Connecticut General Statutes 17b-260a-16(5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes17b-260a-16(d); Connecticut General Statutes17b-260a-16(e) for the ABI/TBI Medicaid Waiver Program on March 26, 2013.

L. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e)) for the ABI/TBI Medicaid Waiver Program on March 26, 2013 and by adoption of said regulations on April 1, 2013, exerted behavioral control over self-employed, Petitioner's, in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii) and exercised control that did not exist prior to adoption of said regulations prior to April 1, 2013.

M. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-16(5)(3)(B)) for the ABI/TBI Medicaid Waiver Program on March 26, 2013 and by adoption of said regulations, exerted behavioral control over self-employed Petitioner's, in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii) and exercised control that did not exist prior to adoption of said regulations prior to adoption of said regulations on April 1, 2013.

N. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes17b-260a-16(d); Connecticut General Statutes17b-260a-16(e) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and with the adoption of the aforementioned regulations on April 1, 2013, established "new" criteria for documentation of services rendered to ABI/TBI Medicaid Waiver participants, resulting in a loss of autonomy, resources, and other legally protected interests for Petitioners, that did not exist prior to the adoption of said regulations prior to April 1, 2013.

O. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes17b-260a-16(d); Connecticut General Statutes17b-260a-16(e) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and required that Petitioner's 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 and 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

resulting in a loss of autonomy, resources, privacy, dignity, and status for self-employed or agency employed Petitioner's that did not exist prior to the adoption of said regulations prior to April 1, 2013.

P. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-16(b)) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and required that Petitioner's upon written request presented to the petitioner's, the department or its authorized agent may be given immediate access to, and permitted to review and copy any and all records and documentation used to support claims billed to Medicaid resulting in a loss of security, privacy, dignity, and an obligation to legally protect public health information from an individual that the petitioner may not know is operating in the capacity as a representative of or behalf of Department of Social Services, a requirement that did not exist prior to the adoption of said regulations on April 1, 2013.

Q. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes17b-260a-16(d)) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and required that petitioner's for purposes of Connecticut General Statutes 17b-260a-16(b) provide "immediate access" and "immediate access" means, access to records at the time the written request is presented to the provider, resulting in a loss of security, privacy, dignity, and an obligation to legally protect public health information from an individual that the petitioner's may be unable to verify as operating in the capacity as a representative or on behalf of Department of Social Services, a requirement that did not

exist prior to the adoption of said regulations prior to April 1, 2013.

R. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes17b-260a-16(d)) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and required that Petitioner's, for purposes of Connecticut General Statutes 17b-260a-16(d) submit monthly reports and written updates on the individual's progress in a form that is set forth by the department and by adoption of said regulation established new documentation requirements that did not exist prior to adoption of said regulation on April 1, 2013.

S. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes17b-260a-16(d)) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and determined that Petitioner's, for purposes of Connecticut General Statutes 17b-260a-16(e), may not receive payment for services if petitioner's failed to comply with Connecticut General Statutes 17b-260a-16(a)(1) Connecticut General Statutes 17b-260a-16(a)(2) Connecticut General Statutes 17b-260a-16(a)(3) Connecticut General Statutes 17b-260a-16(a)(4) Connecticut General Statutes 17b-260a-16(a)(5) Connecticut General Statutes 17b-260a-16(a)(6) Connecticut General Statutes 17b-260a-16(b) Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); and by adoption of said regulation, established new documentation requirements and penalties that did not exist prior to adoption of said regulation on April 1, 2013.

T. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and petitioner's determined that it was best to comply, due to threats from Department of Social Services based on Connecticut General Statutes 17b-260a-16(e), and execution of audits and fines without regulations, against other providers prior to April 1, 2013 (See Exhibits 25-30) that the Petitioner's should comply with the coercive action to gather new documentation data, but DSS provided no method of reimbursement for the work required to gather new documentation data and by adoption of said regulations, adopted new requirements that did not exist prior to adoption of said regulations on April 1, 2013, as there was no cost required in meeting the documentation requirements under the Provider Agreement, signed January 15, 2004, as the invoice submitted for billing met the prior documentation requirements detailed in "Item 9" of the Provider Agreement as demonstrated in

(Exhibit 40) and Table 1. (see below).

Table 1.

PROVIDER AGREEMENT: ITEM 9	INVOICE
I WILL	Names of Petitioner's
MAINTAIN RECORDS	Invoice
THAT FULLY DISCLOSE SERVICES/GOODS RENDERED AND/OR DELIVERED	Cognitive Behavioral Programs is one of two services that the Petitioner is approved to provide. See application attached to the Provider Agreement, signed on January 15, 2004.
TO ABI WAIVER PARTICIPANTS	Participants Name
THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST	As provided by Petitioner's on June 16, 2014, during a Records Review scheduled at the earliest time possible, based on a mutually agreed upon date and time for both parties.

U. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b) Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and by Connecticut General Statutes 17b-260a-16(e) compelled Petitioner's to gather data but provided no authority for providers to compel participants and/or their legal representatives or the Department of Social Services (the department holds all services plans for all participants but haphazardly provides such service plans based on the discretion of the department despite such plans containing the name of the participant, signature of the participant and/or their legal representative, provider's name, dates of the service plan, a brief description of services provided and additional information including but not limited to the number of service hours available to petitioner's) to provide said information and by adoption of said regulations placed petitioner's at a disadvantage, when submitting an invoice, if or when their records are reviewed, Petitioner's are more likely to fail a records review, and will be subject to penalties under Connecticut General Statutes 17b-260a-16(e), and by adoption of said regulations established a requirement that did not exist prior to adoption of said regulation on April 1, 2013.

V. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-16(d) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and determined that

Petitioner's for purposes of Connecticut General Statutes 17b-260a-16(d) shall "submit monthly reports and written updates in a form that is set forth by the department" and by adoption of said regulations established a requirement that did not exist prior to adoption of said regulation on April 1, 2013.

W. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes (5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b; Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e)) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and failed to submit said regulations to the Licensing Regulation Review Committee (LRRC) within 180 days as required by Connecticut General Statues 17b-10 and by adoption of said regulations failed to comply with a mandatory requirement and created legislation without legislative review by adoption of said regulation on April 1, 2013.

X. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-16(5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b; Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e)) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and failed to submit said regulations to the Licensing Regulation Review Committee (LRRC) within 180 days as required by Connecticut General Statues 17b-10 and failed to allow said regulations to be considered while operating under said regulations as required by Connecticut General Statues 17b-10(b) and by adoption of said regulations failed to comply with a mandatory requirement and created legislation without legislative review by adoption of said regulation on April 1, 2013.

Y. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-16(5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and failed to submit said regulations to the Licensing

Regulation Review Committee (LRRC) within 900 days, exceeding the requirement of 180 days as required by Connecticut General Statues 17b-10 and by adoption of said regulations failed to comply with a mandatory requirement "five-fold" and created legislation without legislative review by adoption of said regulation on April 1, 2013.

Z. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-16(5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and develop regulations in a manner that was "intentionally vague" as attested in an email from Department of Social Services, as required by Connecticut General Statutes 17b-10, which requires that regulations be written in a manner that is "clear and concise" and by adoption of said regulations on April 1, 2013 failed to comply with Connecticut General Statutes 17b-10.

AA. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-16(5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and failed to distribute said regulations to subregional offices and town halls as required by Connecticut General Statutes 17b-10 and by adoption of said regulations on April 1, 2013 failed to comply with Connecticut General Statutes 17b-10.

BB. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-16(5)(3)(B); Connecticut General Statutes17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) for the ABI/TBI Medicaid Waiver Program on March 26, 2013, and adopted said regulations on April 1, 2013 prior to legislative changes to Connecticut General Statues 4-168 and Connecticut General Statutes 17b-10(b) that became effective July 1, 2013.

CC. The Petitioner's include NeuroStrategies, Inc and Tariq Abdulaziz, Ph.D., M.S., M.S., MBA. NeuroStrategies, Inc. is a Connecticut Corporation that is approved to provide Cognitive Behavioral Programs on the ABI/TBI Medicaid Waiver Program. NeuroStrategies, Inc. receives form 1099-MISC as acknowledgement of payments received for services rendered on ABI/TBI Medicaid Waiver Program. The approval of NeuroStrategies, Inc. as a provider is based on the credentials of Tariq Abdulaziz, Ph.D., M.S., M.S., MBA as an Educational Psychologist based on ABI/TBI Medicaid Waiver Guidelines within the ABI Waiver Provider Manual (Exhibit 12).

Tariq Abdulaziz, Ph.D., M.S., M.S., MBA is an employee of NeuroStrategies, Inc. and receives for W-2 to document wages earned through employment as a Cognitive Behavioral Programs provider for NeuroStrategies, Inc. on the ABI/TBI Medicaid Waiver Program.

Allied Community Resources, Inc (ACR) serves as the fiduciary agent for the ABI/TBI Medicaid Waiver Program and the agency is contractually obligated to Department of Social Services (DSS) to provide fiduciary services for the ABI/TBI Medicaid Waiver Program. The relationship among,

ACR is identified as the payer of services on form 1099 received by NeuroStrategies, Inc.

The Provider Manual (Exhibit 12) for the ABI/TBI Medicaid Waiver Program identifies Educational Psychologists (Dr. Abdulaziz) as being self-employed.

The Petitioner's had a signed Provider Agreement with Department of Social Services signed, January 15, 2004 and effective throughout 2013 (Exhibit 1).

The Department of Social Services (DSS) is the employer of record for the Petitioner's.

As a self-employed entity (NeuroStrategies, Inc) and provider (Tariq Abdulaziz, Ph.D., M.S., M.S., MBA) the self-employed entity must be free from control, in the contract for hire and in fact as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii).

DSS has detached itself from the responsibility of an employer-employee relationship with the Petitioner. DSS has hired a fiduciary agent to execute its (DSS) responsibilities.

The Petitioner's are responsible for paying unemployment compensation

and Petitioner's pay unemployment compensation to the State of Connecticut.

Department of Social Services exercises behavioral control as demonstrated through its adoption of regulations
Connecticut General Statues 17b-260a-5(3)(B);
Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);
Connecticut General Statutes 17b-260a-16(b);
Connecticut General Statutes 17b-260a-16(c);
Connecticut General Statutes 17b-260a-16(d),
Connecticut General Statutes 17b-260a-16(e), and
Connecticut General Statutes 17b-260a-17

is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii) Department of Social Services, must either assume responsibilities, of an employer/employee relationship (pay unemployment compensation, workers compensation, professional liability insurance, health insurance, retirement benefits or pension and other entitlements) as assumed by the Petitioner's to date

OR

refrain from exercising control of the Petitioner's through adoption and implementation of policies and regulations that impair the autonomy of the Petitioner's;
Connecticut General Statues 17b-260a-5(3)(B),
Connecticut General Statutes 17b-260a-16(a)(1),
Connecticut General Statutes 17b-260a-16(a)(4),
Connecticut General Statutes 17b-260a-16(a)(5),
Connecticut General Statutes 17b-260a-16(a)(6),
Connecticut General Statutes 17b-260a-16(b),
Connecticut General Statutes 17b-260a-16(c),
Connecticut General Statutes 17b-260a-16(d),
Connecticut General Statutes 17b-260a-16(e), and
Connecticut General Statutes 17b-260a-17

and violate Connecticut General Statutes 31-222(a)(1)(B)(ii) and the previously signed Provider Agreement signed by the Petitioner's on January 15, 2004

DD. The Department of Social Services printed a Notice of Intent to adopt regulations (Connecticut General Statutes 17b-260a-17) on March 26, 2013 and adopted said regulations on April 1, 2013. Said regulation is as follows;

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

EE. The Department of Social Services conducted a "Records Review" of the Petitioner's records on June 16, 2014, the Petitioner's cooperated with the departments "Records Review". The Department communicated that all regulations printed on March 26, 2013 and adopted on April 1, 2013 (Connecticut General Statues 17b-260a-1 to Connecticut General Statutes 17b-260a-17) are in effect as of April 1, 2013, inclusive of regulations governing "new documentation" requirements;

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);
Connecticut General Statutes 17b-260a-16(b);
Connecticut General Statutes 17b-260a-16(c);
Connecticut General Statutes 17b-260a-16(d), and
Connecticut General Statutes 17b-260a-16(e)
Connecticut General Statutes 17b-260a-17

and used said regulations, as a basis for a "Review of Records" conducted on June 16, 2014

and as said regulations, cited above, are adopted and may be implemented as a measure of the Petitioner's compliance with documentation

and the department communicated that it would apply the following regulations to an evaluation of the new documentation requirements adopted April 1, 2013;

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);

and despite the petitioner's signed Provider Agreement, signed January 15, 2004

Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6); were adopted and

Department of Social Services requested immediate access to records to be reviewed and applied the following regulations as a basis for their demand for access that must be immediately provided by

Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c);

and Department of Social Services Quality Assurance requested monthly reports for the period of the Records Reviewed and forwarded a request for monthly reports to Petitioner's on July 29, 2014, and the following regulation

Connecticut General Statutes 17b-260a-16(d),

addresses the requirement to produce monthly reports, and a failure to do so will result in suspension of payment as outlined by

Connecticut General Statutes 17b-260a-16(e);

and Connecticut General Statutes 17b-260a-17 established that, Provider Termination or De-Qualification may result unless

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

FF. The Department of Social Services pays the Petitioner's based on services provided hourly (Exhibit 40). The Department of Social Services has established an hourly wage for the Petitioner's (Exhibit 40). The Department of Social Services (DSS) determines the rate of pay for Cognitive Behavioral Programs services (Exhibit 40) and (Exhibit 45). The number of hours that may be provided on a daily basis is established by DSS (Exhibit 40). Therefore, the amount of pay that can be earned on a daily, monthly, and yearly basis is controlled by DSS.

GG. The Petitioner's have signed three Provider Agreements including January 15, 2004, October 23, 2014, and October 28, 2015 hereafter referred to as "PA1" (Exhibit 1), "PA2" (Exhibit 46), and "PA3" (Exhibit 47) respectively.

HH. The Department of Social Services upon adoption of Connecticut General Statutes 17b-260a-16, terminated the Petitioner's PA1 due to a failure to properly adopt Connecticut General Statutes 17b-260a-16 and Connecticut General Statutes 17b-260a-1 to Connecticut General Statues 17b-260a-17.

II. The Petitioner's operated under PA1 from 2004 until its termination on April 1, 2013, termination that occurred due to the adoption of "new" documentation requirements (Connecticut General Statutes 17b-260a-16) without proper notice with specific reference to
Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);
Connecticut General Statutes 17b-260a-16(a)(b);
Connecticut General Statutes 17b-260a-16(a)(c);
Connecticut General Statutes 17b-260a-16(a)(d); and
Connecticut General Statutes 17b-260a-16(a)(e);

after adoption of said regulations, Petitioner's continued to operate on the ABI/TBI Medicaid Waiver Program without a Provider Agreement until October 23, 2014 when the Petitioner signed PA2.

JJ. The Petitioner's operated under PA2 from October 23, 2014 until October 28, 2015 when PA3 was signed. The signing of PA3 is not binding on the Petitioner's t this time as the Provider Agreement (PA3) is under review.

KK. The Petitioner's attest that the documentation requirements between the three Provider Agreements are as follows "Item 9" of PA1 describes documentation requirements as follows;

I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES/GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST

PA2 and PA3, in "Item 7" of each agreement, describe documentation requirements as follow;

THE AGENCY WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES AND GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF DSS UPON REQUEST

LL. The Petitioner's attest that the billing requirements between the three Provider Agreements (PA1, PA2, and PA3) describe billing as follows, in PA1, there is no specific reference as to how services are to be billed. In PA2 and PA3, in "Item 4" of the Provider Agreements, billing is described as follows

THE AGENCY WILL ADHERE TO THE UNITS AND SERVICES ASSIGNED IN ACCORDANCE WITH THE ABI WAIVER PARTICIPANT'S SERVICE PLAN TO WHICH THE AGENCY IS NAMED AS A SERVICE PROVIDER

The Department of Social Services upon adoption of new policies on December 1, 2015 (Exhibit 48 and Exhibit 49) changed the terms of the billing requirements in the Petitioner's signed Provider Agreement. The change in requirements is considered to have terminated PA2, which was the operating Provider Agreement at the time of adoption of new policies on December 1, 2015. The Petitioner's attest that PA3 (presently under review at Department of Social Services at the time of submission of this Request for Declaratory Ruling) is "void" as the changes in description of Cognitive Behavioral Program, that formed the basis of the application has been altered since signing of PA3 on October 28, 2013.

Furthermore, by changing the terms of PA2, Department of Social Services placed the Petitioner's in a position where billing as requested under the December 1, 2015 requirements, places the Petitioner in a position where there is a violation of the terms of agreement with the participant (Exhibit 50, p.4). The participant's have a signed (Exhibit 50 p.4-5) service plan (agreement) with Department of Social Services that contains a section entitled;

"PART A. ABI WAIVER SERVICES COSTS"

The petitioner's are listed, along with the number of months, units per month, unit rate, monthly total, and total.

Each aspect of the terms for billing is explicitly stated in the agreement. The Petitioner's will be in violation of these terms if the Petitioner's bill at the rate required by Department of Social Services (DSS) on December 1, 2015 ($105.00 per hour or $19.50 per quarter hour and each iteration thereof).

MM. The Centers for Medicare and Medicaid Services (CMS) requires State's to meet Assurances including "Financial Accountability & Integrity". In Appendix I-1 (Exhibit 9, pp.248-251), CMS inquires as to the "audit protocols" that states have to ensure the integrity of Provider billing. It is this area and this particular questions and set of criteria that is the basis of where Department of Social Services initiates its deception with respect to audits, record reviews, violations of provider agreements, purposeful misapplication of a federal conforming requirement, and development and implementation of audit protocols through its fiduciary (Allied Community Resources) that has no basis in Connecticut General Statutes 17b-99.

NN. Department of Social Services (DSS) falsified its 2006 and 2012 applications to Centers for Medicare and Medicaid Services (CMS) by attesting that DSS had "audit protocols" for its ABI Waiver program when no "audit protocols" existed. The Department of Social Services submitted their falsified 2012 application on October 1, 2012 and sixteen days later on October 16, 2012, printed a Notice of Intent to adopt "audit protocols". The "audit protocols" adopted were never approved by Licensing Rules and Regulation Committee (LRRC). Department of Social Services used the federal requirement to adopt "audit protocols" as a means of adopting "documentation requirements" which are not "audit protocols".

OO. Department of Social Services has initiated "audit protocols" without legislative review and has implemented "audit protocols" against the petitioner's on October 31, 2015 (Exhibit 58). The requirements placed on the petitioner's are onerous and exceed requirements in place one year earlier and the Petitioner's are harmed by the illegal adoption of "audit protocols" without legislative review.

PP. The Department of Social Services modified the description of Cognitive Behavioral Programs (CBP) and separated the service into Face to Face and Non Face-to-Face services. In addition, Department of Social Services assigned a new procedural code 1448P for "NFF" services and associated "units" with the service in violation of the Petitioner's Provider Agreement. The Department of Social Services exercised behavioral control over CBP providers by adoption of new policies under Connecticut General Statutes 17b-8. The Department of Social Services has violated Connecticut General Statutes 31-222(a)(1)(B)(ii) by requiring setting

requirements for frequency of visits with participants, demanding FF visits, and imposing the CBP providers operate at the discretion of a case manager.

QQ. In addition, Petitioner's will violate the participant's service plan if for example the Petitioner's have 8 hours of Cognitive Behavioral Program service per month at $82.40 per hour for 12 months;

(8)(82.40) = $659.20(12) = $7,940.00 per year

if the Petitioner's bill at a rate of $105.00 per hour for all services in a month, as is allowed by December 1, 2015 policies, the client will receive fewer hours of service than found in the service plan, thereby violating the number of units available

$659.20 (monthly total available to the participant in the service contract)

$105.00 (Face-to-Face rate, imposed on the Petitioner's December 1, 2015)

$659.20/$105.00 = 6.27 hours of service per month

8.00 hours per month in plan – 6.27 hours maximum realized at $105.00

= (1.73) hours of lost service time effective December 1, 2015

if the Petitioner's use a combination of 1548P and 1448P service codes to meet the needs of the participant, 8 hours can be delivered, however, the Petitioner's will have employed the use of a procedure code that cannot be found in the service plan and the procedure code has units that fluctuate as the number of units billed on 1448P are determined by the Petitioner's.

RR. The Petitioner's will have violated the terms of the service contract and violated the Provider Agreement. the Petitioner's down a "garden path" to violating the terms of the Provider Agreement" due to coercion and previous violation of the Provider Agreement by Department of Social Services by changing the terms of the agreement.

SS. The Petitioner's attest that after December 1, 2015, and adoption of new requirements, that are not a part of the Provider Agreements previously signed (PA1, PA2, nor PA3) that the Petitioner's are operating without a Provider Agreement due to a change in terms, related to billing, that was not mutually agreed upon by the parties.

TT. The Department of Social Services is in violation of requirements from Centers for Medicare and Medicaid Services. Centers for Medicare and Medicaid Services (CMS), requires that the Department of Social Services maintain Provider Agreements with all providers on the ABI/TBI Medicaid Waiver Program.

UU. The Department of Social Services by adoption of a new description of Cognitive Behavioral Programs has violated the terms of the Provider Agreement signed on October 23, 2014 and the Provider Agreement signed on October 28, 2015. The Petitioner's signed the Provider Agreement with the belief that the valid description of Cognitive Behavioral Programs is listed in the Provider Manual (Exhibit 12). The Department of Social Services acknowledges in its Notice of Intent, printed on March 26, 2013 that the ABI/TBI Medicaid Waiver Program was governed at the time by the ABI/Medicaid Waiver application and the Provider Manual. It is the description of Cognitive Behavioral Programs in the Provider Manual that was the basis of the petitioner's signing of the Provider Agreements in October 2014 and October 2015. The Petitioner's will argue that the description of Cognitive Behavioral Programs in Connecticut General Statutes 17b-260a-5(3) is not valid. as the regulations were not properly adopted. The Petitioner's further assert that the description of Cognitive Behavioral Programs as adopted on December 1, 2015, is not the definition of Cognitive Behavioral Programs that existed at the time of the signing of the Provider Agreement and the language is not contained anywhere in the Agreements signed by the Petitioner's in October 2014 and October 2015.

VV. The Department of Social Services in its December 1, 2015, change in description of Cognitive Behavioral Programs, adopts a description that did not exist at the time the Provider Agreements (2014

and 2015) were signed. This adoption is in violation of the Provider Agreements.

WW. The Department of Social Services by adoption of the December 1, 2015 description of Cognitive Behavioral Programs directs the Petitioner's to provide services "face to face," a new requirement that did not exist prior to its adoption on December 1, 2015. A new requirement that exercises behavioral control over the Petitioner's who are not employees of the Department of Social Services.

XX. The Department of Social Services exercises behavioral control over the Petitioner's with the following requirement

"A quarterly, in person meeting with the waiver participant is required for this service"

YY. The Department of Social Services exercises behavioral control over the Petitioner's by determining which products (Skype) and methods are to be employed by the Petitioner's in execution of their service to participants.

ZZ. The Department of Social Services dictates that the Petitioner's, as Cognitive Behavioral Program providers must work in concert with a "case manager". The requirement exercises behavioral control over the Petitioner's who are self-employed. Behavioral control exercised by Department of Social Services is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

AAA. The Department of Social Services acknowledges that the service contract with participants is violated and Petitioner's are to be complicit in the violation given the "significant increase" in pay from $83.22 per hour to $105.00 per hour (Exhibit 48);

> Just for the purposes of clarification. The service plan will not differentiate "face-to-face" versus "non-face-to-face" hours. As a provider, you can determine that breakdown as long as the billing doesn't exceed the authorized hours in the service plan. Please

note the significant increase in the rate for providing the in person service.

The Petitioner's are impacted by such a change, as said change violates "Item 4" of the Provider Agreement and the terms of the service contracts on which the Petitioner's name (NeuroStrategies, Inc) appears that is signed by the participant as well as the Department of Social Services (Exhibit 50, p.4-5).

BBB. The Department of Social Services falsified several ABI Waiver applications submitted to Centers for Medicare & Medicaid Services regarding the existence and use of audit protocols. The falsified waiver applications include 2006, 2012, amended 2012, ABI Waiver II, and Petitioner's predict that the 2016 ABI Waiver renewal will reference "documentation requirements" (17b-260a-16) and "audit protocols" that have not been adopted by Connecticut General Statutes 17b-99.

CCC. False claims submitted to Centers for Medicare & Medicaid Services by DSS, make no mention of a process entitled "Records Review" which is found in the Provider Agreements of the Petitioner's. When the Petitioner's received a request to review records, the Petitioner's assumed, based on information within the falsified ABI Waiver applications, that an audit was being conducted, not some conveniently constructed process that has no basis in the ABI Waiver culture (records review). The Petitioner's believe that if they had not sought legal counsel and had chosen to discuss the outcome of the "Records Review" with DSS without the benefit of counsel, that the Petitioner's would have had their "Records Review" transitioned into an audit and it is likely that elements of Connecticut General Statutes 17b-99 would have been applied to the Petitioner's, resulting in an illegal audit, similar to illegal audits initiated against other providers (Exhibits 25-30 and Exhibits 65-65H) with significant financial consequences (Exhibit 65E) unless a "good deal" could be achieved (Exhibit 65F). It is unlikely that the Petitioner's would have been provided a "good deal" as the Petitioner's have a negative relationship with Commissioner Roderick Bremby due to their challenge of Commissioner Bremby at an ABI Waiver hearing in the Spring 2014. Less than a month later, the Petitioner's were sent a request for "Records Review" (audit) by DSSQA.

DDD. The Department of Social Services conducted audits of providers (Exhibits 25-30 and Exhibits 65-65H) on the ABI Medicaid Waiver Program prior to adoption of regulations required to conduct audits of providers by Connecticut General Statutes 17b-99 (Exhibit 65A). The Department of Social Services printed a Notice of Intent to adopt regulations to audit providers on October 16, 2012. Regulations were never secured and despite not having regulations, heavy fines were levied

against providers (Exhibit 65E).

EEE. The ABI Waiver is due for renewal on January 1, 2016 and the Petitioner's predict that the "documentation requirements" which were adopted despite numerous errors and falsification of a conforming requirement will be combined with illegally adopted audit protocols that have no basis in Connecticut General Statutes 17b-99. The combining of this "two-pronged" approach will also serve as a "cover-up" of the previously falsified waiver applications (2006, 2012, 2012 amended and ABI Waiver II).

FFF. The Department of Social Services terminated the Petitioner's Provider Agreement upon adoption of "new" documentation requirements (Connecticut General Statutes 17b-260a-16) in contravention to "Item 9" of said Provider Agreement.

GGG. The Department of Social Services terminated the Petitioner's Provider Agreement signed on October 23, 2014, upon adoption of reimbursement policies on December 1, 2015 as said policies violate "Item 4" of the Provider Agreement.

HHH. The Department of Social Services voided the Petitioner's Provider Agreement signed on October 28, 2015, upon adoption of reimbursement policies on December 1, 2015 as said policies violate "Item 4" of the Provider Agreement, as adopted policies could not have been considered at the time of the signing of said Provider Agreement, as such policies could not have been considered because the policies did not exist.

PETITIONER'S RESPONSE TO QUESTIONS

1. Did Department of Social Services print more than one notice in Connecticut Law Journal regarding the adoption of

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

   as required by Connecticut General Statues 17b-10(b) prior to July 1, 2013, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

   No! The Department of Social Services printed a Notice of Intent related to said regulations on March 26, 2013. The March 26, 2013 printing was the only printing of a notice related to adoption of said regulations. The failure to print a Notice of Intent on or prior to February 26, 2013 violates Connecticut General Statutes 4-168.

2. Given that Department of Social Services adopted the following regulations on April 1, 2013,

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

   did Department of Social Services print a Notice in Connecticut Law Journal regarding said regulations on either April, 2, 2013, April 9, 2013 or April 16, 2013, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

   No! The Department of Social Services printed only one notice related to the adoption of said regulations. The Department of Social Services printed that notice on March 26, 2013. Failure to print a notice in the Connecticut Law

Journal on April 2, 9, or 16th is a violation of Connecticut General Statues 17b-10(b)

3. Given that Department of Social Services adopted the following regulations on April 1, 2013,

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

   did Department of Social Services print a Notice in Connecticut Law Journal regarding said regulations on February 26, 2013 or prior to February 26, 2013, as required by Connecticut General Statutes 4-168, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

No! The only notice printed regarding said regulations was printed on March 26, 2013. Failure to print a notice on Tuesday February 26, 2013 or on a prior Tuesday is a violation of Connecticut General Statutes 4-168

4. Given that a printing of a Notice of Intent, 30 days prior to adoption of a regulation is required by Connecticut General Statutes 4-168, including

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

   did Department of Social Services print a Notice in Connecticut Law Journal, for said regulations, on or prior to March 2, 2013, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

No! The Department of Social Services printed one notice regarding said

regulations. The notice was printed on March 26, 2013, which does not comply with Connecticut General Statutes 4-168.

5. Given that a printing of a Notice, 20 days after adoption is required by Connecticut General Statutes 17b-10(b), prior to July 1, 2013, including

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

   did Department of Social Services print a Notice in Connecticut Law Journal, for said regulations, after April 1, 2013 but not later than April 21, 2013, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

No! The Department of Social Services printed one notice regarding said regulations. The notice was printed on March 26, 2013, which does not comply with Connecticut General Statutes 17b-10(b).

6. In its Notice of Intent printed on March 26, 2013, did Department of Social Services, disclose that "1999 non-promulgated policies" existed and were used to administer the Acquired Brain Injury/Traumatic Brain injury Waiver Program prior to adoption of regulations, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

No! The Department of Social Services failed to disclose that 1999 non-

promulgated policies were used in legal decision making and were used prior to adoption of Connecticut General Statutes 17b-260a-16

7. Given that referencing the correct statutory authority, in a Notice of Intent, is required by Connecticut General Statutes 4-168, prior to July 1, 2013 including,

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

   did Department of Social Services, reference the correct statutory authority in the notice printed on March 26, 2013 for said regulations, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

No! The Department of Social Services references Connecticut General Statutes 17b-260b. The correct statute for the ABI Waiver Program is Connecticut General Statutes 17b-260a.

8. Given that Connecticut General Statutes 17b-10(b) requires a federal conforming requirement to use said statute in adoption of

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

   did Department of Social Services provide a reference to the federal conforming requirement in its Notice of Intent printed on March 26, 2013, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

No! Lara Stauning in an exchange of emails with Phyllis Hyman, indicated

that she wanted to include a reference to the federal conforming requirement but she could not find any requirement in the waiver or in the waiver application that served as a basis for using Connecticut General Statutes 17b-10(b) in the adoption of said regulations.

9. Given that Connecticut General Statutes 17b-10(b) requires, Department of Social Services to forward,

   Connecticut General Statutes 17b-260a-16(a)(1);
   Connecticut General Statutes 17b-260a-16(a)(4);
   Connecticut General Statutes 17b-260a-16(a)(5);
   Connecticut General Statutes 17b-260a-16(a)(6);
   Connecticut General Statutes 17b-260a-16(a)(b);
   Connecticut General Statutes 17b-260a-16(a)(c);
   Connecticut General Statutes 17b-260a-16(a)(d); and
   Connecticut General Statutes 17b-260a-16(a)(e);

   to the Licensing Regulation and Review Committee (LRRC) within 180 days of adoption, did Department of Social Services forward said regulations by October 1, 2013, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

No! The regulations were not forwarded to LRRC by October 1, 2013

10. Given that Connecticut General Statutes 17b-10(b) requires, Department of Social Services to forward,

    Connecticut General Statutes 17b-260a-16(a)(1);
    Connecticut General Statutes 17b-260a-16(a)(4);
    Connecticut General Statutes 17b-260a-16(a)(5);
    Connecticut General Statutes 17b-260a-16(a)(6);
    Connecticut General Statutes 17b-260a-16(a)(b);
    Connecticut General Statutes 17b-260a-16(a)(c);
    Connecticut General Statutes 17b-260a-16(a)(d); and
    Connecticut General Statutes 17b-260a-16(a)(e);

    to the Licensing Regulation and Review Committee within 180 days of adoption, did Department of Social Services forward said regulations by October 1, 2014, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

No! The regulations were not forwarded to LRRC by October 1, 2014

11. Given that Connecticut General Statutes 17b-10(b) requires, Department of Social Services to forward,

    Connecticut General Statutes 17b-260a-16(a)(1);
    Connecticut General Statutes 17b-260a-16(a)(4);
    Connecticut General Statutes 17b-260a-16(a)(5);
    Connecticut General Statutes 17b-260a-16(a)(6);
    Connecticut General Statutes 17b-260a-16(a)(b);
    Connecticut General Statutes 17b-260a-16(a)(c);
    Connecticut General Statutes 17b-260a-16(a)(d); and
    Connecticut General Statutes 17b-260a-16(a)(e);

    to the Licensing Regulation and Review Committee within 180 days of adoption, did Department of Social Services forward said regulations by October 1, 2015, given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

No! The regulations were not forwarded to LRRC by October 1, 2015 The regulations have not been submitted to the LRRC as of December 7, 2015.

12. Did Petitioner's enter into a Provider Agreement, dated January 15, 2004 with Department of Social Services prior to adoption of the following regulations;

    Connecticut General Statutes 17b-260a-16(a)(1);
    Connecticut General Statutes 17b-260a-16(a)(4);
    Connecticut General Statutes 17b-260a-16(a)(5);
    Connecticut General Statutes 17b-260a-16(a)(6);
    Connecticut General Statutes 17b-260a-16(a)(b);
    Connecticut General Statutes 17b-260a-16(a)(c);
    Connecticut General Statutes 17b-260a-16(a)(d); and
    Connecticut General Statutes 17b-260a-16(a)(e);

    given that the Petitioner's are providers on the ABI Waiver, operating under a signed Provider Agreement

Yes! The Petitioner's signed said Provider Agreement on January 15, 2004

    and did the Petitioner's operate under the Provider Agreement until adoption of said regulations, on April 1, 2013

Yes! The Provider Agreement was in place prior to April 1, 2013 .

and did the Petitioner's have their Provider Agreement terminated upon adoption of Connecticut General Statutes 17b-260a-16 on April 1, 2013, but Petitioner's signed a new Provider Agreement on October 23, 2014

Yes! The documentation requirements in CGS 17b-260a-16 violated the documentation requirements thereby voiding the Provider Agreement signed January 15, 2004. The Petitioner's signed a new Provider Agreement on October 23, 2014

and did the Petitioner's operate under said Provider Agreement until signing a subsequent agreement on October 28, 2015, and were the 2014 and 2015 Provider Agreements violated by DSS upon adoption of December 1, 2015 policies that violate "Item 4" of each Agreement (2014 and 2015)

Yes! The Petitioner's operated under said Provider Agreement from October 23, 2014 until October 28, 2015. However, Provider Agreement signed October 28, 2015 is under review and has not been approved by Department of Social Services. But on December 1, 2015 and Petitioner's Provider Agreement was violated by DSS as the department changed the terms of "Item 4" in both the 2014 and 2015 Agreements. As a result, both Agreements are now voided

and are "documentation requirements", detailed in the January 15, 2004 Provider Agreement and October 23, 2014 and October 28, 2015 Provider Agreements, essentially identical with the October 23, 2014 and October 28, 2015 "documentation requirements" being exactly identical as outlined below on January 15, 2004,

> I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES/GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST
>
> and in 2014 and 2015,
>
> THE AGENCY WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES/GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST

Yes! The 2004 Provider Agreement "documentation requirement" is as displayed prior and the 2014 and 2015 "documentation requirements" are accurately

represented in the former display

13. Did Department of Social Services, in its Notice of Intent printed on March 26, 2013, or in regulations adopted on April 1, 2013, or in any communication distributed to the Petitioner's, make reference to the Petitioner's Provider Agreements signed on January 15, 2004; October 23, 2014; or October 28, 2015, and did Department of Social Services, disclose that said Provider Agreements are contingent upon any of the regulations adopted on April 1, 2013, with specific emphasis on the following regulations including

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5);
Connecticut General Statutes 17b-260a-16(a)(6);
Connecticut General Statutes 17b-260a-16(a)(b);
Connecticut General Statutes 17b-260a-16(a)(c);
Connecticut General Statutes 17b-260a-16(a)(d); and
Connecticut General Statutes 17b-260a-16(a)(e);

No! There is no reference to the said regulations in the Provider Agreements nor is their reference to the Petitioner's Provider Agreements in the regulations adopted on April 1, 2013. The Provider Agreements and regulations adopted on April 1, 2013, are separate and distinct documents with no reference in one respective document to the other document.

and did Department of Social Services indicate that either the 2004, 2014, or 2015 Provider Agreement(s) were modified, altered, terminated or dependent upon, future or previous adoption of said regulations adopted on April 1, 2013, and is their any explicit reference to the said regulations in any of the previously signed Provider Agreements or any reference in the 2013 Regulations adopted on April 1, 2013 to the previously signed Provider Agreements.

No! The Provider Agreements and Regulations adopted on April 1, 2013 are separate and distinct documents and there is no reference in the Provider Agreements to the Regulations and no reference in the Regulations adopted April 1, 2013 to any of the previously signed Provider Agreements

14. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the

ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement in which Item 9 of said Agreement, details documentation requirements as follows;

> I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES/GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST

and having provided CBP services on an ongoing basis both prior to April 1, 2013 and subsequent to April 1, 2013, are Petitioner's required to retain records (signature of the individual or their legal representative, start time for each visit, end time for each visit, a brief description of duties performed, and monthly reports and written updates) that were not required to be maintained, prior to adoption of regulation Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); and Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(d) adopted on April 1, 2013, are Petitioner's required to adhere to said regulations.

The position of the Petitioner's is that the Petitioner's and Department of Social Services had a signed Provider Agreement that details a number of Items including documentation requirements.

The signed Agreement was in effect at the time of adoption of Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes17b-260a-16(a)(4); Connecticut General Statutes17b-260a-16(a)(5); and Connecticut General Statutes17b-260a-16(a)(6); Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(d), adopted on April 1, 2013. The Petitioner's consider the new documentation requirements to be invalid as they are different than the requirements in the previously signed provider agreement (January 15, 2014) and were adopted after the provider agreement was in effect, were not properly noticed, cite the incorrect statutory authority in its notice, makes no reference to the termination of the provider agreement, and fails to give the petitioner's an option to decline a new Provider Agreement.

15. Are the Petitioners', as providers of Cognitive Behavior Programs (CBP), on the ABI/TBI Medicaid Waiver, having signed a Provider Agreement on January 15, 2004, and having provided CBP services on an ongoing basis prior and subsequent to April 1, 2013, required to provide

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

"immediate access", that was not required to be provided prior to adoption of regulation Connecticut General Statutes 17b-260a-16(b), on April 1, 2013 and said requirement is not included in the previously signed Provider Agreement. In addition, the authority to "review and copy any and all records and documentation used to support claims billed to Medicaid" is not a condition of the Petitioner's previously signed provider agreement dated January 15, 2004.

The Provider Agreement signed on January 15, 2004, prior to adoption of Connecticut General Statutes 17b-260a-16(b) on April 1, 2013, does not provide Department of Social Services (DSS) with "immediate access" to documentation and is a change from the previously signed Provider Agreement. The demand that DSS be allowed to copy "any and all records and documentation used to support claims billed to Medicaid" is a violation of the Petitioner's privacy, is an illegal search and seizure, a violation of the Petitioner's dignity, and a violation of the previously signed Provider Agreement. Connecticut General Statutes 17b-260a-16(b) is interpreted by these Petitioner's as DSS' right to demand access to records from this Petitioner during a time when the Petitioner may be unavailable. These requirements exceed documentation requirements and are audit protocols that have not been approved under Connecticut General Statutes 17b-99. The Department of Social Services is attempting to initiate audit protocols within its "documentation requirements" and is attempting to do so without legislative review (Exhibit 56).

The DSS representative could immediately determine that the Petitioner's are not in compliance, if the Petitioner's are not readily available to provide records. The regulation provides no guidelines with respect to scheduling a reasonable time and place to exchange records, notice is immediate, no reasonable time to prepare is provided and there is no reasonable expectation of privacy for the Petitioner's as is required under Connecticut General Statutes 17b-99.

The policy would allow DSS to visit my office or home office at anytime and demand access to files. The regulation would appear, on its face, to be intrusive and possibly illegal. It is the position of the Petitioner's that the regulation violates the dignity of the Petitioner's, their security, autonomy, expectation of privacy, and liberty.

16. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI/TBI Medicaid Waiver, having signed a Provider Agreement on January 15, 2004, and having provided CBP services on an ongoing basis prior and subsequent to April 1, 2013, required to provide

"immediate access" to records at the time the written request is presented

to the provider

and given that "immediate access" to records at the time the written request is presented to the provider" was not required prior to adoption of regulation Connecticut General Statutes 17b-260a-16(c), on April 1, 2013, and is not included in the previously signed Provider Agreement.

Under Connecticut General Statutes 17b-99, providers are afforded 30 days prior to presentation of records. The Department of Social Services is conducting an "end-run" around the "audit protocol" adoption process required under Connecticut General Statutes 17b-99 by bypassing protections afforded to providers in Connecticut General Statutes 17b-99 by placing requirements into improperly adopted "documentation requirements" under the umbrella of a perverted federal conforming requirement that does not exist under Connecticut General Statues 17b-10(b)

The Provider Agreement signed on January 15, 2004, prior to adoption of Connecticut General Statutes 17b-260a-16(c) on April 1, 2013, does not provide Department of Social Services (DSS) with "immediate access" to documentation and is a change from the previously signed Provider Agreement.

The Petitioner's participated in a Records Review on June 16, 2014. The records were reviewed for the year 2013. The Petitioner's 2013 records included records that preceded the adoption of Connecticut General Statutes 17b-260a-16(c) on April 1, 2013, as well as records that were developed after adoption of said regulation on April 1, 2013.

The Department of Social Services is attempting to initiate audit protocols within its "documentation requirements" and is attempting to do so without legislative review (Exhibit 56).

The regulation could be interpreted such that, any DSS worker could demand access to records during a time when the Petitioner is occupied and unable to comply. The DSS representative could immediately determine that the Petitioner is not in compliance. The regulation provides no limits, no notice, and no reasonable expectation of privacy. The policy allows DSS to visit my office or home office at anytime and demand access to files. The regulation would appear, on its face to be intrusive and possibly illegal. It is the position of the Petitioner that the regulation violates the dignity of the Petitioner's, as well as their security, autonomy, expectation of privacy, and liberty.

17. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI/TBI Medicaid Waiver, having signed a Provider Agreement on January 15, 2004, and having provided CBP services on an ongoing basis prior and subsequent to April 1, 2013, required to provide

> monthly reports and written updates on the individual's progress in a form set forth by the department,

and given that monthly reports and written updates on the individual's progress in a form set forth by the department, were not required prior to adoption of proposed regulation Connecticut General Statutes 17b-260a-16(d), on April 1, 2013, and is not included in the previously signed Provider Agreement (January 15, 2004)

The Provider Agreement signed January 15, 2004, prior to the adoption of Connecticut General Statutes 17b-260a-16(d) adopted on April 1, 2013 did not require monthly reporting and written updates in a form set forth by the department.

The Petitioner's view this "new documentation requirement" as onerous as the

Petitioner's did not agree to provide monthly reports as a condition of the previously signed Provider Agreement dated January 15, 2004. Monthly reporting and written updates are not a service the Petitioner's provide as Cognitive Behavioral Program providers and the burden to provide said reports has no bearing on the services provided. The Petitioner's assert that a demand that Connecticut General Statutes 17b-260a-16(d) be complied with to receive payment for services rendered is not a condition of the Provider Agreement. Department of Social Services (DSS) is attempting to tie payment for services rendered to the completion of monthly reports and "written updates" which are not services found in the Provider Agreement or in Regulations (Connecticut General Statutes 17b-260a-1 to Connecticut General Statutes 260a-17; Provider Manual description of Cognitive Behavioral Programs (Exhibit 12); and Provider Agreement (Exhibit 1)
The Petitioner's serve approximately 120 participants on the ABI/TBI Medicaid Waiver Program. Cognitive Behavioral Program services are billed on an hourly basis not a quarterly basis, as required by DSS (Exhibit 12). The rate of pay for Cognitive Behavioral Programs is $83.22 per hour. Assuming that each monthly report takes less than one hour to complete, and 120 reports are written and submitted per month, as is the case for the Petitioner's, the cost to the Petitioner's is at a rate of $83.22 per four at 120 reports per month, for a total of $9,986.40 per month and a yearly total of $119,836.80 per year. The costs that the Petitioner's incur due to the requirement of Connecticut General Statutes 17b-260a-16(d) is a tremendous burden, it is an attack on the Petitioner's legally protected interests (Petitioner's business) as the costs associated are unsustainable, impair the Petitioner's autonomy and dignity as the requirement to provide monthly reports is not a service that the Petitioner's agreed to provide.

18. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI/TBI Medicaid Waiver Program and having signed a Provider Agreement on January 15, 2004, and having provided CBP services on an ongoing basis prior and subsequent to April 1, 2013, subject to penalties

suspension of payment for failure to provide monthly reports and written updates, as detailed in Connecticut General Statutes 17b-260a-16(e)

adopted on April 1, 2013, given that suspension of payment for failure to comply with Connecticut General Statutes 17b-260a-16(a)(1) Connecticut General Statutes 17b-260a-16(a)(2) Connecticut General Statutes 17b-260a-16(a)(3)

Connecticut General Statutes 17b-260a-16(a)(4) Connecticut General Statutes 17b-260a-16(a)(5) Connecticut General Statutes 17b-260a-16(a)(6) Connecticut General Statutes 17b-260a-16(b) Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); was not a consequence prior to adoption of Connecticut General Statutes 17b-260a-16(e) on April 1, 2013, and is not included in the previously signed Provider Agreement.

The Provider Agreement signed January 15, 2004 does not contain a condition that nonpayment of services will result if the Petitioner's failed to provide documentation as detailed in Connecticut General Statutes 17b-260a-16(e) with reference to documentation requirements in Connecticut General Statutes 17b-260a-16(a)(1) Connecticut General Statutes 17b-260a-16(a)(2) Connecticut General Statutes 17b-260a-16(a)(3) Connecticut General Statutes 17b-260a-16(a)(4) Connecticut General Statutes 17b-260a-16(a)(5) Connecticut General Statutes 17b-260a-16(a)(6) Connecticut General Statutes 17b-260a-16(b) Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d) adopted on April 1, 2013. These are new requirements that are a significant change to the previously signed Provider Agreement.

The requirement is onerous and in essence requires the Petitioner's to gather data for DSS, at significant cost, and loss of their legally protected interests, and as a self-employed Petitioner (NeuroStrategies, Inc) loses its autonomy as a self-employed entity and as Petitioner, is being held hostage, to research, gather, obtain, and maintain documentation that has no bearing on the services provided.

However, payment for services provided may be suspended if the unilaterally established conditions that are not a part of the previously signed Provider Agreement are not met as adopted on April 1, 2013 in

Connecticut General Statutes 17b-260a-16(a)(1) Connecticut General Statutes 17b-260a-16(a)(2) Connecticut General Statutes 17b-260a-16(a)(3) Connecticut General Statutes 17b-260a-16(a)(4) Connecticut General Statutes 17b-260a-16(a)(5) Connecticut General Statutes 17b-260a-16(a)(6) Connecticut General Statutes 17b-260a-16(b) Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); was not required prior to adoption of Connecticut General Statutes 17b-260a-16(e)

The Petitioner's assert that payment for services rendered, is not a condition of the previously signed Provider Agreement dated January 15, 2004.

19. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, required to comply with Connecticut General Statutes 17b-260a-16(a)(1) if a participant chooses not to provide a signature for services submitted for Medicaid reimbursement, given that said regulatory requirement did not exist prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

The Provider Agreement signed January 15, 2004 does not contain a condition that nonpayment of services will result if the Petitioner's failed to provide documentation. These are new requirements that are a significant change to the previously signed Provider Agreement.

The requirement is onerous and in essence requires the Petitioner's to gather data for DSS, at significant cost, and loss of their legally protected interests, including its designation as being self-employed, results in a loss of autonomy as Petitioner's are being held hostage to research, gather, obtain, and maintain documentation that has no bearing on the services provided. However, payment for services provided may be suspended if the unilaterally established conditions that are not a part of the previously signed Provider Agreement are not met as adopted on April 1, 2013 in

Connecticut General Statutes 17b-260a-16(a)(1), adopted on April 1, 2013

The Provider Agreement signed January 15, 2004 does not require that the Petitioner's obtain a signature to receive reimbursement for services provided. The requirement is onerous as the participants on the ABI/TBI Medicaid Waiver Program are individuals with significant brain injuries. Many of the participants have significant behavioral challenges including physical aggression.

Many of the waiver participants have challenging behaviors and are unlikely to provide a signature and others would likely use a providers' need to obtain a signature to their strategic advantage to manipulate the terms of their relationship with this Petitioner's, who are responsible for establishing highly structured behavioral plans that are used to manage the participants effectively in the community.

Most importantly, the requirement cannot be executed due to the nature of the Petitioner's with respect to behavioral management, the requirement is not practical, cannot be reliably executed, is not a condition of the previously signed (January 15, 2004) Provider Agreement, and places an unnecessary burden on providers at the expense of waiver participants.

20. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15 2004, a Provider Agreement that does not require a signature to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, required to comply with Connecticut General Statutes 17b-260a-16(a)(1) if a participant is physically unable to provide a signature for services submitted for Medicaid reimbursement, given that said regulatory requirement did not exist prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

The Provider Agreement signed January 15, 2004 does not contain a condition that nonpayment of services will result if the Petitioner's failed to provide documentation. These are new requirements that are a significant change to the previously signed Provider Agreement.

The requirement is onerous and in essence requires the Petitioner's to gather data for DSS, at significant cost, and loss of their legally protected interests, and as a self-employed entity, Petitioner (NeuroStrategies, Inc) loses its autonomy as a self-employed entity as Petitioner is being held hostage to research, gather, obtain, and maintain documentation that has no bearing on the services provided. However, payment for services provided may be suspended if the unilaterally established conditions that are not a part of the previously signed Provider Agreement are not met as adopted on April 1, 2013 in

Connecticut General Statutes 17b-260a-16(a)(1), adopted on April 1, 2013

The participants on the ABI/TBI Medicaid Waiver Program are individuals with significant brain injuries. There are participants who are physically unable to sign, even if they are willing to provide a signature. The requirement cannot be executed due to the physical challenges of many participants and the Petitioner's cannot obtain a signature if it cannot be provided.

Most importantly, the requirement cannot be executed, is not a condition of the previously signed (January 15, 2004) Provider Agreement, and places unnecessary burden on providers who are physically unable to comply.

21. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, required to comply with Connecticut General Statutes 17b-260a-16(a)(1), if a participant is conserved of person and is legally not permitted to provide a signature for services submitted for Medicaid reimbursement, given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

The Provider Agreement signed January 15, 2004 does not contain a condition that nonpayment of services will result if the Petitioner's failed to provide documentation. These are new requirements that are a significant change to the previously signed Provider Agreement.

The requirement is onerous and in essence requires the Petitioner's to gather data for DSS, at significant cost, and loss of their legally protected interests, and as a self-employed Petitioner (NeuroStrategies, Inc), loses its autonomy as a self-employed entity as Petitioner is being held hostage to research, gather, obtain, and maintain documentation that has no bearing on the services provided. However, payment for services provided may be suspended if the unilaterally established conditions that are not a part of the previously signed Provider Agreement are not met as adopted on April 1, 2013 in

Connecticut General Statutes 17b-260a-16(a)(1), adopted on April 1, 2013

The Provider Agreement signed January 15, 2004 does not require that the Petitioner's obtain a signature to receive reimbursement for services provided.

The requirement is onerous and in essence requires the Petitioner's to gather data for DSS, at significant cost, and loss of their legally protected interests, and as a self-employed Petitioner (NeuroStrategies, Inc) loses its autonomy as a self-employed entity as Petitioner is being held hostage to research, gather, obtain, and maintain documentation that has no bearing on the services provided. However, payment for services provided may be suspended if the unilaterally established conditions that are not a part of the previously signed Provider Agreement are not met as adopted on April 1, 2013 in

Connecticut General Statutes 17b-260a-16(a)(1), adopted on April 1, 2013

The Petitioner's assert that significant time, money, and energy will be required to obtain a signature from legal representatives who are not readily accessible. DSS representatives have communicated to the Petitioner's directly that if the individual is conserved of person and not legally authorized to sign that the Petitioner's must obtain a signature from the conserved person, if the legal representative is not present.
The Petitioner submits that knowing that an individual is conserved or person and requesting that they provide a signature is at a minimum unethical and I hope, it is illegal as well. In addition, denying an individual an approved service because there is no one to provide a signature is immoral.

Many of the Petitioner's clients,' who are Conserved of Person have cognitive deficits that impair their ability to understand "what" is being signed, "why" a signature is being requested and "how" their signature will be used! The requirement is not practical and cannot be executed and is not a condition of the

previously signed Provider Agreement (January 15, 2004).

22. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, required to comply with Connecticut General Statutes 17b-260a-16(a)(1) if the participant is conserved of estate and is legally not allowed to provide a signature for services submitted for Medicaid reimbursement, given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

The Provider Agreement signed January 15, 2004 does not contain a condition that nonpayment of services will result if the Petitioner's failed to provide documentation. These are new requirements that are a significant change to the previously signed Provider Agreement.

The requirement is onerous and in essence requires the Petitioner's to gather data for DSS, at significant cost, and loss of their legally protected interests, and as a self-employed Petitioner (NeuroStrategies, Inc), loses its autonomy as a self-employed entity as Petitioner is being held hostage to research, gather, obtain, and maintain documentation that has no bearing on the services provided. However, payment for services provided may be suspended if the unilaterally established conditions that are not a part of the previously signed Provider Agreement are not met as adopted on April 1, 2013 in Connecticut General Statutes 17b-260a-16(a)(1), adopted on April 1, 2013

The requirement is onerous as the participants on the ABI/TBI Medicaid Waiver Program are individuals with significant brain injuries and many of these individuals are conserved of estate and are not legally authorized to sign for themselves.

The Petitioner's will spend significant time attempting to obtain a signature at significant cost to the Petitioner.

In addition, it is my understanding that individuals who are conserved of estate are not allowed to legally authorize payment.

The Petitioner's, cannot knowingly, request a signature from an individual who is legally not approved to sign.

The Petitioner's cannot comply with the requirement because obtaining a signature is not practical, is costly, illegal, and unethical when knowingly requesting said signature from a conserved individual. Again, the requirement

is unreasonable, cannot be executed and requires tremendous effort on the part of the Petitioner and is not a condition of the Provider Agreement signed on January 15, 2004.

23. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15 2004, a Provider Agreement that does not require a signature of the individual or their legal representative to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, required to comply with Connecticut General Statutes 17b-260a-16(a)(1) if the legal representative of the participant is not present to provide a signature for services submitted for Medicaid reimbursement, given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

The Provider Agreement signed January 15, 2004 does not contain a condition that nonpayment of services will result if the Petitioner's failed to provide documentation. These are new requirements that are a significant change to the previously signed Provider Agreement.

The requirement is onerous and in essence requires the Petitioner's to gather data for DSS, at significant cost, and loss of their legally protected interests, and as a self-employed Petitioner (NeuroStrategies, Inc), loses its autonomy as a self-employed entity as Petitioner is being held hostage to research, gather, obtain, and maintain documentation that has no bearing on the services provided. However, payment for services provided may be suspended if the unilaterally established conditions that are not a part of the previously signed Provider Agreement are not met as adopted on April 1, 2013 in

Connecticut General Statutes 17b-260a-16(a)(1), adopted on April 1, 2013

As a self-employed Petitioner (NeuroStrategies, Inc) loses its autonomy as a self-employed entity, as said Petitioner is essentially held hostage by DSS to research, educate, obtain, and maintain documentation that has no bearing on the services provided. However, payment for services provided may be suspended if the unilaterally established conditions that are not a part of the previously signed Provider Agreement are not met as adopted on April 1, 2013 in

Connecticut General Statutes 17b-260a-16(a)(1), adopted on April 1, 2013

The requirement is onerous as the participants on the ABI/TBI Medicaid Waiver Program are individuals with significant brain injuries and their legal representative is not present when services are provided.

For example, the Petitioner's may have 4 hours of available service to provide to

a given client each month. The Petitioner's could provide service on the participants' case for years without ever seeing the legal representative. The legal representative is often an attorney who has been assigned the case by Probate Court. The legal representative may or may not attend quarterly team meetings and many of the legal representatives who are assigned to my clients' do not attend team meetings and are inaccessible to the Petitioner's. Furthermore, legal representatives change and this Petitioner is rarely informed of such changes until months later.

In addition, legal representatives cannot verify that services were provided. The clients' have suffered a brain injury and many have significant memory deficits that would make it unlikely that the client could verify that services were rendered. If the legal representative must rely on the Petitioner's as a source for documenting service provision, it is difficult to understand the reason for the exercise.

Also, the Petitioner's develop and review goals and objectives, develop interventions, and meet with providers regarding the clients' performance without the client present. The legal representative and the client may be unaware that a consultation with a team member has occurred. The legal representative would then be required to call the team member to verify that services were provided. What happens if the service provider does not recall, is upset with Petitioner's counsel, or simply refuses to verify that a meeting was held? Is the assumption that services were not provided if the signature is not obtained? Again, the requirement is unreasonable, cannot be executed and requires tremendous effort on the part of the Petitioner and is not a condition of the Provider Agreement signed on January 15, 2004.

24. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature of the individual or their legal representative to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, required to comply with Connecticut General Statutes 17b-260a-16(a)(1) if a participant is conserved of person and/or conserved of estate and their legal representative was not present during the time services were provided, given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

The Provider Agreement signed January 15, 2004 does not require the Petitioner's to obtain a signature to receive reimbursement for services provided.

The requirement is onerous and in essence requires the Petitioner's to gather data for DSS, at significant cost, and loss of their legally protected interests, and as a self-employed Petitioner (NeuroStrategies, Inc) loses its autonomy as a

self-employed entity as Petitioner is being held hostage to research, gather, obtain, and maintain documentation that has no bearing on the services provided. However, payment for services provided may be suspended if the unilaterally established conditions that are not a part of the previously signed Provider Agreement are not met as adopted on April 1, 2013 in

Connecticut General Statutes 17b-260a-16(a)(1), adopted on April 1, 2013

Legal representatives are often not accessible nor can someone who is not present, verify that services were provided. Again, the requirement is unreasonable, cannot be executed and requires tremendous effort on the part of the Petitioner and is not a condition of the Provider Agreement signed on January 15, 2004 prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1), adopted on April 1, 2013

25. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature of the individual or their legal representative to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013 required to comply with Connecticut General Statutes 17b-260a-16(a)(1) if a participant may be conserved of person and/or conserved of estate and the legal representative is denied access during service delivery due to a request for privacy during service delivery, given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013

The Provider Agreement signed January 15, 2004 does not contain a condition that nonpayment of services will result if the Petitioner's failed to provide documentation. These are new requirements that are a significant change to the previously signed Provider Agreement.

The requirement is onerous and in essence requires the Petitioner's to gather data for DSS, at significant cost, and loss of their legally protected interests, and as a self-employed Petitioner (NeuroStrategies, Inc), loses its autonomy as a self-employed entity as Petitioner is being held hostage to research, gather, obtain, and maintain documentation that has no bearing on the services provided. However, payment for services provided may be suspended if the unilaterally established conditions that are not a part of the previously signed Provider Agreement are not met as adopted on April 1, 2013 in

Connecticut General Statutes 17b-260a-16(a)(1), adopted on April 1, 2013

There are participants on the ABI/TBI Medicaid Waiver who are conserved by a parent, family member, or friend and prefer to not have these individuals present during service provision, as is their right.

In addition, parents, family members, and friends who are conservators have many of the same challenges as attorneys who serve as conservators. The family member or friend often hold jobs and have other obligations that make it impractical to provide signatures. It is important to explain that the service (Cognitive Behavioral Programs) is not usually provided in an office based setting. The service is typically provided in the community, in real-time, while the individual is engaged with service providers. The Cognitive Behavioral Program provider often strategizes with service providers regarding service provision and not the client themselves. Again, said requirement is not a condition of the previously signed Provider Agreement and is a new requirement that was not agreed upon by the parties. The requirement places a burden on the Provider that is unreasonable and costly.

26. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15 2004, a Provider Agreement that does not require a signature of the individual or their legal representative to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, required to spend time, resources, and incur financial losses in pursuit of a signature as is required in Connecticut General Statute 17b-260a-16(a)(1), given said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

The Provider Agreement signed January 15, 2004 does not require the Petitioner's to obtain a signature to receive reimbursement for services provided. The requirement (Connecticut General Statute 17b-260a-16(a)(1)) adopted on April 1, 2013 is onerous as the participants on the ABI/TBI Medicaid Waiver Program are individuals with significant brain injuries.

The requirement demands that the provider pursue individuals to obtain a signature. Significant time and energy is expended attempting to obtain a signature from legal representatives. The cost of obtain a signature is substantial and impairs the function of the Petitioner's practice.

The Petitioner's are placed at-risk of nonpayment of services rendered despite provision of services. Obtaining a signature to substantiate that services were provided is neither necessary nor sufficient for effective service provision and is an extraneous factor that has no basis in the Petitioner's previously signed agreement that services would be provided as agreed to in the Provider Agreement signed January 15, 2004. However, the cost associated with obtaining signatures is essentially a tax on the rates paid for service provision. The tax is a significant burden that violates the function of the Petitioner's practice.

27. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature of the individual or their legal representative to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, allowed to submit a bill for reimbursement for time spent, resources expended, and any financial losses incurred in pursuit of the signature required in Connecticut General Statutes 17b-260a-16(a)(1) given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

The Provider Agreement signed January 15, 2004 does not allow the Petitioner's to submit billing for data gathered in furtherance of DSS' adoption of new documentation requirements. The Provider Agreement signed January 15, 2004 requires the Petitioner's to submit payment for services rendered. The invoice submitted for reimbursement met the "documentation requirements" in the Provider Agreement signed on January 15, 2004 (see Table 1).
The new documentation requirements are not a service. Given that DSS is requiring that new documentation be gathered or loss of payment will result, Petitioner's are forced to engage in strenuous activities to gather data for DSS at significant loss to the Petitioner's including autonomy, liberty, financial resources, and other tangible items such as fuel in an attempt to meet the new and arbitrarily adopted requirements that are not a part of the previously signed Provider Agreement (January 15, 2004).

28. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require a signature of the individual to document services submitted for Medicaid reimbursement prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013, granted legal authority to compel individuals and/or their legal representative to provide a signature for services rendered, given that no such authority existed prior to adoption of Connecticut General Statutes 17b-260a-16(a)(1) on April 1, 2013.

The Provider Agreement signed January 15, 2004 does not include a condition that the Petitioner's obtain a signature to document services provided for submission of payment for Medicaid reimbursement.

The Petitioner's have no authority to compel individuals to provide a signature. The Department of Social Services has not informed participants and their legal representatives that they are required to provide a signature.

The Department of Social Services has not provided a form for signatures nor have they provided insight to the Petitioner's as to how signatures are to be gathered. The Department of Social Services has not established a system for

reporting failures to provide signatures by participants and their legal representatives.

However, if audit protocols are established by DSS, it is likely that the existing requirements will be used as a basis for auditing providers and recouping funds that can be used to offset state budgetary needs.

The establishment of unattainable requirements places small business owners, such as the Petitioner's at a strategic disadvantage with no method to resolve said issues, as DSS chooses to adopt arbitrary criteria in violation of the Provider Agreement signed January 15, 2004 with no practical means for the Petitioner's to meet said requirements or obtain redress.

29. Are the Petitioners', as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require "visit" required to determine to the best of their ability the definition of the term "visit" after adoption of Connecticut General Statute 17b-260a-16(a)(4) and 17b-260a-16(a)(5) on April 1, 2013, given that the term "visit" as adopted in Connecticut General Statutes 17b-260a-16(a)(4) and 17b-260a-16 (a)(5) is not defined within Connecticut General Statutes 17b-260a-1 to Connecticut General Statutes 17b-260a-17, given that said requirement, did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes 17b-260a-16(a)(5) on April 1, 2013.

The requirement to document "visit" is not a requirement of the Provider Agreement and is a "new" requirement that did not exist prior to the adoption of said regulations. It is the position of the Petitioner's that said requirement is invalid.

Furthermore, the term "visit" is not defined in the definitions included in the regulations Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes 17b-260a-16(a)(5), adopted April 1, 2013. The Petitioner's provide services through multiple methods and in multiple venues.

DSS was required to submit the proposed regulation to the Licensing Rules and Regulations Committee within 180 days of their adoption. The failure of DSS to do so leads to challenges and issues such as extraneous definitions (i.e., visits) that may have no functional basis in the practice of Cognitive Behavior Programs.

The checks and balances between branches of government serve multiple purposes. DSS is attempting to circumvent that requirement at the expense of the Petitioner's. That said, "visit" is not a condition of the previously signed Provider Agreement and is a violation of the terms of the Agreement.

30. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that references but does not specify "duties," either in the Provider Agreement or ABI/TBI Medicaid Provider Manual, required to determine to the best of their ability the definition of the term "duties" after adoption of Connecticut General Statutes 17b-260a-16(6) on April 1, 2013, given that the term "duties" as adopted in Connecticut General Statutes 17b-260a-16(a)(5) and Connecticut General Statutes 17b-260a-16 (a)(6) has not been defined, given that said requirement, did not exist prior to adoption of Connecticut General Statutes 17b-260a-16(a)(6).

The requirement to document "duties" is not a requirement of the Provider Agreement and is a "new" requirement that did not exist prior to the adoption of said regulations. The term "duties" is not defined in the definitions included in the regulations, Connecticut General Statutes 17b-260a-16(a)(6), adopted April 1, 2013.

Duties are not a defined condition of the Provider Agreement and despite the inclusion of the term "visit" in the Provider Agreement (Exhibit 1, Item 2) a search of the Provider Manual reveals that the Provider Manual (Exhibit 12) does not specify duties required of the Petitioner's.

31. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that references, but does not specify "duties," either in the Provider Agreement or ABI/TBI Medicaid Provider Manual, required to determine "to the best of their ability" the definition of the term "duties" after adoption of Connecticut General Statutes 17b-260a-16(6) on April 1, 2013, given that the term "duties" as adopted in Connecticut General Statutes 17b-260a-16(a)(5) and Connecticut General Statutes 17b-260a-16 (a)(6) is consistent with functions performed by employees and not independent contractors as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii), given that said requirement to define "duties" was not required prior to adoption of Connecticut General Statutes 17b-260a-16(a)(6).

The requirement to document "duties" , as outlined in Connecticut General Statute 17b-260a-16(a)(5), adopted April 1, 2013, is not a requirement of the Provider Agreement and is a "new" requirement that did not exist prior to the adoption of said regulations and is not a condition of the previously signed Provider Agreement (January 15, 2004).

The Petitioner's are considered to be self-employed. Duties are a description of tasks performed by employees. While Tariq Abdulaziz is an employee of NeuroStrategies, Inc. the Petitioner is not an employee of Department of Social Services. The Department of Social Services, if insisting on use of the term "duties," may have misclassified the Petitioner (NeuroStrategies, Inc.), as being self-employed, and use of the term "duties" implies behavioral control over the

Petitioner's in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

Interestingly, the Provider Agreement mentions the term "duties" in Item 2 of the Provider Agreement (Exhibit 1) but Item 2 refers the "Petitioner's" to the Provider Manual (Exhibit 12). A search of the general provisions of the Provider Manual as well as the detailed description of Cognitive Behavioral Programs does not identify or specify "duties"! The use of this term is an anomaly but the use of the term in regulations is concerning as DSS could use the term to serve whatever basis they desire. This exacerbates the concern that DSS has not forwarded the regulations for review at the Licensing Rules Regulations Committee (LRRC).

The checks and balance among the branches of government serve multiple purposes. DSS is attempting to circumvent that process, create legislation, and do so at the expense of the Petitioner's.

32. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require documentation of "start time for each visit" and "end time for each visit" determined to be employees of either the participant, their legal representative, and/or State of Connecticut after adoption of Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes 17b-260a-16(a)(5) on April 1, 2013, given that the phrases "start time for each visit" and "end time for each visit" exercises behavioral control over the Petitioner's who are either self-employed or employed by the Petitioner (NeuroStrategies, Inc) and such control is consistent with tasks performed by employees and not self-employed entities and private agencies, as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii) and as said requirement did not exist, prior to adoption of Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes 17b-260a-16(a)(5) on April 1, 2013.

The requirement to document "start time for each visit" and "end time for each visit" is not a requirement of the Provider Agreement (January 15, 2004) and is a "new" requirement, adopted on April 1, 2013 (Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes 17b-260a-16(a)(5)) that did not exist prior to the adoption of said regulations. The requirement to document such information is consistent with an employer-employee relationship and is inconsistent with a relationship between an employer and self-employed entity Petitioner's) that has been designated as a qualified provider.

The Department of Social Services is not the employer of record for NeuroStrategies, Inc. or Tariq Abdulaziz, Ph.D., M.S., M.S., MA.

Despite not being the employer of record DSS dictates the terms of the relationship by making demands that it has no authority to make given the

nature of the relationship. DSS is simply the administrative authority that oversees the program and reports back to the federal government.

The Petitioner (NeuroStrategies, Inc) is self-employed (see Exhibit) for purpose of the ABI/TBI Medicaid Waiver Program and receives a 1099 from DSS (its fiduciary Allied Community Resources) for services rendered. The Petitioner (Tariq Abdulaziz, Ph.D., M.S. M.S., MBA) is an employee of NeuroStrategies, Inc. and receives a W-2 from NeuroStrategies, Inc.

The requirement to document "start time for each visit" and "end time for each visit" combined with behavioral requirements to document "duties" demonstrate a continued attempt on the part of DSS to serve as employer or "third-party" employer with respect to its Home and Community Based Services (HCBS) programs.

It is the position of this Petitioner that the adoption and implementation of Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes17b-260a-16 (a)(5) as well as Connecticut General Statutes 17b-260a-16(a)(1) Connecticut General Statutes 17b-260a-16(a)(6) Connecticut General Statutes 17b-260a-16(b) Connecticut General Statutes 17b-260a-16(c) Connecticut General Statutes 17b-260a-16(d) Connecticut General Statutes 17b-260a-16(e) is an attempt to reclassify NeuroStrategies Inc. (Petitioner of record for all ABI/TBI Medicaid Waiver services) as an employer of DSS which is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii) and it is assumed by the Petitioner's that it is not possible for a Corporation to be an employee of the State of Connecticut.

Therefore, the Petitioner's request that each behaviorally controlling regulation (Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes17b-260a-16 (a)(5) as well as Connecticut General Statutes 17b-260a-16(a)(1) Connecticut General Statutes 17b-260a-16(a)(6) Connecticut General Statutes 17b-260a-16(b) Connecticut General Statutes 17b-260a-16(c) Connecticut General Statutes 17b-260a-16(d) Connecticut General Statutes 17b-260a-16(e); Connecticut General Statutes 17b-260a-5(3)(B)) be repealed due to their lack of validity and applicability as it relates to Connecticut General Statutes 31-222(a)(1)(B)(ii)

33. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not specify "when" services are to be delivered, required to provide a service at a time (within 30 days) determined by Department of Social Services as required in Connecticut General Statutes 17b-260a-16-5(3)(B) after adoption of Connecticut General Statutes 17b-260a-16-5(3)(B) on April 1, 2013, given that determining "when" services are provided exercises behavioral control over Cognitive Behavioral Programs providers who

are either self-employed or employees of an agency and such control is consistent with tasks performed by employees and self-employed or agency employed individuals, in this case NeuroStrategies, Inc. and not Department of Social Services, as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii) and was not required prior to adoption of Connecticut General Statutes 17b-260a-16-5(3)(B) on April 1, 2013.

The requirement to determine "when" Cognitive Behavioral Program (CBP) providers develop and implement structured cognitive/behavioral assessment within 30 days of the individual becoming a participant in the waiver program, as well as periodic reassessments that addresses the following:
(i) Executive functions;
(ii) attention and concentration;
(iii) information processing skills;
(iv) learning and memory;
(v) planning;
(vi) problem solving;
(vii) self-control; and
(viii) visual-spatial functioning;
exercises behavioral control over the Petitioner's designation as a "self-employed" private provider (Exhibit 12) designated as an Educational Psychologist for purposes of providing services on the ABI/TBI Medicaid Waiver Program.

The relevant background information regarding the designations held by the Petitioner's are as follows:

Petitioner-1: Tariq Abdulaziz, Ph.D., M.S., M.S., MBA is an employee of NeuroStrategies Inc. (Petitioner)

Petitioner-2: NeuroStrategies, Inc., which has the designation as the agency designated to provide Cognitive Behavioral Program services.

Petitioner Tariq Abdulaziz' employment at NeuroStrategies Inc. allows NeuroStrategies, Inc. to provide CBP services as Tariq Abdulaziz meets the following qualifications (see Exhibit 12)
vv. Doctoral Degree in Special Education (Instruction and Learning)
vv. Certification in Special Education
vv. Two years experience with individuals with brain injury in a community-based setting
NeuroStrategies, Inc is a self-employed entity for the purposes of providing Cognitive Behavioral Programs on the ABI/TBI Medicaid Waiver and Tariq Abdulaziz (Petitioner) is the agency employee approved to provide said service.

As a self-employed agency "NeuroStrategies, Inc" must be free from control

as required by

Connecticut General Statutes 31-222(a)(1)(B)(ii)

The adoption of Connecticut General Statutes 17b-260a-5(3)(B) on April 1, 2013 places behavioral control on the Petitioner's that is consistent with an employer-employee relationship and is not a condition of the Provider Agreement signed on January 15, 2014.

34. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not, require the signature of the individual or their legal representative (Connecticut General Statutes 17b-260a-16(a)(1), required to comply with said regulations, given that said requirement for purposes of reimbursement, exercises behavioral control over Petitioner's, places unreasonable burden on petitioner's to spend time and resources to obtain a signature, at a cost to the petitioner since "signature seeking: is not listed as a service, and many of the individuals on the ABI/TBI Medicaid Waiver are physically unable to sign, unwilling to sign, conserved of person, conserved of estate, conserved of person and estate, legally not authorized to sign, and conservators or legal representatives are not present during service provision, and services can be offered through digital communication and telephone, therefore making obtaining a signature an unreasonable expectation and given that the petitioner's as CBP providers are either self-employed or employees of an agency and such control is consistent with tasks performed by employees and not self-employed or agency employed individuals, except by the employing agency which is NeuroStrategies, Inc. and not Department of Social Services, as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii) and was not required prior to adoption of said regulation on April 1, 2013.

There is no condition in the Provider Agreement that requires the Petitioner's to obtain a signature to receive reimbursement for Medicaid services

The Department of Social Services is not the employer of record for NeuroStrategies, Inc. or Tariq Abdulaziz, Ph.D., M.S., M.S., MA.

Despite not being the employer of record DSS dictates the terms of the relationship by making demands that it has no authority to make given the nature of the relationship.

The Petitioner (NeuroStrategies, Inc) is self-employed (see Exhibits 40, 42 58, 60, 62) for purpose of the ABI/TBI Medicaid Waiver Program and receives a 1099 from DSS (its fiduciary Allied Community Resources) for services rendered. The Petitioner (Tariq Abdulaziz, Ph.D., M.S. M.S., MBA) is an

employee of NeuroStrategies, Inc. and receives a W-2 from NeuroStrategies, Inc.

The requirement to obtain a signature combined with behavioral requirements to document "start time of each visit" and "end time of each visit"" demonstrate a continued attempt on the part of DSS to serve as employer or "third-party" employer with respect to its Home and Community Based Services (HCBS) programs constitutes a pattern of behavioral control exercised by Department of Social Services

It is the position of this Petitioner that the adoption and implementation of Connecticut General Statutes 17b-260a-16(a)(1) is an attempt to reclassify NeuroStrategies Inc. (Petitioner of record for all ABI/TBI Medicaid Waiver services) as an employer of DSS which is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

Therefore, the Petitioner's request that each behaviorally controlling regulation be repealed including but not limited to Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes17b-260a-16(a)(5).

35. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require "start time for each visit" and "end time for each visit" (Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes 17b-260a-16(a)(5)) required to comply with said regulations, given that monitoring of "time in and time out" for purposes of reimbursement exercises behavioral control over Petitioner's who are either self-employed or employees of an agency and such control is consistent with tasks performed by employees and not self-employed or agency employed individuals, except by the employing agency which is NeuroStrategies, Inc. and not Department of Social Services, as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii) and was not required prior to adoption of Connecticut General Statutes 17b-260a-16-5(3)(B) on April 1, 2013.

The Petitioner's are designated as "self-employed" providers (see previous question for a detailed explanation) as indicated in the previously signed Provider Agreement (Exhibit 1) and Application (January 15, 2004) and the Provider Manual (Exhibit 12)

Requiring documentation of "time in" and "time out" as required in

Connecticut General Statutes 17b-260a-16(a)(4) and Connecticut General Statutes 17b-260a-16(a)(5), adopted on April 1, 2013

is an exercise behavioral control over CBP providers and is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii)

The Department of Social Services (DSS) is not the employer of record and does not have the authority to demand that a self-employed entity track their work time in a manner that is similar to using a time clock.

36. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require "duties" (Connecticut General Statutes 17b-260a-16(a)(6)) required to comply with said regulations, given that duties, for purposes of reimbursement exercises behavioral control over Cognitive Behavioral Programs providers (CBP) who are either self-employed or employees of an agency and such control is consistent with tasks performed by employees and not self-employed or agency employed individuals, except by the employing agency which is NeuroStrategies, Inc. and not Department of Social Services, as determined by Connecticut General Statutes 31-222(a)(1)(B)(ii) and was not required prior to adoption of Connecticut General Statutes 17b-260a-16-5(3)(B) on April 1, 2013.

The Petitioner's are designated as "self-employed" providers (see previous question for a detailed explanation) as indicated in the previously signed Provider Agreement and Application (January 15, 2004) and Provider Manual (Exhibit 1) and (Exhibit 12)

A demand that the Petitioner's complete "duties" as detailed in

Connecticut General Statutes 17b-260a-16(a)(6)

is an exercise behavioral control over CBP providers and is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

The Department of Social Services (DSS) is not the employer of record and does not have the authority to demand that a self-employed entity complete "duties" not detailed in the Provider Agreement signed January 15, 2004.

37. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require "submission of monthly reports and written updates on the individual's progress in a form that is set forth by the department as detailed in Connecticut General Statutes 17b-260a-16(d), required to comply with said regulations, given that submission of monthly reports and written updates on the individual's progress in a form that is set forth by the department, exercises behavioral control over Petitioner's who are either self-employed or employees of an agency and such control is consistent with tasks performed by employees and not self-employed or agency employed individuals, except by the employing agency which is NeuroStrategies, Inc. and not Department of Social Services, as determined by Connecticut General Statutes

31-222(a)(1)(B)(ii) and was not required prior to adoption of Connecticut General Statutes 17b-260a-16-5(3)(B) on April 1, 2013, and costs associated with producing monthly reports is tremendous when evaluated based upon costs associated with CBP hourly service rates of $83.22 per hour for

The Petitioner's are designated as "self-employed" providers (see previous question for a detailed explanation) as indicated in the Provider Agreement, Provider Agreement Application and Provider Manual (Exhibit 1) and (Exhibit 12).

A demand that the Petitioner's comply with a submission of monthly reports and written updates on the individual's progress in a form that is set forth by the department as detailed in Connecticut General Statutes 17b-260a-16(d)

Such a request exercises behavioral control over CBP providers and is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

The Department of Social Services (DSS) is not the employer of record and does not have the authority to demand that a self-employed entity complete "duties" not detailed in the Provider Agreement signed January 15, 2004.

38. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not require said regulatory requirements, and having provided CBP services on an ongoing basis prior and subsequent to April 1, 2013, required to provide "monthly reports and written" updates on the individual's progress in a form set forth by the department," a form provided by the department, a form requiring submission of information determined by the department to be relevant (service goals, target date for achieving specific goals, strategies utilized, monthly progress toward each goal in measurable terms, and comments and/or concerns) as such a practice exercises behavioral control over Petitioner's who are either self-employed or employees of an agency and such control is consistent with tasks performed by employees and not self-employed or agency employed individuals, and having adopted proposed regulation 17b-260a-16(d), on April 1, 2013, despite said requirement not being required prior to adoption of 17b-260a-16(d) on April 1, 2013 and in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

The Petitioner's are designated as "self-employed" providers (see previous question for a detailed explanation). A demand that the Petitioner's complete a "form" as detailed in Connecticut General Statutes 17b-260a-16(d) is an exercise behavioral control over the Petitioner's and is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii). The Department of Social Services (DSS) is not the employer of record and does not have the authority to demand that a self-employed entity employ a form as detailed in Connecticut General Statutes 17b-260a-16(d)

39. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) required to comply with the terms of said regulations, adopted on April 1, 2013, if a Notice of Intent for said regulations, was not printed in the Connecticut Law Journal at least 30 days prior to adoption of said regulations on April 1, 2013, as required under Connecticut General Statutes 4-168(a) prior to July 1, 2013.

Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) were all noticed on March 26, 2013 and adopted on April 1, 2013. The Petitioner's were not provided 30 days notice prior to adoption of said regulations, in violation of Connecticut General Statutes 4-168 prior to July 1, 2013.

40. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) required to comply with the terms of said regulations, printed in the Connecticut Law Journal on March 26, 2013 and adopted on April 1, 2013, if a Notice for said regulations, was not printed in the Connecticut Law Journal after April 1, 2013 and not later than April 21, 2013, indicating that the department will operate under the policy while it is being considered, provided that the department prints its Notice in the Connecticut Law Journal within 20 days after adoption as required under Connecticut General Statutes 17b-10(b) prior to July 1, 2013.

The aforementioned regulations were published prior to July 1, 2013, which was prior to legislative changes to Connecticut General Statues 17b-10(b). There was only one Notice of Intent printed in the Connecticut Law Journal for said regulations. The Notice of Intent was published on March 26, 2013 and within the same notice, DSS indicated that it would adopt the regulations effective April 1, 2013.

Again, printing of the Notice occurred on March 26, 2013. Connecticut General Statutes 17b-10(b) required printing of a Notice within 20 days after adoption. The printing of the Notice occurred five days prior to adoption not within the 20 days after (after April 1, 2013 but not later than April 21, 2013) adoption.

The Department of Social Services (DSS) will attempt to minimize this issue by indicating that the "department" gave more time than required by printing before the required time period of 20 days after adoption.

DSS misses a number of critical mistakes and makes an error in judgment when making this argument.

1) The Department of Social Services is not identified as having authority to adopt emergency regulations (Connecticut General Statutes 4-168).
2) The closest that DSS comes to having authority to adopt emergency regulations is Connecticut General Statutes 17b-10(b)

3) Among the many requirements of Connecticut General Statutes 17b-10(b), prior to July 1, 2013, is a requirement to print "TWO" Notices.

4) The requirement to print "two notices" is not explicitly outlined in the statute, but it is functionally impossible to comply with Connecticut General Statutes 17b-10(b) when adopting regulations under a federal conforming requirement, prior to July 1, 2013, unless DSS prints TWO notices (a notice 30 days prior to adoption, as required under Connecticut General Statutes 4-168(a); and a notice that informs the public of implementation that is printed within 20 days after adoption, Connecticut General Statutes 17b-10(b))

5) Connecticut General Statutes 17b-10(b) requires adherence to Chapter 54 including adherence to Connecticut General Statutes 4-168(a) which requires 30 days notice prior to adoption. However, prior to July 1, 2013, Connecticut General Statutes 17b-10(b) also required printing of a Notice, within 20 days after adoption.

6) Given the requirement to print a notice of intent, 30 days prior to adoption and within 20 days after adoption, it is clear that it is not possible to meet the requirements of both statutes in the same Notice, as was done, in error, by DSS on March 26, 2013.

   The Department failed to comply with Connecticut General Statutes 17b-10(b) prior to July 1, 2013

   To ensure clarity regarding this issue of error in adoption, it is important to explain what "DSS" should have done, if their goal was to

have an adoption date of April 1, 2013, based on the relevant regulations (CGS 4-168; CGS 17b-10(b) prior to July 1, 2013.

1) The department would need to comply with Connecticut General Statutes 4-168(a) and print a notice of intent 30 days prior to adoption, which took place on April 1, 2013.
2) Connecticut Law Journal only prints on Tuesdays, therefore a notice of intent would need to be published on or prior to Tuesday February 26, 2013. The only Notice was printed on March 26, 2013.
3) The department would need to comply with Connecticut General Statutes 17b-10(b), and print a notice within 20 days after adoption.
4) Given that DSS adopted said regulations on April 1, 2013, a notice would need to be published in Connecticut Law Journal on a Tuesday within 20 days after adoption on April 1, 2013. The options available to DSS included, April 2, 2013; April 9, 2013; or April 16, 2013, as all subsequent dates exceed the 20-day limit. There was no printing other than the March 26, 2013 printing.
5) Therefore, assuming DSS had a federal conforming requirement, which it did not, it would have taken only 35 days (February 26, 2013 to April 2, 2013) to move from Notice to implementation.

While DSS does not have the authority to adopt emergency regulations, use of Connecticut General Statutes 17b-10(b) is a very generous option afforded to DSS. However, DSS chose to use the anticipated statutory authority for Connecticut General Statutes 17b-10(b) which became effective after July 1, 2013, which allows the department to post a policy prior to adopting.

The subtle change now allows DSS to meet the requirements of Connecticut General Statutes 4-168(a) and Connecticut General Statues 17b-10(b) in the same Notice of Intent if they so choose. This was not the case prior to July 1, 2013.

Therefore, DSS committed an error in adoption that violates the Petitioner's rights to procedural due process and an expectation of fairness. The adoption of all relevant regulations discussed herein must be repealed including Connecticut General Statutes 17b-260a-16 and Connecticut General Statutes 17b-260a-17

41. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statute 17b-260a-16(e), subjected to suspension of payment for services rendered

if monthly reports and written updates are not provided as required in Connecticut General Statute 17b-260a-16(e) adopted on April 1, 2013, if a Notice of Intent for Connecticut General Statute 17b-260a-16(e) was not printed in the Connecticut Law Journal at least 30 days prior to adoption of Connecticut General Statute 17b-260a-16(e) on April 1, 2013 as required under Connecticut General Statutes 4-168(a) prior to July 1, 2013.

The Petitioner's asserts that Connecticut General Statutes 17b-260a-16(e), is not valid, as no Notice of Intent was published 30 days prior to adoption on April 1, 2013. Connecticut General Statues 17b-10(b) requires adherence to Section 54. Section 54, includes Connecticut General Statutes 4-168(a),which requires printing of a Notice of Intent, at least 30 days prior to adoption. These requirements were not met by DSS and it is possible that this error muted public comment resulting in no hearing be held regarding any of the aforementioned regulations.

42. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statute 17b-260a-16(e), subjected to suspension of payment for services rendered if monthly reports and written updates are not provided as required in Connecticut General Statutes 17b-260a-16(e) adopted on April 1, 2013, if a Notice of Intent for Connecticut General Statutes 17b-260a-16(e) was not printed in the Connecticut Law Journal after April 1, 2013 and not later than April 21, 2013, indicating that the department will operate under the policy while it is being considered, provided that the department prints its Notice of Intent in the Connecticut Law Journal within 20 days after adoption as required under Connecticut General Statutes 17b-10(b) prior to July 1, 2013.

The Petitioner's asserts that Connecticut General Statutes 17b-260a-16(e), is not valid as no Notice of Intent was printed within 20 days after adoption on April 1, 2013. Given an adoption date of April 1, 2013, a notice indicating that DSS would operate under the policy while it is being considered would have had to be printed after April 1, 2013 but not later than April 21, 2013 as required by Connecticut General Statues 17b-10(b).

43. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut

General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to follow said regulations, given that the incorrect statutory authority is referenced in the Notice of Intent published on March 26, 2013 thereby rendering adoption of said regulations defective.

The Petitioner's assert that referencing the correct statutory authority is a mandatory requirement in the adoption of a regulation. The Department of Social Services, cited the incorrect statute for the ABI/TBI Medicaid Waiver Program by citing Connecticut General Statutes 17b-260b.

The correct statute is Connecticut General Statutes 17b-260a
Therefore, Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), are each invalid due to improper adoption. The Department of Social Services is implementing improperly adopted regulations against the Petitioner's despite the errors in adoption.

44. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations, given that the proposed regulations were not submitted to the Licensing Rules Regulation Committee (LRRC) within 180 days as required under Connecticut General Statutes 17b-10(b) and can the Department of Social Services be considered to have abandoned the promulgation of said regulations given the failure to follow Connecticut General Statutes 17b-10(b) is mandatory.

The Petitioner's assert that the requirement to submit the proposed regulations, Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) to the LRRC within 180 days is a mandatory requirement that was not met and as a result invalidates the regulations. The assumption is that the department has abandoned its pursuit of

adoption of said regulations.

45. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations, given that the proposed regulations are not being considered by the legislature (LRRC) as "consideration" is a requirement to operate under the regulations while they are being developed during the 180 day period by Connecticut General Statutes 17b-10.

The Petitioners assert that DSS is required to submit the proposed regulation for review by the LRRC within 180 days of publication.

Failure to submit to the LRRC within 180 days, renders the regulations

Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) invalid. The use of the word "shall" makes the submission within 180 days of publication mandatory Connecticut General Statutes 17b-10(c)
On and after July 1, 2004, the department shall submit proposed regulations that are required by subsection (b) of this section to the standing legislative regulation review committee, as provided in subsection (b) of section 4-170, not later than one hundred eighty days after publication of the notice of its intent to adopt regulations. The department shall include with the proposed regulation a statement identifying (1) the date on which the proposed regulation became effective as a policy as provided in subsection (b) of this section, and (2) any provisions of the proposed regulation that are no longer in effect on the date of the submittal of the proposed regulation, together with a list of all policies that the department has operated under, as provided in subsection (b) of this section, that superseded any provision of the proposed regulation.

Furthermore, Connecticut General Statutes 17b-10(d) provides the department with an option to resolve the 180 day requirement, but the options provided require the department to submit a notice 35 days prior to the 180 day deadline. The 180-day deadline is mandatory and a failure to meet the deadline invalidates the proposed regulation.

46. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations, given that the proposed regulations were not submitted to the Licensing Rules Regulation Committee (LRRC) in over 900 days and tolling, thereby exceeding the 180 day requirement under Connecticut General Statutes 17b-10(b) by five times the maximum time allowed for consideration and after more than 900 days of failure to submit said regulations, and not submitting notice to LRRC as to the departments' reason for failing to submit the regulations for consideration and Commissioner of Department of Social Services, not choosing to explain his decision not to forward said regulations to LRRC, by Connecticut General Statutes 17b-10(b) and Connecticut General Statutes 17b-10(c) respectively.

The Petitioners assert that DSS is required to submit the proposed regulation for review by the LRRC within 180 days of publication.

Failure to submit to the LRRC in over 900 days, renders the regulations

Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) invalid and is an unconscionable practice designed to extend the power and authority of the executive.

47. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations, given that there was no federal conforming requirement issued by Centers for Medicare and Medicaid

Services (CMS) requiring adoption of said regulations, as required in Connecticut General Statutes 17b-10(b).

The Petitioner's assert that no federal conforming requirement exists as communicated by Dianne Kayala in her communication with Petitioner's through an exchange of emails (Exhibit 10) and the Technical Manual for Home and Community Based Waivers (2015) does not reference any policy that demands that state's adopt "documentation requirements" to operate a waiver (Exhibit 9) and the Petitioner's FOIA request for all communications between DSS and Health and Human Services and Centers for Medicare and Medicaid Services for 9/12/2009 to 09/01/2014 (Exhibit 18)

DSS confirmed that all communications were provided to the Petitioner's on 12/2/2014 (Exhibit 19)

A review of documents received by the Petitioner's in response to the FOIA request reveals no federal conforming requirement.

In Neurostrategies et al., v. Department of Social Services et al. (2015) the transcribed administrative record reveals no federal conforming requirement despite requests by the Plaintiff's that DSS reveal the federal conforming requirement in its Request for Reconsideration. DSS chose not to answer that question.

Given the multiple lines of evidence listed above, it is the position of the Petitioner's that no federal conforming requirement exists!

Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e)
Are each invalid given that there is no federal conforming requirement

48. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations, given that there was no

federal conforming requirement to adopt "documentation requirements" thereby misapplying, Connecticut General Statutes 17b-10(b).

The Petitioner's assert that no federal conforming requirement to adopt "documentation requirements" exists as communicated by Dianne Kayala in her communication with Petitioner's through an exchange of emails (Exhibit 10).

The Technical Manual for Home and Community Based Waivers (2015) does not reference any policy that demands that state's adopt "documentation requirements" to operate a waiver (Exhibit 9)

The Petitioner's submitted a FOIA request for all communications between DSS and Health and Human Services and Centers for Medicare and Medicaid Services for 9/12/2009 to 09/01/2014 (Exhibit 18)

DSS confirmed that all communications were provided to the Petitioner's on 12/2/2014 (Exhibit 19)

A review of documents received by the Petitioner's in response to the FOIA request reveals no federal conforming requirement.

In Neurostrategies et al., v. Department of Social Services et al. the transcribed administrative record reveals no federal conforming requirement despite requests by the Plaintiff's that DSS reveal the federal conforming requirement in its Request for Reconsideration. The department chose not to answer that question.

Given the multiple lines of evidence it is the position of the Petitioner's that no federal conforming requirement was issued nor was there a requirement to adopt "documentation requirements!"

Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e) are each invalid given that there is no federal conforming requirement

49. Are the Petitioner's, as providers of Cognitive Behavior Programs (CBP), on the ABI Medicaid Waiver Program, having signed a Provider Agreement on January 15, 2004, a Provider Agreement that does not reference Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c);

Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), required to comply with said regulations, given that the application for the ABI/TBI Medicaid Waiver Program was submitted in January 2012, prior to adoption of said regulations, on April 1, 2013 and the department confirms that there were no changes to the ABI/TBI Medicaid Waiver Program application submitted in 2012

The Petitioner's assert that the ABI/TBI Medicaid Waiver was renewed in January 2012 and that the proposed regulations

Connecticut General Statues 17b-260a-5(3)(B); Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4); Connecticut General Statutes 17b-260a-16(a)(5); Connecticut General Statutes 17b-260a-16(a)(6), Connecticut General Statutes 17b-260a-16(b); Connecticut General Statutes 17b-260a-16(c); Connecticut General Statutes 17b-260a-16(d); Connecticut General Statutes 17b-260a-16(e), were developed based on the 2012 waiver application, which did not contain any changes (no new requirements and no federal conforming requirements) in its application as communicated in an exchange of emails amongst DSS employees (Exhibit 4).

In addition, less than one month prior to the printing of the Notice of Intent on March 26, 2013, DSS in an exchange of emails indicates that there is no federal conforming requirement (Exhibit 5)

In the absence of a federal conforming requirement that proposed regulations are invalid.

50. Given that Department of Social Services (DSS) submitted an application (Exhibit 51) to Centers for Medicare and Medicaid Services on October 6, 2006 and in said application, claimed in "Appendix I-1 Financial Accountability" that DSS (1) conducts audits of Medicaid providers and (2) the Office of Quality Assurance (QA) conducts financial audits of Medicaid providers and (3) all waiver providers are subject to audits performed by the QA, has Department of Social Services ever promulgated and received legally enforceable approved regulations, including but not limited to

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

as required by Connecticut General Statues 17b-99 (Exhibit 35), which may be used to audit the Petitioner's as it relates to the Petitioner's, as providers on the ABI/TBI Medicaid Waiver program since 1999

There are no audit regulations for the ABI Waiver program. The Department of

Social Services printed a Notice of Intent to adopt regulations to audit providers on October 16, 2012 by Connecticut General Statutes 17b-99. The proposal was submitted to LRRC and withdrawn on several occasions until finally withdrawn in August of 2014. There was also a Public Act (14-162) that requires modifications of Connecticut General Statutes 17b-99 effective July 1, 2014. The "bar" for obtaining approval of regulations under Connecticut General Statutes 17b-99 has always been high but with Public-Act 14-162 (Exhibit 56) the bar is raised even higher. Therefore, Department of Social Services withdrew their proposal for the last time. Therefore, begging the question, how will Department of Social Services obtain new revenues by auditing providers if DSS cannot obtain approval for audit regulations? The Department of Social Services will use "documentation regulations" and or "documentation requirements" disguised as "audit protocols" to fine providers at the administrative level. If a provider does not understand that Connecticut General Statutes 17b-99 is required for a legally enforceable audit, the provider will assume that the audit is valid and pay fines levied by the Department of Social Services.

51. Given that the Department of Social Services submitted an application (Exhibit 52) to Centers for Medicare and Medicaid Services on October 1, 2012 and in said application, claimed in "Appendix I-1 Financial Accountability" that

> (1) DSS Office of Quality Assurance conducts financial audits of Medicaid providers and (2) all waiver providers are subject to audits performed by the QA, and (3) the auditor reviews supporting documentation maintained by the provider and claim information maintained by the department,

has Department of Social Services ever promulgated and received legally enforceable approved regulations, including but not limited to
Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

as required by Connecticut General Statues 17b-99, that may be used to audit the Petitioner's as it relates to the Petitioner's, as providers on the ABI/TBI Medicaid Waiver program

No! There have never been audit regulations established by Department of Social Services by Connecticut General Statutes 17b-99. The answer to the question in the CMS application was falsified by Department of Social Services.

52. Given that the Department of Social Services (DSS) submitted an application to Centers for Medicare and Medicaid Services on October 6, 2006 and in said

application (Exhibit 51), claimed in "Appendix I-1 Financial Accountability that" DSS (1) conducts audits of Medicaid providers and (2) the Office of Quality Assurance (QA) conducts financial audits of Medicaid providers and (3) all waiver providers are subject to audits performed by the QA,
having never promulgated and received legally enforceable approval of "audit regulations" including but not limited to

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

as required under Connecticut General Statues 17b-99 to audit providers on the ABI/TBI Medicaid Waiver program since 1999, did Department of Social Services, submit a false claim in its application to CMS on October 6, 2006, and by doing so, did Department of Social Services mislead the Petitioner's regarding the potential for them to be audited under Connecticut General Statutes 17b-99

Yes! The Department of Social Services falsified their application to CMS. The Department of Social Services claimed that it had "audit protocols" which in Connecticut means that you have protocols that meet the requirement of Connecticut General Statutes 17b-99. The Department of Social Services does not have such protocols and has never had such protocols, and we attest that the Department of Social Services has abandoned any attempt to secure such protocols. The Department of Social Services is devising a scheme that will allow them to audit the Petitioner's without having approval under Connecticut General Statutes 17b-99

53. Given that the Department of Social Services submitted an application to Centers for Medicare and Medicaid Services on October 1, 2012 and in said application, claimed in "Appendix I-1 Financial Accountability" that

    (1) DSS Office of Quality Assurance conducts financial audits of Medicaid providers and (2) all waiver providers are subject to audits performed by the QA, and (3) the auditor reviews supporting documentation maintained by the provider and claim information maintained by the department,
    having never promulgated and received legally enforceable approval of "audit regulations" including but not limited to

    Connecticut General Statutes 17b-260a-16(a)(1);
    Connecticut General Statutes 17b-260a-16(a)(4);
    Connecticut General Statutes 17b-260a-16(a)(5); and
    Connecticut General Statutes 17b-260a-16(a)(6);

96. If it is determined that Department of Social Services falsified its 2006 application to CMS regarding "Appendix I-1 Financial Accountability & Integrity" by attesting that "audit protocols" existed and were in effect for the ABI Waiver, despite Department of Social Services' repeated failures to adopt "audit protocols" by Connecticut General Statutes 17b-99,

can Commissioner of Department of Social Services and those who signed the ABI Waiver application and those who were designated as contact persons for said waiver application, be considered to have committed Medicaid Fraud by deceiving CMS that "audit protocols" existed when they did not

Yes! The falsification is considered a "false claim!"

and can it be said that the actions of said individuals was malicious and reckless and was an attempt to secure federal funding for its ABI Waiver program by attempting to give the impression that an Assurance had been met when it had not

Yes! Connecticut General Statutes 17b-99 is clear that regulations are required to implement audits.

97. If it is determined that Department of Social Services falsified its 2012 application to CMS regarding "Appendix I-1 Financial Accountability & Integrity" by attesting that "audit protocols" exist and are in effect for the ABI Waiver, despite Department of Social Services' repeated failures to adopt "audit protocols" by Connecticut General Statutes 17b-99,

can Commissioner of Department of Social Services (Roderick Bremby) and those who signed the ABI Waiver application and those who were designated as contact persons for said waiver application, be considered to have committed Medicaid Fraud by deceiving CMS that "audit protocols" existed when they did not

Yes! The falsification is considered a "false claim!"

and can it be said that the actions of said individuals was malicious and reckless and was an attempt to secure federal funding for its ABI Waiver program by attempting to give the impression that an Assurance had been met when it had not

Yes! The falsification was willful and wanton as evidenced by printing of a Notice of Intent to adopt regulations by Connecticut General Statutes 17b-99 only 15 days (October 16, 2012) after submission of the ABI Waiver application on October 1, 2012

98. If it is determined that Department of Social Services falsified its amended 2012 application to CMS regarding "Appendix I-1 Financial Accountability & Integrity" by attesting that "audit protocols" exist and are in effect for the ABI Waiver, despite Department of Social Services' repeated failures to adopt "audit protocols" by Connecticut General Statutes 17b-99,

    can Commissioner of Department of Social Services (Roderick Bremby) and those who signed the ABI Waiver application and those who were designated as contact persons for said waiver application, be considered to have committed Medicaid Fraud by deceiving CMS that "audit protocols" existed when they did not

Yes! The falsification is considered a "false claim!"

    and can it be said that the actions of said individuals was malicious and reckless and was an attempt to secure federal funding for its ABI Waiver program by attempting to give the impression that an Assurance had been met when it had not

Yes! The falsification was willful and wanton as evidenced by printing of a Notice of Intent to adopt regulations by Connecticut General Statutes 17b-99 only 15 days (October 16, 2012) after submission of the ABI Waiver application on October 1, 2012 and repeated failures by DSS regarding the adoption of the regulations via LRRC

99. If it is determined that Department of Social Services falsified its 2014 ABI Waiver II application to CMS regarding "Appendix I-1 Financial Accountability & Integrity" by attesting that "audit protocols" exist and are in effect for the ABI Waiver, despite Department of Social Services' repeated failures to adopt "audit protocols" by Connecticut General Statutes 17b-99,

    can Commissioner of Department of Social Services (Roderick Bremby) and those who signed the ABI Waiver application and those who were designated as contact persons for said waiver application, be considered to have committed Medicaid Fraud by deceiving CMS that "audit protocols" existed when they did not

Yes! The falsification is considered a "false claim!"

and can it be said that the actions of said individuals was malicious and reckless and was an attempt to secure federal funding for its ABI Waiver program by attempting to give the impression that an Assurance had been met when it had not

Yes! The falsification was willful and wanton as evidenced by printing of a Notice of Intent to adopt regulations by Connecticut General Statutes 17b-99 only 15 days (October 16, 2012) after submission of the ABI Waiver application on October 1, 2012 and repeated failures by DSS regarding the adoption of the regulations via LRRC. Also, after enactment of Public Act 14-162 in July 2014, DSS withdrew its application for regulations. DSS was well aware that an alternate plan would need to be executed to "cover-up" falsifications on previous applications (2006, 2012, 2012 amended).

100. If the Department of Social Services falsifies its 2016 renewal application to CMS regarding "Appendix I-1 Financial Accountability & Integrity" by attesting that "audit protocols" exist and are in effect for the ABI Waiver, despite Department of Social Services' repeated failures to adopt "audit protocols" by Connecticut General Statutes 17b-99,

will Commissioner of Department of Social Services and those who will sign the ABI Waiver application and those who are designated as contact persons for said waiver application, be considered to have committed Medicaid Fraud by deceiving CMS that "audit protocols" exist when they do not,

Yes! If the Department of Social Services (DSS) reiterates that previous falsification that audit protocols exist the various players will have committed fraud. If DSS attest that either its "documentation requirements" CGS 17b-260a-16 and/or its credential policies adopted October 31, 2015 are audit protocols, which they are not "audit protocols" by CGS 17b-99, it can be said that the Commissioner and those who sign the waiver can be considered to have committed Medicaid fraud.

and can it be said that the actions of said individuals are malicious and reckless and are an attempt to secure federal funding for its ABI Waiver program by attempting to give the impression that an Assurance (Financial Accountability & Integrity) has been met and is in accordance with Connecticut General Statutes 17b-99

Yes! The falsification will be willful and wanton as evidenced by printing of a Notice of Intent to adopt regulations by Connecticut General Statutes 17b-99 only 15 days (October 16, 2012) after submission of the ABI Waiver application on October 1, 2012 and repeated failures by DSS regarding the adoption of the regulations via LRRC. Also, after enactment of Public Act 14-

162 in July 2014, DSS withdrew its application for regulations. DSS was well aware that an alternate plan would need to be executed to "cover-up" falsifications on previous applications (2006, 2012, 2012 amended, and ABI Waiver II) and DSS will likely employ the "documentation requirements" and credential policies as the basis for their "audit protocols" despite the policies not being approved in accordance with CGS 17b-99.

and will Petitioner's have been harmed by such actions given that the Petitioner's will have submitted private information to the fiduciary for Department of Social Services including financial information and insurance accounts information and incurred significant costs that were not previously required when applying to be a provider on the ABI Waiver program

Yes! The Petitioner's will attempt to comply with the flawed polices resulting in a loss of autonomy, dignity, freedom and financial costs to the Petitioner's

101. Given that the Provider Agreements signed October 23, 2014 and October 28, 2014 have been terminated due to violation of "Item 4" in each Provider Agreement, does Department of Social Services retain any authority to conduct a Review of the Petitioner's records given that the Petitioner's attest that the Provider Agreement has been terminated by Department of Social Services and what is the legal authority that serves as the authority to compel Petitioner's to participate

No! The Provider Agreements have been terminated and there is no authority to compel the Petitioner's to participate in what are illegal audits and/or record reviews.

102. Given that "documentation requirements" are not "audit protocols" as communicated by Attorney Hugh Barber (Exhibit 36) are Petitioner's required to participate in any "Records Review" or "audit" that requires adherence to the following regulations,

Connecticut General Statutes 17b-260a-16(a)(1)
Connecticut General Statutes 17b-260a-16(a)(4)
Connecticut General Statutes 17b-260a-16(a)(5)
Connecticut General Statutes 17b-260a-16(a)(6)

No! The federal conforming requirement was for audit protocols. There are no audit protocols adopted by DSS. The "documentation requirements" are not "audit protocols" per Hugh Barber (Exhibit 36)

and given that "documentation requirements" were not adopted in accordance with Connecticut General Statutes 17b-99, are Petitioner's required to participate in a review of records or an audit, and please provide the legal authority that serves as the authority to compel Petitioner's to participate

No! There is no legal authority that requires the Petitioner's to participate in a review of records or an audit as the regulations and policies were not adopted in accordance with Connecticut General Statutes 17b-99

and given that "documentation requirements" were not adopted in accordance with Connecticut General Statutes 4-168, are Petitioner's required to participate in a review of records or an audit, and please provide the legal authority that serves as the authority to compel Petitioner's to participate

No! The errors related to adoption regarding Connecticut General Statutes 17b-260a-16 are obvious as there was only one printing of a notice of intent and that printing did not take place 30 days prior to adoption and there was no printing within 20 days after adoption. The Department of Social Services in its haste committed an error or given all of the data presented herein, DSS may have purposely attempted to "slip" through the documentation requirements in an attempt to facilitate their "two-pronged" approach to circumventing Connecticut General Statutes 17b-99

103. Are Petitioner's required to forego protections outlined in Connecticut General Statutes 17b-99 including but not limited to (1) 30 days notice prior to complying with an audit (2) training related to record keeping and (3) requirements regarding evaluation of errors and (4) opportunities to resolve discrepancies related to findings resulting from an audit, given that the Petitioner's are providers on the ABI Waiver program

No! The protections detailed in Connecticut General Statutes 17b-99 are designed to ensure that the audit process is fair. The protections afforded to those who are enrolled in Medicaid must be afforded to all providers including the Petitioner's who are Medicaid providers.

104. Given that Connecticut General Statutes 17b-260a-16(d) is not a "documentation requirement" and there was no federal conforming requirement to adopt a regulation that requires monthly reporting and monthly reporting was not required prior to the adoption of said requirement on April 1, 2013 and said requirement was not adopted in accordance with Connecticut General Statutes 4-168 and Connecticut General Statutes 17b-10(b), are Petitioner's required to submit monthly report

No! There is no legal basis to require the Petitioner's to complete monthly report

105. Given that audit protocols must be adopted in accordance with Connecticut General Statutes 17b-99 and Department of Social Services has adopted "audit protocols' without promulgating said protocols in accordance with Connecticut General Statues 4-168 and Connecticut General Statutes 17b-99, are the Petitioner's being providers on the ABI Waiver required to

participate in said "audits" and what is the legal authority to require Petitioner's to participate

No! A regulation or requirement to conduct an audit by Department of Social Services must be conducted in adherence to regulations adopted in accordance with Connecticut General Statutes 17b-99. The audits to be conducted by Allied Community Resources have no legal basis

106. Given that Connecticut General Statutes 17b-260a-1 to Connecticut General Statutes 17b-260a-15 are not "audit protocols" and were not adopted in accordance with Connecticut General Statutes 4-168, are Petitioner's required to adhere to said regulations

No! There are no "audit protocols" amongst the regulations adopted by Department of Social Services including Connecticut General Statutes 17b-260a-1 to Connecticut General Statutes 17b-260a-15. All regulations were improperly adopted and are invalid and the failure to adopt said regulations according to Connecticut General Statutes 4-168 means that all regulations are invalid

and given that Connecticut General Statutes 17b-260a-1 to Connecticut General Statutes 17b-260a-15 are not "audit protocols" and the federal conforming requirement was to adopt "audit protocols"(Exhibit 9, pp.248-251) and Department of Social Services improperly applied Connecticut General Statutes 17b-10(b) to said regulations are Petitioner's required to adhere to said regulations

No! A regulation or requirement to conduct an audit by Department of Social Services must be conducted in adherence to regulations adopted in accordance with Connecticut General Statutes 17b-99. The audits to be conducted by Allied Community Resources have no legal basis

ARGUMENT

Due to the volume of information presented, it is best to provide the Department of Social Services (DSS) with additional perspective regarding the crux of the issues as viewed from the position of the Petitioner's. The Petitioner's believe that it is best to begin with the "false claims" that DSS has repeatedly submitted to CMS for at least ten years, that "audit protocols" exist and are in effect for providers on the ABI Waiver Program.

1. DSS falsified its application to Centers for Medicare and Medicaid Services submitted on October 6, 2006 when it claimed that "audit protocols" exist for the ABI Waiver (Exhibit 51)
2. DSS perpetuated its 2006 falsification "with similar language" and in each subsequent ABI Waiver application submitted to CMS including;
    a. ABI/TBI Medicaid Waiver submitted to CMS on October 1, 2012 (Exhibit 52)
    b. ABI/TBI Medicaid Waiver II submitted to CMS on October (not included)
    c. ABI/TBI Medicaid Waiver I Amended submitted on October 1, 2015 (not included)

The Department of Social Services will use "documentation requirements" (Connecticut General Statutes 17b-260a-16 to Connecticut General Statutes 260a-17) that it has secured by manipulation of CMS' requirement for "audit protocols." DSS has the authority to adopt regulations under Connecticut General Statutes 17b-10(b) and operate under such policy while it is being considered, provided that there is a "requirement to which it must conform," DSS must conform to CMS' requirement for "audit protocols" (Exhibit 9, pp. 248-251). However, DSS used Connecticut General Statutes 17b-10(b) to adopt "documentation requirements" and Hugh Barber (Assistant Attorney General) confirmed that regulations (Connecticut General Statutes 17b-260a-16 to Connecticut General Statutes 260a-17) are not "audit protocols" but are "documentation requirements" (Exhibit 36). Therefore, Connecticut General Statutes 17b-10(b) should not have been applied to said "documentation requirements" as the requirement was for "audit protocols."

In addition, DSS adopted a practice of having Petitioner's engage in activities, labeled by CMS as "audit protocols" Exhibit 9, pp.248-251) including requirements that Petitioner's provide financial documents (taxes, balance sheet, income statement, statement of cash flows) and an independent audit, as well as other "audit requirements" without adopting such policies in accordance with Connecticut General Statutes 17b-99. These policies have been adopted without legislative review, are disguised to Petitioner's as "credentialing policies" but are "audits" as described by CMS and must be developed in accordance with Connecticut General Statutes 17b-99.

The "documentation requirements" combined with "credentialing policies" constitute a "two-pronged" approach that will be used to "cover-up" false claims made in previous ABI Waiver applications. In addition, LRRC will have been circumvented, audit protocols will appear to Petitioner's as having been legally adopted and DSS will have avoided compliance with Connecticut General Statutes 17b-99.

Falsification of ABI Waiver Applications

The Centers for Medicare & Medicaid Services (CMS) requires State's to meet Assurances when applying for Home and Community Based Waivers. The Assurance of interest is "Financial Accountability". There are a number of Appendices in the area of "Financial Accountability" but the Appendix of specific interest is "Financial Integrity & Accountability" which can be found in "Appendix I-1," (Exhibit 9, pp.248-251). The instructions provided to Department of Social Services in Appendix I-1are as follows;

> In the text field, describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits that are conducted; and, (c) the agency (or agencies) responsible for conducting the financial audit program.

The Department of Social Services is governed by Connecticut General Statutes 17b-99 regarding audits (Exhibit 35). In short, the requirements to adopt "audit protocols" within Department of Social Services are extensive and approval is not guaranteed unless a number of criteria are met including approval from Licensing Regulation and Review Committee (LRRC). The Department of Social Services has never secured approval of "audit protocols" for providers, as detailed in a Notice of Intent printed in Connecticut Law Journal of October 16, 2012 and DSS abandoned any attempt to secure "audit protocols" through Connecticut General Statutes 17b-99 in August 2014 when DSS withdrew its proposal from review at LRRC for the final time after several failed attempts to obtain approval (Exhibit 56; Exhibit 63).

The Centers for Medicare and Medicaid Services (CMS) provides "Technical Guidance" to support the "Instruction" quoted previously, "Technical Guidance" is as follows;

> This item focuses on how the state assures the integrity of payments that have made for waiver services. It concentrates on post-payment financial audit activities rather than on the methods of ensuring the validity of provider billings prior to payment (those methods are addressed in Item 2-d below).
>
> The description must address the following:
>
> - State requirements concerning the independent audit of provider agencies – i.e., whether waiver providers are required to secure an independent audit of their financial statements;
>
> - The state's own financial audit program to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits conducted by the State. A financial audit program might include testing a sample of provider billings to ensure that they are properly supported by documentation of the actual provision of waiver services or the review of provider cost accounting systems to ensure that, when rates are based on provider costs, costs have been properly recorded and do not include unallowable expenses; and,

- The state agency (or agencies) responsible for conducting the state's financial audit program. If the financial audit program is conducted by contractors, specify the state agency responsible for overseeing contractor performance.

If the description cites applicable state laws, regulations, and policies, the documents cited must be readily available through the Medicaid agency or the operating agency (if applicable) when requested by CMS.

Again, given that no "audit protocols" exist for the ABI Waiver, it would appear that the details provided by CMS in its "Technical Guidance" are not relevant. However, due to DSS' falsification of its 2006 and 2012 (Exhibits 51 & 52), ABI Waiver applications and failure to secure audit protocols between October 16, 2012 (Exhibit 63) and abandoning the pursuit of said "audit protocols after the passage of Public Act 14-162 (Exhibit 56), DSS realized, that the possibility of securing "audit protocols" that meet the terms of the falsifications found in the 2006 and 2012 ABI Waiver applications, by Connecticut General Statutes 17b-99, was not a viable option, given the scrutiny given to such proposals by LRRC, as a result, at some point, DSS initiated an alternate plan to "cover-up" falsifications in their applications.

Circumventing Connecticut General Statutes 17b-99

The failures to secure "audit protocols" (Exhibit 63) as required by Connecticut General Statutes 17b-99, "set in motion" an attempt to secure "audit protocols" without legislative review. The Department of Social Services decided to take a "two-pronged" approach to securing the requirements outlined in Appendix I-1 of the ABI Waiver application submitted to CMS.

1. The Department of Social Services chose to use the requirement to have "audit protocols" as a basis to adopt "documentation requirements" or "documentation regulations" under Connecticut General Statues 17b-10(b) despite no federal conforming requirement to adopt "documentation requirements" or "documentation regulations". The federal requirement is to obtain "audit protocols" which could not be achieved due to the failures of the department. The Department of Social Services adopted Connecticut General Statutes 17b-260a-16 and Connecticut General Statutes 17b-260a-17 on April 1, 2013 in an attempt to secure documentation requirements as a part of the overall "audit protocols" but Office of Attorney General has denied, in court, that said documentation requirements are "audit protocols" which begs the question, "what are they" if not a failed attempt to circumvent Connecticut General Statutes 17b-99 in an attempt to secure "documentation requirements" as a part of the requirement to have "audit protocols as required by CMS?

2. The Department of Social Services chose to initiate departmental audits that are consistent with the criteria outlined in CMS Appendix I-1 (Exhibit 9, pp.248-251) by compelling providers on the ABI Waiver to participate in a process that DSS terms, "Credentialing," (Exhibit 58). In essence, these are the "audit protocols" that are required by CMS but have never

been secured by DSS in accordance with Connecticut General Statutes 17b-99. With this "prong" of the approach, Department of Social Services has reached the pinnacle of hubris as there was no attempt to promulgate these policies as was done with the aforementioned "documentation requirements" and despite an attempt to promulgate said policies, Department of Social Services terms the process "audits" in direction violation of Connecticut General Statutes 17b-99.

An amalgamation of the "two-pronged" approach when put together, provides DSS with an illegal "audit protocol" that has circumvented Connecticut General Statutes 17b-99, conceals falsifications presented in ABI Waiver applications, and as will be discussed later, will allow DSS an avenue to generate new revenues by "clawing back" payments from unsuspecting ABI Waiver provider's including the Petitioner's.

A comparison of the CMS Technical Guidance and "documentation requirements" paired with "Credentialing" criteria provides a potentially effective tool for unsuspecting providers such as the Petitioner's.

	CMS REQUIREMENT	FALSE AUDIT CRITERIA	FALSE FEDERAL CONFORMING REQUIREMENT
	Technical Guidance (Exhibit 9, pp.248-251)	Credentialing (Exhibit 58)	Documentation Requirements (Exhibit 8)
1	Independent audit of provider agencies	CPA Opinion letter	
2	Independent audit of their financial statements	Balance sheet; Income statement; Statement of cash flows: Disclosures	
3	A financial audit program might include testing a sample of provider billings to ensure that they are properly supported by documentation of the actual provision of waiver services.....		Connecticut General Statutes 17b-260a-16; and Connecticut General Statutes 17b-260a-17
4	The state agency (or agencies) responsible for conducting the state's financial audit program	Allied Community Resources and Department of Social Services Quality Assurance	Department of Social Services Quality Assurance and Allied Community Resources as designee

The Department of Social Services has made an "end-run" around the "audit" adoption promulgation procedure outlined in Connecticut General Statutes 17b-99. The Department of Social Services (DSS) will combine these "two-prongs" and call the process implemented by ACR an audit (Exhibit 58 and Exhibit 60). Given that DSS has stipulated in its regulations (Connecticut General Statutes 17b-260a-16(b)) that

"immediate access" must be granted to any DSS employee or its designee, members of ACR, being a designee, may request a review of "documentation" to support provider billings, as outlined in Connecticut General Statutes 17b-260a-16. The Department of Social Services will implement their "two-pronged" (credentialing and documentation requirements) approach without any of the protections afforded to the Petitioner's outlined in Connecticut General Statutes 17b-99. Most importantly, these will be illegal audits, as Department of Social Services is required to seek approval for "audit protocols" by Connecticut General Statutes 17b-99 prior to conducting audits. While the deception is not elegant, at "face-value," it will appear to some providers to be legitimate.

The harm caused by DSS is voluminous and some of the harm was likely due to the Departments' perception that it needed to continue to falsify its application to Centers for Medicare & Medicaid Services (CMS). However, some of the variance has to be due to DSS' benefitting from with the falsifications in the ABI Waiver applications for nearly ten years, while the need for power and control over the Petitioner's is likely to have also contributed to the variance.

In the "collective conscious" of DSS, what could one expect DSS to do as the date of their 2012 ABI Waiver application approached? DSS could have chosen to inform CMS that DSS falsified its 2006 application and endure an investigation that would confirm that no "audit protocols" ever existed?

However, Department of Social Services, under leadership of Commissioner Roderick Bremby, chose to perpetuate the 2006 deception, and likely assumed that obtaining "audit protocols" for providers operating on ABI Waiver would not be onerous. The Department, miscalculated, and it is believed that during the review process, conducted by LRRC, of its "audit protocols," decided that DSS would create its own legislation and as long as providers, including the Petitioner's, did not challenge the authority of DSS, the "two-pronged" approach would be efficacious, unless or until, legally adopted "audit protocols" could be obtained.

Harm

Unfortunately, Petitioner's have been harmed by the actions of Department of Social Services (DSS). The Petitioner's will provide a detailed historical review of the actions taken by Department of Social Services related to the matters of interest, while also providing the Petitioner's position on these matters with evidence that supports the position of the Petitioner's.

Critical Events

1. January 15, 2004: DSS and Petitioner's enter into an Agreement
2. October 6, 2006: Falsification of ABI Waiver Application
3. October 1, 2012: Falsification of 2012 ABI Waiver Application
4. October 16, 2012 Prints Notice of Intent to adopt audit protocols
5. April 1, 2013: Adoption of Connecticut General Statutes 17b-260a-16 and Connecticut General Statutes 17b-260a-17 and termination of Agreement
6. June 16, 2014: Conducts an audit of Petitioner's, disguised as a review of records.
7. October 23, 2014: DSS and Petitioner's enter into an Agreement
8. October 28, 2015: DSS and Petitioner's enter into an Agreement
9. December 1, 2015: Falsification of ABI Waiver I Amendment and termination of October 23, 2014 Agreement and voided October 28, 2015 Agreement
10. January 1, 2016: Predicted Falsification of ABI Waiver Renewal

PROVIDER AGREEMENT: January 15, 2004

1. Tariq Abdulaziz, Ph.D., M.S., M.S., MBA and NeuroStrategies, Inc. hereafter referred to as, "Petitioner's provide Cognitive Behavior Programs on the Acquired Brain Injury/Traumatic Brain Injury Medicaid Waiver Program (ABI/TBI Medicaid Waiver) as a self-employed entity as supported by a Provider Agreement signed on January 15, 2004 (Exhibit 1).

2. January 1, 2004: DSS and Petitioner's enter into an Agreement (Exhibit 1)

3. The Petitioner's entered the waiver program as self-employed entities free of behavioral and financial control (Connecticut General Statutes 31-222(a)(1)(B)(ii) (Exhibit 32).

4. The Petitioner's entered into the relationship with specific criteria regarding documentation "Item 9" (Exhibit 1)

5. The Petitioner's entered into the relationship with specific criteria regarding submitting invoices for reimbursement. The service plan (Exhibit 59) served as the contract and Petitioner's could only obtain reimbursement for services and units outlined in the service plan. Despite this requirement not being explicitly communicated in the initial Agreement, it was not possible to submit for reimbursement for any other services or units other than those in the service plan and any attempt to submit an invoice for reimbursement that did not comply with the "services" and "units" in the participants' service plan (contract) was rejected by the fiduciary (Allied Community Resources).

6. The Petitioner's are self-employed as evidenced by the excerpt in the ABI/TBI Medicaid Provider Manual (Exhibit 12, p. 12) that provides a description of Cognitive Behavioral Program providers (Exhibit 12, p.12).

7. Petitioner (Tariq Abdulaziz, Ph.D., M.S., M.S., MBA) is designated as an Educational Psychologist for purposes of the ABI/TBI Medicaid Waiver program. The Educational Psychologist is designated as a self-employed provider (Exhibit 12, p.12)

8. The Petitioner's received a 1099 (2013 and 2014) as acknowledgement of payment for services rendered on the ABI/TBI Medicaid Waiver Program, which supports the designation of self-employment (Exhibit 42). The Petitioner's operate under a Federal Employment Identification Number (FEIN) and not a Social Security Number, which is consistent with a private entity and/or self-employment (Exhibits 42, 60, 64).

FALSIFICATION OF ABI WAIVER APPLICATION: October 6, 2006

9. The Department of Social Services hereafter referred to as "DSS" has been in the process of developing regulations for the ABI/TBI Medicaid Waiver Program for several years (Exhibit 6; Exhibit 4) and DSS considered having Petitioner's sign a Medicaid Enrollment Agreement that establishes an agreement regarding fraud and abuse and potential penalties (Exhibit 3; Exhibit 55). However, signing of the Medicaid Enrollment Agreement was not possible because the DSS does not allow Home and Community Based providers to enroll in Medicaid as there are protections afforded through Connecticut General Statutes 17b-99 and DSS never adopted regulations for auditing providers (Exhibit 55).

10. DSS operated under 1999 non-promulgated policies (Exhibit 31) from the inception of the ABI/TBI Medicaid Waiver Program until adoption of the proposed regulations on April 1, 2013(Exhibit 8) and thereafter and until as late as 2015 (Exhibit 31).

11. The Department of Social Services falsified their application to CMS in Appendix I-1 Financial Accountability & Integrity (Exhibit 51). While this deception did not have an impact for some time. The Petitioner's believe that this falsification led to a cascade of events.

FALSIFICATION OF ABI WAIVER APPLICATION: October 1, 2012

12. The Department of Social Services again falsifies its application to CMS in "Appendix I-1 Financial Accountability & Integrity." (Exhibit 52; Exhibit 53; Exhibit 54)

NOTICE OF INTENT TO ADOPT AUDIT PROTOCOLS: October 16, 2012

13. The Department of Social Services prints a Notice of Intent to adopt regulations to support the falsification printed and submitted to CMS in its October 1, 2012 ABI Waiver application. The reader must note that the Notice of Intent is printed just fifteen days after the October 1, 2012 application is submitted to CMS (Exhibit 57). Given that the Connecticut Law Journal prints on Tuesday's it is likely that the Notice of Intent was developed by October 10, 2012 and possibly prior to October 1, 2012. Any evidence that demonstrates that the Notice printed on October 16, 2012 was developed prior to submission of the ABI Waiver application on October 1, 2012 would be clear and convincing evidence that there was a willful and malicious attempt to deceive the Petitioner's regarding the falsification of the ABI Waiver application submitted on October 1, 2012. Nevertheless a cascade of additional events occurred which further contribute to the current entanglement including;

(1) Continued falsifications of its ABI Waiver Applications with regard to Appendix I-1 (Exhibit 9, pp.248-251) including 2014 ABI Waiver II, Amendment of 2012 ABI Waiver effective December 1, 2015, and 2016 ABI Waiver Renewal is anticipated to continue the falsification of Appendix I-1 "Financial Integrity & Accountability" with a two-pronged approached described earlier.

(2) A "cover-up" is initiated in an attempt to compensate for DSS' failure to secure regulations for audits in accordance with Connecticut General Statutes 17b-99 (Exhibit 31 and Exhibit 35), by use of the "two-pronged" approach which includes "documentation requirements" and "audit protocols" disguised as "credential policies" effective October 31, 2015 (Exhibit 58 and Exhibit 60)

(3) A Freedom of Information Act (FOIA) request (Exhibit 23) and an email confirming that documents were received (Exhibit 24) reveals that audits were conducted against ABI Waiver providers (Exhibits 25, 26, 27, 28, 29, 30 and 65A) prior to approval of regulations to govern the audit process as required by Connecticut General Statutes 17b-99. The providers are harmed (Exhibits 25, 26, 27, 28, 29, 30 and 65B, 65C, 65D, 65E, 65G, and 65H). However, providers are operating under the assumption that "audit protocols" exist as delineated in ABI Waiver applications submitted to CMS on October 6, 2006 and October 1, 2012. Therefore, providers had reason to believe that the audits that were conducted were legal.

(4) The outcome of at least one and possibly additional audits were negotiated by John McCormick (Exhibits 65D, 65F, and 65H) in violation of Connecticut General Statutes 17b-99(8) as the Commissioner of Department of Social Services is required to appoint an impartial arbiter in negotiations, not a member of Department of Social Services Quality Assurance.

(5) It is well documented that Commissioner Roderick Bremby was well aware of the negotiations (Exhibit 65E) and it is alleged that at least one of the audited providers employed a former DSS employee as a consultant regarding negotiations related to the audit (Exhibits 37, 38 and 39).

ADOPTION OF DOCUMENTATION REQUIREMENTS: Connecticut General Statutes 17b-260a-16 to Connecticut General Statutes 17b-260a-17: April 1, 2013

(6) Department of Social Services initiates the first phase of its "two-pronged" approach to develop its own set of "audit protocols" by developing "documentation requirements" (Exhibit 8, pp. 28-29) that are embedded within regulations for the ABI Waiver program (Exhibit 8). It is the "documentation requirements" that will be used as a tool to apply Connecticut General Statutes 17b-10(b) to the entire set of regulations (Exhibit 8). The CMS requirement for "audit protocols" (Exhibit 9, pp.248-251) that are elusive for DSS will be

perverted into a requirement to adopt "documentation requirements" and the entire set of regulations are printed on March 26, 2013 and adopted April 1, 2013 in circumvention of Connecticut General Statutes 4-168 and in violation of Connecticut General Statutes 17b-10(b).

(7) errors in adoption, related to Connecticut General Statutes 17b-260a-16 and Connecticut General Statutes 17b-260a-17 (Exhibit 2; Exhibit 8), including but not limited to the following;

a. fails to provide 30 days notice prior to adoption as required in accordance with Connecticut General Statutes 4-168 (Exhibit 33 and Exhibit 61 contains the current version of said statute)
b. fails to print notice within 20 days after adoption as required in accordance with Connecticut General Statutes 17b-10(b)
c. fails to identify federal conforming requirement in notice printed on March 26, 2013 despite stated desire to find a federal conforming requirement (Exhibit 5)
d. references incorrect statutory authority in Notice of Intent (Exhibit 2)
e. failure to provide a federal conforming requirement in Notice of Intent printed on March 26, 2013 (Exhibit 2)
f. failure to forward proposed regulations including "documentation requirements" to Licensing Regulation Review Committee (LRRC) within 180 days as required by Connecticut General Statutes 17b-10(b) (Exhibit 31; Exhibit 34; Exhibit 41)
g. development of regulations in a manner that was "intentionally vague" (Exhibit 7) in violation of Connecticut General Statutes 17b-10(b)

(8) Circumvention of Connecticut General Statutes 17b-99, by adopting Connecticut General Statutes 17b-260a-16 and Connecticut General Statutes 17b-260a-17 by falsifying a federal conforming requirement (Exhibit 10) as it is clear that no additional request has been requested by CMS. The requirements that exist have always existed with minor changes and "minor changes" are due at the time that ABI Waiver I renews on January 1, 2016 (Exhibit 10; Exhibit 44).

(9) In an attempt to provide additional confirmation that no federal conforming requirement exists, Petitioner's secured all communication between CMS and DSS from 2009 to 2014 (Exhibit 18; Exhibit 19; Exhibit 20). The documents are enclosed (Exhibit 20) and no federal conforming requirement can be found and DSS confirms that the FOIA request has been fulfilled (Exhibit 20).

AUDIT DISGUISED AS A RECORDS REVIEW IS INITIATED AGAINST THE PETITIONER'S: June 16, 2014

(10) Department of Social Services Quality Assurance (DSSQA) contacts the Petitioner's and requests that the Petitioner's produce their records in accordance with the Provider Agreement signed on January 15, 2004. The Petitioner's request that DSS provide feedback regarding "documentation requirements," with specific reference to "what" should be included in the files. The representative from DSSQA indicates,

I advised him that to my knowledge there was no a detailed description or list and to look within the Provider Manual for guidance (Exhibit 11; Exhibit 12)

(11) The DSSQA representative forwards the request for feedback to members of the DSS Social Work Unit and to date there has been no response from this group.

(12) The Office of Legal Counsel responds to the legal representative for the Petitioner's and communicates that the Petitioner's will be required to adhere to "Item 9" of the January 15, 2004 Provider Agreement for "documentation requirements" prior to April 1, 2013 and Connecticut General Statutes 17b-260a-16 on and after April 1, 2013 with potential penalties as outlined in Connecticut General Statutes 17b-260a-17 printed on March 26, 2013 and adopted on April 1, 2013 (Exhibit 13).

(13) The Petitioner's are harmed by DSS' application of Connecticut General Statutes 17b-10(b) in the adoption of "documentation requirements" or "documentation regs" as the "documentation regulation" specifically

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

are not consistent with the Provider Agreement signed on January 15, 2004, which established "documentation requirements", to be as follows

I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES/GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST

and with the Provider Agreement, prior to adoption of said regulations, the Petitioner's could meet the burden of complying with documentation requirements by maintaining a copy of the invoice submitted for reimbursement (Exhibit, 40) by applying the language from the Provider Agreement signed January 15, 2004 to the invoice submitted for reimbursement in the following manner;

PROVIDER AGREEMENT: ITEM 9	INVOICE
I WILL	Names of Petitioner's
MAINTAIN RECORDS	Invoice
THAT FULLY DISCLOSE SERVICES/GOODS RENDERED AND/OR DELIVERED	Cognitive Behavioral Programs is listed as a "service" in the waiver application (see Exhibit 1) and is on the invoice as "Service Type"
TO ABI WAIVER PARTICIPANTS	Participants Name
THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST	As provided by Petitioner's on June 16, 2014, during a Records Review scheduled at the earliest time possible, based on a mutually agreed upon date and time for both parties.

prior to adoption of "documentation regulations"

Connecticut General Statutes 17b-260a-16(a)(1);
Connecticut General Statutes 17b-260a-16(a)(4);
Connecticut General Statutes 17b-260a-16(a)(5); and
Connecticut General Statutes 17b-260a-16(a)(6);

As a result, the Petitioner's have expended tremendous time, energy, and lost autonomy, and dignity in an attempt to comply with regulatory requirements that did not exist prior to the adoption of said regulations.

The Petitioner's are required to gather and provide data as outlined in the "documentation requirements or documentation regulations," as a condition for services rendered, despite no previous requirement to adhere to said requirements prior to adoption of said regulations on April 1, 2013.

The Petitioner's have attempted to gather signatures since immediately after the adoption of documentation requirements (Exhibit 62), Petitioner's have developed various forms to document "time-in" and "time-out" as well as provision of a brief description of the service provided (Exhibit 62). The Petitioner's have engaged in these activities despite the Departments refusal to establish a process to provide Petitioner's with service plans that serve as a contract between the participant and DSS but includes services and units available to the Petitioner's.

The Petitioner's believe that they were "audited" but their decision to choose legal counsel that had no previous relationship with DSS, unlike other providers and said representation (Exhibit 28; Exhibit 37, Exhibit 38, Exhibit 39) resulted in DSS continuing to label the process a "Records Review" despite no reference to "Records Reviews" in their application to CMS and their application of "audit protocols" against providers without adoption of regulations in accordance with Connecticut General Statutes 17b-99. (Exhibit 25-30; Exhibit 65A).

The cost to the Petitioner's with regard to these activities are tremendous including the loss of autonomy, dignity, and status as a self-employed entity have been violated.

(14) The Department of Social Services attests that each of the regulations printed on March 26, 2013 and adopted on April 1, 2013 are in effect, including Connecticut General Statutes 17b-260a-16(d) which includes monthly reporting and written updates which were not required prior to adoption of Connecticut General Statutes 17b-260a-16(d). Requests for monthly reports have been numerous (Exhibit 14; Exhibit 17; Exhibit 21). The Petitioner's provide Cognitive Behavioral Programs services to approximately 120 participants per month (Exhibit 45).

(15) The Petitioner's attest that the service rate for Cognitive Behavioral Programs from January 1, 2015 until November 30, 2015 was either $82.40 per hour or $83.22 per hour due to a change in rate that occurred during 2015. During this period, Cognitive Behavioral Programs was billed at an hourly rate whether Petitioner's provided less than 60 minutes of service or no more than 60 minutes of service. Given that approximately 120 monthly reports are completed each month at less than 60 minutes per report at a rate of $82.40 per hour, the monthly cost to the Petitioner's, is $9,888.00 per month and $118,656.00 per year and the cost to the Petitioner's continues to accrue.

(16) Please note that the Petitioner's began to consistently provide monthly reports to DSS for the final quarter of 2014, which brings the total cost to the Petitioner's effective November 30, 2015 to $148,320.00 from October 2014 to November 30, 2015. Given that monthly reports are not a service listed under Cognitive Behavioral Programs the Petitioner's attest that the Department of Social Services has previously established that the hourly rate is applicable for the production of such reports.

(17) Given that the hourly rate for Cognitive Behavioral Programs has moved to $105.00 per hour and is not listed as a service, Petitioner's attest that the previous rate of $83.22 is applicable moving forward if not the $105.00 rate recently adopted by DSS. Given the previous argument the total cost to date at a rate of $105.00, with December 2015 included ($12,600.00 + $148,320.00) is $160,920.00

(18) The Petitioner's are self-employed as demonstrated by the previously signed Provider Agreements (Exhibit 1; Exhibit 46; Exhibit 47). The Provider Manual supports the position of the Petitioner's as self-employed (Exhibit 12) and the Petitioner's are established as agency providers as documented by the Provider Agreements signed in 2014 and 2015 (Exhibits 46 and 47) as well as communications with Allied Community Resources (Exhibit 58).

(19) There are a number of instances where Department of Social Services exercises behavioral control is voluminous, including "documentation requirements" outlined in

Connecticut General Statutes 17b-260a-16. The requirement to track, time-in and time-out, complete and document duties performed, obtain signatures on behalf of Department of Social Services, and complete monthly reports (Connecticut General Statutes 17b-260a-16(d) and provide said monthly reports on a form designated by DSS is consistent with an employer-employee relationship and is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

(20) In addition, the requirement to meet with each participant in a Face-to-face setting as required by Credential Policies (discussed later) is an additional example of behavioral control as well as the requirement to employ "Skype" if video-conferencing with a participant despite said platform not being HIPPA compliant which places the Petitioner's at-risk of liability if there is a breach of the platform. In addition, dictating where services are to be provided (Exhibit 22) and demanding the Petitioner's submit for reimbursement based on "units" that are not in the participants' service plan (Exhibit 48) and at a rate determined by the Department of Social Services which exercises financial control (Exhibit 49) are all done in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii) and is all done in violation of the participants service plan (Exhibit 50).

(21) The Petitioner's have paid unemployment compensation, workers compensation, health insurance, Social Security Administration costs of the employer and employee, professional liability insurance, and federal and sate taxes in excess of what is required of an employee. The Department of Social Services has not contributed to these costs but consistently exercises behavioral and financial control over the Petitioner's in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

PROVIDER AGREEMENT SIGNED: October 23, 2014

(20) The Petitioner's pursued status as an agency under the ABI Waiver Program. The agency completed its application and met with representatives of Allied Community Resources. The agency status was granted and NeuroStrategies, Inc. was granted the ability to hire employees (Exhibit

CREDENTIAL POLICIES DISGUISED AS AUDIT PROTOCOLS: October 31, 2015

(22) Allied Community Resources distributed guidance that all agency providers are required to credential to be considered for continued participation on the ABI Waiver Program (Exhibit 58). The credential requirements are a direct correlation to the "audit protocols" required by CMS (Exhibit 9, pp.248-251).

(23) Allied Community Resources (ACR) indicates that the process is an audit and that ACR will be conducting said audits. The audits were not adopted in accordance with Connecticut General Statutes 17b-99 and there are no provision for trainings, or 30 days notice prior to an audit being conducted or any of the additional protections found in Connecticut General Statutes 17b-99 nor any of the protections found in Public Act 14-162 (Exhibit 35; Exhibit 56)

(24) When "Credential Policies" are combined with Connecticut General Statutes 17b-260a-16 and Connecticut General Statutes 17b-260a-17, an "audit protocol" as

required by CMS has been adopted, false claims found in previous ABI Waiver applications have been covered-up, and Petitioner's are now the target of DSS without any of the protections afforded to other providers by Connecticut General Statutes 17b-99.

(25) In addition, ACR could be considered a designee of DSS and would be allowed to review "documentation" as outlined in said regulations and examine documentation requirements under the "guise" of credentialing policies. Despite Attorney Barber's assertion that the "documentation requirements" are not "audit protocols" if one assumes that the adoption of the "documentation requirements" is valid there would be no redress to a request from ACR to review documentation as afforded under Connecticut General Statutes 17b-260a-16

(26) These policies allow DSS to operate in compliance with Appendix I-1 "Financial Integrity & Accountability" while violating Connecticut State Law and causing harm to any and all providers, including the Petitioner's. That said, the Petitioner's have been harmed as the Petitioner's have submitted sensitive information including financial records, incurred additional costs, adopted new policies, generated satisfaction surveys, and obtained letters of reference amongst a host of additional requirements at substantial cost, loss of autonomy, dignity and finances.

PROVIDER AGREEMENT: October 28, 2015

(25) The Petitioner's having signed a Provider Agreement as part of the Credential package consider the Provider Agreement to be voided as well as the Provider Agreement signed October 23, 2014 due to policies initiated on December 1, 2015 (Exhibit 47).

COGNITIVE BEHAVIORAL PROGRAMS POLICY ADOPTED: December 1,2015

(26)On December 1, 2015, Department of Social Services adopted new policies under Connecticut General Statutes 17b-8,

Sec. 17b-8. (Formerly Sec. 17-2k). Commissioner's submission of application for waiver from federal law and proposed amendment to the Medicaid state plan. Legislative review. Public hearing. Procedural requirements. (a) The Commissioner of Social Services shall submit an application for a federal waiver of any assistance program requirements, except such application pertaining to routine operational issues, and any proposed amendment to the Medicaid state plan to make a change in program requirements that would have required a waiver were it not for the passage of the Patient Protection and Affordable Care Act, P.L. 111-148, and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies prior to the submission of such application or proposed amendment to the federal government. Not later than thirty days after the date of their receipt of such application or proposed amendment, the joint standing committees shall: (1) Hold a public hearing on the waiver application, or (2) in the case of a proposed amendment to the Medicaid state plan, notify the Commissioner of Social Services whether or not said joint standing committees intend to hold a public hearing. Any notice to the commissioner indicating that the

joint standing committees intend to hold a public hearing on a proposed amendment to the Medicaid state plan shall state the date on which the joint standing committees intend to hold such public hearing, which shall not be later than sixty days after the joint standing committees' receipt of the proposed amendment. At the conclusion of a public hearing held in accordance with the provisions of this section, the joint standing committees shall advise the commissioner of their approval, denial or modifications, if any, of the commissioner's waiver application or proposed amendment. If the joint standing committees advise the commissioner of their denial of the commissioner's waiver application or proposed amendment, the commissioner shall not submit the application for a federal waiver or proposed amendment to the federal government. If such committees do not concur, the committee chairpersons shall appoint a committee of conference, which shall be composed of three members from each joint standing committee. At least one member appointed from each joint standing committee shall be a member of the minority party. The report of the committee of conference shall be made to each joint standing committee, which shall vote to accept or reject the report. The report of the committee of conference may not be amended. If a joint standing committee rejects the report of the committee of conference, that joint standing committee shall notify the commissioner of the rejection and the commissioner's waiver application or proposed amendment shall be deemed approved. If the joint standing committees accept the report, the committee having cognizance of matters relating to appropriations and the budgets of state agencies shall advise the commissioner of their approval, denial or modifications, if any, of the commissioner's waiver application or proposed amendment. If the joint standing committees do not so advise the commissioner during the thirty-day period, the waiver application or proposed amendment shall be deemed approved. Any application for a federal waiver or proposed amendment submitted to the federal government by the commissioner, pursuant to this section, shall be in accordance with the approval or modifications, if any, of the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies.

(b) If in developing the budget for the department for the next fiscal year, the commissioner contemplates applying for a federal waiver or submitting a proposed amendment to the federal government, the commissioner shall notify the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and the joint standing committee of the General Assembly having cognizance of matters relating to human services of the possibility of such application or proposed amendment.

(c) Prior to submission of an application for a waiver from federal law or proposed amendment to the joint standing committees of the General Assembly under subsection (a) of this section, the Commissioner of Social Services shall publish a notice that the commissioner intends to seek such a waiver or submit a proposed amendment to the federal government in the Connecticut Law Journal, along with a summary of the provisions of the waiver application or the proposed amendment and the manner in which individuals may submit comments. The commissioner shall allow fifteen days for written comments on the waiver application or proposed amendment prior to submission of the application for a waiver or proposed amendment to the General Assembly under subsection (a) of this section and shall include all written comments with the waiver application or proposed amendment in the submission to the General Assembly.

(d) The commissioner shall include with any waiver application or proposed amendment submitted to the federal government pursuant to this section: (1) Any written comments received pursuant to subsection (c) of this section; and (2) a complete transcript of the joint standing committee proceedings held pursuant to subsection (a) of this section, including any additional

written comments submitted to the joint standing committees at such proceedings. The joint standing committees shall transmit any such materials to the commissioner for inclusion with any such waiver application or proposed amendment.

regarding the behavioral control of Cognitive Behavioral Programs providers including the Petitioner's. The policies adopted were approved by CMS and were effective December 1, 2015 (Exhibit 51).

(27)The State submitted an amendment on August 26, 2015, to modify the definition of Cognitive Behavioral services and to establish the service as being provided utilizing two procedure codes (1548P and 1448P), one for face to face in person services and one for non face-to-face activities (Exhibit 48)

(28)In an email from Kathy Bruni to the Petitioner's specific details regarding the service is provided (Exhibit 60). In addition, DSS responds to the Petitioner's and explains that the requirements are "legally-binding".

(29)The Petitioner's disagree, Department of Social Services forwarded a billing service code sheet for the ABI Waiver and the service codes for Cognitive Behavioral Programs (CBP) are now separated into 1548P and 1448P (Exhibit 60). The service code used for CBP has always been 1548P.

(30)An examination of a participants' current and operational ABI Waiver Service plan, which serves as a contract between the participant and DSS is enclosed (Exhibit 60). On page 4 of said document Cognitive Behavioral Programs is listed as a service, Petitioner's are listed as the provider and the service code is 1548P at a rate of $82.40 per hour.

(31)The Petitioner's in examining their Provider Agreements signed October 23, 2014 (Exhibit 46) and October 28, 2014 (Exhibit 47) in "Item 4"

> The agency will adhere to the units and services assigned in accordance with the ABI Waiver participant's service plan to which the agency is named as a service provider

(32)There are no units assigned to Procedure Code 1448P. However, if Petitioner's engage in activities that were once coded under 1548P but are now coded under 1448P, the Petitioner's, have submitted invoices for reimbursement with procedure Code 1448P at the behest of DSS, and by submitting said invoice the Petitioner's have violated their Provider Agreement. The Petitioner's have violated the service agreement between DSS and the participant and the Petitioner's have placed themselves "at-risk" of legal action by participants. The Petitioner's have been referred to the Office of Protection & Advocacy and it is possible that participant(s), due to actions initiated by DSS, will pursue Petitioner's legally.

(33)The Petitioner's are now required to invoice for activities identified under Procedure Code 1448P on a "quarter hour" instead of the whole hour as detailed on the participants' ABI service plan/service contract and at a rate that is not identified in the contract ($19.50 per quarter hour) and less than the previous rate for the same activities ($78.00 per hour versus $82.40 per hour) see Exhibit 64.

(34)The Petitioner's have now contributed to a violation of the contract between DSS and the participant and may be liable for damages if the participant pursues the issue legally as has been done against the Petitioner's as one participant has contacted Office of Protection and Advocacy and has informed the Petitioner's that he intends to take legal action.

(35)The Petitioner's are harmed as they are forced to submit invoices for reimbursement with Procedure Code 1448P which does not appear in the participants' service plan but has units assigned which is a direct violation of the Provider Agreement

(36)In addition, prior to adoption of the policy the Petitioner's did not need to track tasks within the service and map said services between two procedure codes. All activities were within one procedure code (1548P).

(37)After adoption of said policy on December 1, 2015 the Petitioner's must do the following at a cost of additional time and cost to the Petitioner's

1) Track activities based on face to face (FF) or non face to face (NFF)
2) Track NFF activities by the quarter hour
3) Complete documentation form (Exhibit 62) in a manner that designates a difference between NFF and FF
4) Invoice FF versus NFF on separate invoices simply to maintain order with respect to the services provided
5) The Petitioner's must now use the gross total to determine how much budget can be used when serving the client based on new rates ($105.00 and $19.50 per quarter hour) see Exhibit 59 and 64. The Petitioner's must maintain documentation according to Connecticut General Statutes 17b-260a-16 under both procedure codes (1548 and 1448) and separate documentation accordingly. This is a requirement that did not exist prior to this new requirement. In addition, the Petitioner's must submit invoices for two separate procedure codes, a requirement that did not exist prior to the adoption of the new policies (Exhibit 64). The new requirements violate the provider agreement signed on October 23, 2014 "Item 2" as the units associated with procedure code 1448P are not in the participants service plan.

(38) None of the previously listed activities were required prior to the adoption of December 1, 2015 policies. The additional documentation requirements are onerous, violate the Petitioner's autonomy with regard to their self-employed status and costs due to time required to document service provision in a NFF/FF manner.

(39) The Department of Social Services has indicated that the Petitioner's are to distribute said hours at their discretion. The Department of Social Services acknowledges that it has not revised the contracts of the participants to reflect the adoption of a new procedure code 1448, units associated with said procedure code and rates related to said procedure code (Exhibit 59). The Petitioner's are harmed as they have invoiced the state "under protest" due to the Petitioner's being forced to use procedure code 1448P for non-face-to-face services without the service and its associated units being identified in the service plan. The Petitioner's are now liable for the violation and have been reported to Office of Protection and Advocacy for said violation.

(40) The Department of Social Services has determined that Petitioner's are required to provision the monies allocated in the service plan based on the new face to face (FF) and non face-to-face rates (NFF) as long as the Petitioner's do not exceed the number of units assigned in the plan under 1548P. The participant has 8 hours of Cognitive Behavioral Programs at a total budget of $659.20 per month. If the Petitioner's provide 6 units of FF service the Petitioner's will have used all but $30.00 of the participants' budget but will have provided the participant with fewer units than allowed (8 hours). The Petitioner's could provide a phone call at $19.50 per hour but would still be approximately 1.50 hours short of the maximum units allowed thereby violating the terms of the Provider Agreement if a participant desires to meet and the Petitioner's refuse or if the participant is physically unable to effectively participate in services unless they are provided FF due to hearing and speech challenges.

(41) The Petitioner's will have violated the Provider Agreement requirement to adhere to units and services provided if the Petitioner's, as they have done, bill for service units that are not in the service plan 1448P. The Petitioner's are harmed because Department of Social Services has compelled the Petitioner's to violate the service contract and Provider Agreements (46 and 47).

(42) In addition, the Petitioner's attest that behavioral control is exercised, in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii), by Department of Social Services when DSS requires the following;

1) Requires that services are provided face-to-face
2) Requires the Petitioner's to use "Skype" for videoconferencing which is not secure and not HIPPA compliant, therefore violating the Provider Agreement and the requirement to maintain confidential information.
3) Requires a quarterly, in person meeting with the waiver participant is required for this service"
4) Must work in concert with a "case manager"

(43)The Petitioner's are now required to drive, "at least quarterly" from Windsor Locks to Wilton Connecticut with the participant who's service contract is included herein

(Exhibit 59). This requirement did not exist prior to the adoption of said policies and Petitioner's are harmed by implementation of said policies due to loss of resources, autonomy, dignity and designation of self-employment. The Petitioner's have assumed costs' (unemployment compensation insurance, workers compensation insurance, dishonesty bond, financial statement provisions, professional liability insurance, general liability insurance, social security and other costs associated with federal and state taxes as well as items required by DSS in its re-credential application) that apply to a self-employed entity and have paid said costs but by adoption of said policies designates the Petitioner's as employees of the Case Managers and said policies are a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

(44)The Petitioner's are required to use "Skype" while the Petitioner's use a telemedicine platform "Vsee" that is HIPPA compliant and encrypted which provides security that exceeds that found in a general platform such as "Skype". The Petitioner's are harmed as they are forced to place their business at-risk by using a platform (Skype) that places their business at-risk of liability if communications are intercepted and participants take legal action. The Petitioner's are required to assume increased risk. The Petitioner's have assumed costs' (unemployment compensation insurance, workers compensation insurance, dishonesty bond, financial statement provisions, professional liability insurance, general liability insurance, social security and other costs associated with federal and state taxes as well as items required by DSS in its re-credential application) that apply to a self-employed entity and have paid said costs but by adoption of said policies designates the Petitioner's as employees of the Case Managers and is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

(45)The Petitioner's are required to travel during the three months of winter at a time convenient for Petitioner's and participant who resides in Wilton Connecticut when winter meetings outside of "team meetings" were almost exclusively done through use of telephone and videoconferencing during winter months due to cold weather and precipitation. The requirement to meet "FF" did not exist prior to adoption of said policy. The Petitioner's must expend resources that were not required prior to the adoption of said policy including autonomy, dignity, time, fuel costs, "wear" on the petitioner's automobile and increased risk of injury. The Petitioner's have assumed costs' (unemployment compensation insurance, workers compensation insurance, dishonesty bond, financial statement provisions, professional liability insurance, general liability insurance, social security and other costs associated with federal and state taxes as well as items required by DSS in its re-credential application) that apply to a self-employed entity and have paid said costs but by adoption of said policies designates the Petitioner's as employees of the Case Managers. The previously mentioned requirements exercise behavioral control and are in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

(46)The Petitioner's who are "self-employed" are now required to coordinate their services with a case manager who is an employee/contractor of the State of

Connecticut and is involved in administration of the program. The requirement exercises behavioral control and is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii) which requires additional time and places the Petitioner's in an employer-employee relationship with the case manager. The Petitioner's have assumed costs' (unemployment compensation insurance, workers compensation insurance, dishonesty bond, financial statement provisions, professional liability insurance, general liability insurance, social security and other costs associated with federal and state taxes as well as items required by DSS in its re-credential application) that apply to a self-employed entity and have paid said costs but by adoption of said policies designates the Petitioner's as employees of the Case Managers and is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

(47)The dictates of a case manager are an extension of the behavioral control exercised by Department of Social Services. The Case Manager will be responsible for establishing the time, location, and frequency of team meetings, which exerts behavioral control over the Petitioner's in violation of Connecticut General Statutes 31-222(a)(1)(B)(ii) as it places the Petitioner's in a position of employee in a employer-employee relationship. The Petitioner's have assumed costs' (unemployment compensation insurance, workers compensation insurance, dishonesty bond, financial statement provisions, professional liability insurance, general liability insurance, social security and other costs associated with federal and state taxes as well as items required by DSS in its re-credential application) that apply to a self-employed entity and have paid said costs but by adoption of said policies designates the Petitioner's as employees of the Case Managers and is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

(48)In addition, Case Managers will determine how the Petitioner's provide services to the participants' despite the Petitioner's being self-employed. Any and all behavioral control exercised by an extension of Department of Social Services through its employees and/or contractors is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii). The Petitioner's have assumed costs' (unemployment compensation insurance, workers compensation insurance, dishonesty bond, financial statement provisions, professional liability insurance, general liability insurance, social security and other costs associated with federal and state taxes as well as items required by DSS in its re-credential application) that apply to a self-employed entity and have paid said costs but by adoption of said policies designates the Petitioner's as employees of the Case Managers and is a violation of Connecticut General Statutes 31-222(a)(1)(B)(ii).

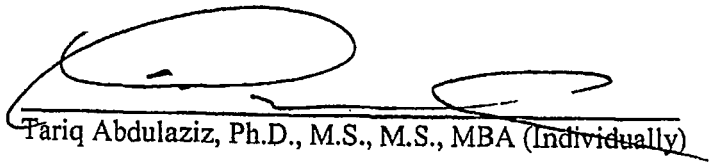
Exhibit No.	Description	Date
1	Provider Agreement between Petitioner's and Department of Social Services	01/15/2004
2	Notice of Intent: 17b-260a-1 to 17b-260a-17	03/26/2013
3	McCormick and Long et al. exchange of emails	05/30/2011
4	Stauning and Long et al. exchange of emails	08/23/2012
5	Stauning and Hyman exchange of emails	03/6/2013 & 03/7/2013
6	Stauning and Long exchange of emails	03/07/2013 03/08/2013 03/11/2013
7	Stauning document developed in response to McCormick email	08/12/2013
8	Connecticut General Statutes 17b-260a-1 to Connecticut General Statutes 17b-260a-17	04/01/2013
9	Technical Guidance Manual HCBS Waivers Centers for Medicare and Medicaid Services	01/2015
10	Dianne Kayala (CMS) and Petitioner's exchange of emails regarding federal conforming requirement	09/08/2014
11	Case and Petitioner's exchange of emails	05/06/2014
12	ABI/TBI Medicaid Waiver Provider Manual excerpt: Cognitive Behavior Programs	12/04/2007
13	Smiga to Marder email	5/20/2014
14	Lynch to Petitioner's exchange of emails: 2013 Monthly Reports Request	07/29/2014
15	Marder to Smiga email: Records Review criteria	8/06/2014
16	Smiga to Marder email: Monthly Reports and Records Review Requirements	8/22/2014
17	Brennan to Petitioner's: email sent by Lara Stauning: Threat regarding monthly reports	01/30/2015 02/14/2015
18	Abdulaziz to DSS: Freedom of Information Act (FOIA) request	09/12/2014
19	DSS to Petitioner's email confirming fulfillment FOIA Request: All communications with CMS and HHS with DSS shown in attachment	12/02/2014
20	FOIA documents emailed from DSS to Petitioner's: All communications with CMS and HHS (Physical Documents)	12/02/2014

Exhibit No.	Description	Date
21	Emails from DSS social workers to Petitioner's	02/05/2015 05/21/2015
22	Email from DSS (Erazo-Martinez) to Petitioner's	11/21/2014
23	Petitioner's FOIA request	06/22/2014
24	DSS email confirming fulfillment of FOIA request	09/03/2014
25	Record Review becomes Audit: Kennedy Center	04/30/2013
26	Records Review becomes an Audit: Ability Beyond Disability	03/26/2013
27	Records Review becomes an Audit: Goodwill Industries of Western Connecticut	03/26/2013
28	Records Review becomes and Audit: Independent Living Solutions	03/26/2013
29	Records Review becomes and Audit: Project Genesis, Inc	03/26/2013
30	Records Review becomes an Audit: Recovery Resources	03/26/2013
31	NeuroStrategies et al., v. Department of Social Services: Administrative Record Transcribed by Department of Social Services	07/31/2015
32	Connecticut General Statutes 31-222(a)(1)(B)(ii)	Current
33	Connecticut General Statutes 4-168: Prior to July 1, 2013	Prior to July 1, 2013
34	Connecticut General Statutes 17b-10: Prior to July 1, 2013	Prior to July 1, 2013
35	Connecticut General Statutes 17b-99	Current
36	NeuroStrategies et al., v. Department of Social Services: Transcribed Record	12/3/2015
37	Tobin, Carberry, O'Malley, Riley, Selinger, P.C. Attorneys at Law: Communication to Petitioner	4/24/2014
38	Weber v. McCormick United States District Court District of Connecticut	11/19/2007
39	James Wietrak Profile Krista Strazza-Profile Tobin, Carberry, O'Malley, Riley, Selinger, P.C. Attorneys at Law communication to Petitioner's	11/28/2015
40	DSS ABI/TBI Medicaid Waiver Billing Invoice (required)	Current
41	Connecticut General Statutes 17b-10 (prior to July 1, 2013)	Modified July 1, 2013
42	1099 (2014) and 1099 (2013): NeuroStrategies, Inc.	2014 & 2013
43	Connecticut Medicaid Enrollment Agreement	Current

44	Modifications to Quality Measures and Reporting in HCBS (1915) Waivers (Centers for Medicare & Medicaid Services)	03/2014
45	DSS Monthly Report Form (required)	Current
46	Provider Agreement: October 23, 2014 • Email ABI credentialing • Quarterly Active Employee List	10/23/2014-current
47	Provider Agreement: October 28, 2015 and Credentialing Paperwork submitted October 31, 2015	Upon review
48	DSS adopts new "units" or billing requirements for Cognitive Behavior Program providers	12/01/2015
49	Billing Rate Sheet separates Cognitive Behavior Programs into two rates	12/01/2015
50	Participant Service Plan with Release of Information included	03/26/15-03/26/16
51	ABI Waiver Application 2006 (Excerpts)	2006-2011
52	ABI Waiver Application October 2012 (Excerpt)	2012-2015
53	DSS answers Financial Integrity and Accountability question in ABI Waiver: "Extracted"	2012
54	DSS answers Financial Integrity and Accountability question in ABI Waiver: "Screen Shots"	2012
55	DSS Map: ABI WAIVER providers are excluded from enrollment in Medicaid	12/09/15
56	Public Act No. 14-162: An Act concerning Provider Audits under Medicaid Program	10/01/2014
57	Notice of Intent to adopt regulations "Audit Protocols"	10/16/2012
58	Audit Protocols initiated without adoption of regulations (1) Letter (2) Application (3) Petitioner's submission (4) email communication w/Shanna Martinez Re: Agency	10/31/2015
59	December 1, 2015 Policies: Cognitive Behavior Programs (1) Approval from CMS (2) Information forwarded to Petitioner's (3) Service Plan of Participant	12/01/15
60	NeuroStrategies 2014 Agency Application and Approval	10/30/2014
61	Connecticut General Statutes 4-168 after July 1, 2013	After 07/01/2013
62	Forms Developed to comply with Connecticut General Statutes 17b-260a-16(a)(1); Connecticut General Statutes 17b-260a-16(a)(4);	10/01/2013 and ongoing

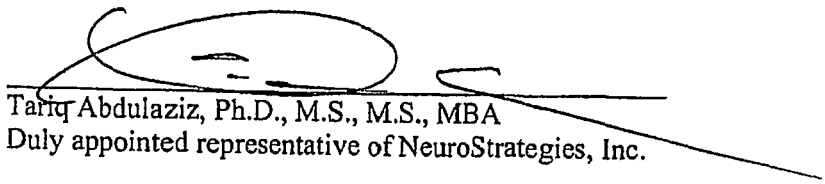
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	Connecticut General Statutes 17b-260a-16(a)(5); and Connecticut General Statutes 17b-260a-16(a)(6) and emails sent to DSS social workers with monthly reports attached Connecticut General Statutes 17b-260a-16(d) • Documentation form • Signature page based on 17b-260a-16 • Emails of monthly reports from Petitioner's to Social Workers • Invoice billed at quarterly hours and a rate $19.50 that is not in the service plan	
63	Department of Social Services fails to obtain approval for modification of Connecticut General Statutes 17b-99 and withdraws its application to Licensing Regulation and Review Committee	08/24/2014
64	Documentation compliance required by Petitioner's due to adoption of Connecticut General Statutes 17b-260a-16 1) 1548P documentation form 2) 1448P documentation form 3) 1548P invoice 4) 1448P invoice ACR refusal to pay invoices billed at $83.22 Invoice billed at $19.50(4) = $78.00 that does not appear in the service plan	Effective 12/01/15
65	Provider Agreement: Supported Living Group, LLC	03/08/06
65A	HMS to SLG: 30 days notice to comply	07/10/12
65B	HMS to SLG: documentation requirements	08/30/12
65C	Adjustments: HMS to SLG	12/10/12
65D	Shea shares McCormick email w/SLG LLC	08/16/13
65E	Congratulations: Shea to Bremby	10/25/13
65F	Shea instructs SLG LLC to pay $40,000.00	11/05/13
65G	Extrapolation used and SLG LLC negotiates settlement w/McCormick	11/18/13
65H	Confirmation: Terms of payment	08/28/14
66	False Claims reported to DSS, CMS, and OIG (1) 2006 ABI Renewal application (2) 2012 ABI Renewal application (3) 2015 ABI Renewal application (4) ABI Waiver II application (5) 2016 ABI Waiver I renewal	12/31/2015



Tariq Abdulaziz, Ph.D., M.S., M.S., MBA (~~Individually~~)

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Duly appointed representative of NeuroStrategies, Inc.

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A TRUE COPY
ATTEST:

ELIZABETH J. OSTROWSKI
CONNECTICUT STATE MARSHAL
HARTFORD COUNTY

EXHIBIT 1

283

ABI WAIVER PROVIDER REGISTRY APPLICATION

The ABI Waiver Program provides 21 home and community-based services to eligible individuals with an acquired brain injury. Providers must be enrolled in the Department's ABI Provider Registry in order to receive payment. In order to be included in the Registry, providers must meet the Department's specific qualifications for each service. This is an application to be included in the ABI Provider Registry. Instructions for completion of this application are on the attached page. Please refer to the Department's ABI Provider Manual for a description of provider qualifications, as well as services, rates, billing and general program information.
ALL PAPERWORK MUST BE SUBMITTED PRIOR TO ATTENDING THE TRAINING.

A. *PROVIDER INFORMATION*

1. AGENCY: ☑ OR INDIVIDUAL: ☐
2. PROVIDER NAME Neuro Strategies, Inc.
2a. CONTACT (if agency provider) TARIQ ABDULAZIZ
3. ADDRESS 75 Hockanum Blvd Unit 2117
(NO.) (STREET)
Vernon (CITY) CT. (ZIP) 06066
4. MAILING ADDRESS (IF DIFFERENT) (Same)
5. TELEPHONE: (860) 377-0641 6. FAX: 860 870-5738 7. Email: neurostrategies@earthlink.net
8. ~~SSN~~ (if individual): _____ OR FEIN (if agency): 02-0712098
9. SERVICE AREA (see instructions) Statewide ☑ OR NorthCentral ☐ SouthCentral ☐ NorthWest ☐ SouthWest ☐ Eastern ☐
10. PLEASE DO NOT INCLUDE MY NAME ON THE REGISTRY DISTRIBUTED TO THE DSS OFFICES: ☐

B. *PROVIDER SPECIALTY and QUALIFICATIONS (check all that apply)*

Column 1 CHECK (✓) SERVICE TYPE	Column 2 A.B.I. WAIVER SERVICES	Column 3 PROVIDER TYPE	Column 4 BRIEFLY DESCRIBE THE PROVIDER QUALIFICATION DOCUMENTATION YOU ARE SUBMITTING
	Case Management		
	Chore Services		
✓	Cognitive Behavioral Programs		
	Community Living Support Services		
	Companion Services		
	Environmental Accessibility Adaptations		
	Home-Delivered Meals		
	Homemaker Services		
✓	Independent Living Skills Training & Devel.		
	Personal Care Assistance		
	Personal Emergency Response Systems		
	Pre-Vocational Services		
	Respite Services		
	Specialized Medical Equipment and Supplies		
	Substance Abuse Programs		
	Supported Employment		
	Transitional Living Services		
	Transportation		
	Vehicle Modification Services		

PROVIDER AGREEMENT

1. ALL OF THE STATEMENTS MADE BY ME ON THIS APPLICATION AND ALL INFORMATION CONTAINED IN MY SUPPORTING PROVIDER QUALIFICATION DOCUMENTATION IS TRUE AND CORRECT.

2. I ACKNOWLEDGE THAT I CAN PERFORM ALL STANDARDS AND DUTIES FOR THE SERVICES I AM APPLYING FOR, AS STATED IN THE PROVIDER MANUAL.

3. I WILL IMMEDIATELY NOTIFY THE DEPARTMENT IF ANY INFORMATION PROVIDED BY ME ON THIS APPLICATION CHANGES.

4. I WILL MAINTAIN CURRENT STANDING WITH RESPECT TO ANY LICENSE AND/OR CERTIFICATION REQUIREMENTS ESTABLISHED BY THE DEPARTMENT FOR MY ABI PROVIDER TYPE AND SERVICE SPECIALTY.

5. I WILL IMMEDIATELY NOTIFY THE DEPARTMENT IF SUCH LICENSES AND/OR CERTIFICATIONS EXPIRE, ARE REVOKED, SUSPENDED OR OTHERWISE TERMINATED FOR ANY REASON.

6. I WILL PROVIDE ALL SERVICES IN ACCORDANCE WITH THE TERMS OF THE ABI WAIVER PARTICIPANT'S APPROVED SERVICE PLAN.

7. THE RATE PAID BY THE DEPARTMENT FOR THE PERFORMANCE OF ABI WAIVER SERVICES IS THE COMPLETE PAYMENT IN FULL FOR ALL SERVICE(S), GOODS OR PRODUCTS DELIVERED TO ELIGIBLE ABI WAIVER PARTICIPANTS.

8. EXCEPT FOR AUTHORIZED CO-PAYMENTS MADE BY ELIGIBLE WAIVER PARTICIPANTS, THE DEPARTMENT'S PAYMENTS TO ME FOR THE PERFORMANCE OF ABI SERVICES CONSTITUTE SOLE AND COMPLETE PAYMENT IN FULL.

9. I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES AND GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST.

10. I ACKNOWLEDGE THAT I MAY BE SUSPENDED OR TERMINATED FROM THE ABI PROVIDER REGISTRY IF I AM FOUND BY THE DEPARTMENT TO HAVE ENGAGED IN FRAUDULENT OR ABUSIVE PROGRAM SERVICES.

11. I AGREE TO NOT USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) OTHER THAN AS PERMITTED OR AS REQUIRED BY LAW AND TO USE APPROPRIATE SAFEGUARDS TO PREVENT IMPROPER USE OR DISCLOSURE OF PHI.

12. I AM OVER 18 YEARS OF AGE.

TARIQ M. ABDULAZIZ
PROVIDER NAME (please print individual or agency name)

AUTHORIZED SIGNATURE (individual or agency rep.) 01/15/04 DATE

ALL PAPERWORK MUST BE SUBMITTED PRIOR TO ATTENDING THE TRAINING

285

EXHIBIT 2

ADMINISTRATIVE REGULATIONS

Regulations and notices published herein, pursuant to General Statutes Sections 4-168 and 4-173, are printed exactly as submitted by the forwarding agencies. These, being official documents submitted by the responsible agencies, are consequently not subject to editing by the Commission on Official Legal Publications.

A cumulative list of effective amendments to the Regulations of Connecticut State Agencies may be found in the Connecticut Law Journal dated March 5, 2013.

DEPARTMENT OF SOCIAL SERVICES

Notice of Intent to Adopt Regulations

In accordance with the provisions of subsection (a) of section 4-168 of the Connecticut General Statutes, notice is hereby given that the Commissioner of Social Services, under section 17b-260b of the Connecticut General Statutes, proposes to establish in regulation, the policies for the administration of the Acquired Brain Injury (ABI) waiver program. The Department, in accordance with 17b-10 of the Connecticut General Statutes, will implement and operate under the proposed regulation effective April 1, 2013.

Statement of purpose: (A) The purpose of the regulation is to set forth in regulation the policies regarding the administration of the ABI waiver program. The ABI waiver program is currently administered through policy set forth in the waiver application. The effect of the proposed regulation would be to formally establish the policies of the ABI waiver program in regulation format. (B) The main provisions of the regulation include: (1) A description of the purpose and scope of the ABI waiver program; (2) definitions of necessary terms; (3) eligibility requirements and determination of need; (4) a description of the home and community-based services available under the ABI Waiver program; (5) assessment and development of a cost-effective service plan; (6) the responsibilities of the individual, the Department and ABI waiver providers; and (7) provider participation requirements and procedures.

(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 set forth the policies for administration of the ABI waiver program.

A copy of the complete text of this regulation is available, at no cost, upon request from the Office of Legal Counsel, Regulations and Administrative Hearings, Department of Social Services, 25 Sigourney Street, Hartford, Connecticut 06106; email: lara.stauning@ct.gov.

All written comments, questions, and concerns regarding this regulation may be submitted within 30 days of the publication of this notice to the Department of Social Services, Office of Legal Counsel, Regulations & Administrative Hearings, 25 Sigourney Street, Hartford, Connecticut, 06106. Attention: Brenda Parrella, Director. A hearing will be scheduled on the proposed regulation if requested by fifteen persons, by a governmental subdivision of an agency or by an association having

EXHIBIT 5

[redacted]

Stauning, Lara

From: Hyman, Phyllis E.
Sent: Thursday, March 07, 2013 2:19 PM
To: Stauning, Lara
Subject: RE: ABI Waiver Regulation

The statute says we must adopt as a regulation any new policy necessary to conform to a requirement of an approved federal waiver application. To me, this means that we need to write regulations to implement the waiver program, and that we can operate under the policy while it's in the process of becoming a regulation, as provided. In other words, if the waiver requires us to provide certain benefits and have certain eligibility requirements, we need to write a regulation that conforms to this requirement, and we may do so and implement prior to its full promulgation.

Are you reading this to say that there must be a requirement in the federal waiver application to write regulations? I don't read it that way.

Let me know if you want to discuss this.

Thanks.

-Phyllis

Hyman, Phyllis E.
Phyllis.Hyman@ct.gov

DSS
25 Sigourney St.
Hartford, CT 06106
860-424-5266 Direct

www.ct.gov/dss

CONFIDENTIAL INFORMATION: The information contained in this e-mail may be confidential and protected from general disclosure. If the recipient or reader of this e-mail is not the intended recipient or a person responsible to receive this e-mail for the intended recipient, please do not disseminate, distribute or copy it. If you received this e-mail in error, please notify the sender by replying to this message and delete this e-mail immediately. We will take immediate and appropriate action to see to it that this mistake is corrected.[*LD*]

From: Stauning, Lara
Sent: Wednesday, March 06, 2013 2:08 PM
To: Hyman, Phyllis E.
Subject: ABI Waiver Regulation

Hi Phyllis,

I am drafting up the NOI for the ABI regulation and I wanted to include the statutory authority for operating the regulation while in the process of adopting and provide an effective date. So far, I haven't been able to figure out the basis for treating the ABI waiver regulation as a 17b-10 regulation so I am not sure that we have the statutory authority to do so. For some reason I thought we had come up with an argument to support treating the regulation as a 17b-10, but there is no supporting language in the ABI waiver statute and I don't think it is covered by 17b-10 although waivers are mentioned in 17b-10(b).

The ABI waiver statute really provides no help:

68

"The Commissioner of Social Services shall seek a waiver from federal law to establish a Medicaid-financed, home and community-based program for individuals with acquired brain injury. Such waiver shall be submitted no later than October 1, 1995."

17b-10(b) provides,

> The department shall adopt as a regulation in accordance with the provisions of chapter 54, any new policy necessary to conform *to a requirement of an approved federal waiver application initiated in accordance with section 17b-8* and any new policy necessary to conform to a requirement of a federal or joint state and federal program administered by the department, including, but not limited to, the state supplement program to the Supplemental Security Income Program, but the department may operate under such policy while it is in the process of adopting the policy as a regulation, provided the Department of Social Services prints notice of intent to adopt the regulation in the Connecticut Law Journal within twenty days after adopting the policy. Such policy shall be valid until the time final regulations are effective.

Although the ABI waiver is a waiver initiated under 17b-8, neither the waiver application nor the federal statute (Sec.1915(c)) requires that the state adopt regulations. Maybe I am reading it too literally, but I don't think we have the authority to begin operating when the NOI is published as we had initially hoped. Please let me know what you think, maybe I am missing something?

Thanks! Lara

Lara K. Stauning, Staff Attorney
Department of Social Services
Office of Legal Counsel, Regulations and Administrative Hearings
25 Sigourney Street, 12th floor
Hartford, CT 06106
Lara.Stauning@ct.gov

Phone: 860-424-4837
Fax: 860-424-5403

EXHIBIT 8

R-39 REV. 04/04
IMPORTANT: Read instructions on bottom of 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

Subject Matter of Regulation

Acquired Brain Injury Waiver Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

An individual shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

aggression toward others;

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

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

(A) The individual's:

(i) Mental capacity;

(ii) behaviors;

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

(iv) illegal or criminal activity;

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

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

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

(i) Illegal or criminal activity;

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

(iii) poor sanitation; or

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

(C) provider issues, such as:

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

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

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

(i) Illegal or criminal activity;

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

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

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

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

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

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

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

(a) General Principles

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Chore services shall not be covered if:

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

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

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

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

(A) A comprehensive assessment of cognition and behaviors;

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

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

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

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

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

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

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

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

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

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

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

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

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

independence.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) **Independent Living Skills Training**

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

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

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

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

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

(12) **Personal Care Assistance**

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

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

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

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

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

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

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

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

(14) **Respite Care**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(18) **Transportation Services**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

department, minus the average applied income;

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

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

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

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

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

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

(b) Individual and Aggregate Caps

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

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

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

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

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

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

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

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

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

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

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

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

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

The department shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) General Provider Responsibilities

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

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

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

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

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

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

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

(b) Agency Providers

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

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

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

(A) Person-centered provision of services;

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

(C) neglect, abuse and harassment of participants;

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

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

(F) critical incident reporting requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) For purposes of this section

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

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

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

(1) Billing for services not rendered;

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

(3) billing for services not medically necessary;

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

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

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

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

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

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

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

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

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

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

(2) provider's name and signature,

(3) dates of service;

(4) start time for each visit;

(5) end time for each visit; and

(6) a brief description of duties performed.

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

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

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

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

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

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

Roderick L. Bremby
Commissioner

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

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Declaratory Ruling

Re: Request for Declaratory Ruling of Tariq Abdulaziz, Individually, and as "Duly Appointed Representative" of NeuroStrategies, Inc.

The Department of Social Services (the "Department") issues this declaratory ruling pursuant to the authority granted to administrative agencies in section 4-176 of the Connecticut General Statutes and sections 17-311-44 to 17-311-46, inclusive, of the Regulations of Connecticut State Agencies

Procedural History

On December 28, 2015, Tariq Abdulaziz, individually, and as "duly appointed representative" of NeuroStrategies, Inc., (the "Petitioners") filed a Request for Declaratory Ruling (the "Request") with the Department

On January 6, 2016 and January 31, 2016, the Petitioners forwarded a total of twelve emails to an attorney in the Department's Office of Legal Counsel, Regulations and Administrative Hearings, stating that the emails were to be included in the record related to the Request, and that "any future emails" sent to that Department attorney "must be included as well."[1]

On February 23, 2016, the Department agreed to issue a declaratory ruling by June 25, 2016 in accordance with sections 4-176(e)(3) and 4-176(i) of the Connecticut General Statutes

[1] The Department does not concede that any of the emails sent to the Department's attorney, or any "future emails," are part of the record

Ruling

The Request contains one hundred and six (106) numbered questions, and at least ninety-nine (99) unnumbered sub-parts, for a total of at least two hundred and five (205) questions. These questions consist of more than fifty-nine (59) single-spaced pages. The Request also contains one hundred and thirty-four (134) pages of separate sections entitled "Facts," "Petitioners Response to Questions," and "Argument." Finally, the Request incorporates sixty-six (66) exhibits.

Many of the questions posed in the Request are argumentative, cumulative, compound, ambiguous, repetitive or opinion, or contain misstatements of fact and law. In addition, many of the questions do not properly constitute a petition for a declaratory ruling "as to the validity of any regulation, or the applicability to specified circumstances of a provision of the general statutes, a regulation, or a final decision on a matter within the jurisdiction of the agency," as required by Conn Gen. Stat. § 4-176(a). Many of the questions are actually allegations.[2] Moreover, many of the questions posed in this Request seek to re-argue issues that the Department conclusively decided in a previous declaratory ruling with respect to the Petitioners dated May 28, 2015. Accordingly, the Department declines to respond individually to each of the two hundred and five (205) questions and sub-questions. Instead, in an effort to address the petitioners' broader concerns, the Department has organized its ruling based on subject matter areas that are raised throughout the Request. Finally, in providing these responses, the Department does not waive any objection to any individual question or sub-question, including, but not limited to, whether such question has already been conclusively determined by the

[2] Some of these allegations are specifically denied herein To the extent that other allegations are not specifically addressed, the Department does not concede their validity.

Department, or whether such question properly constitutes a petition for a declaratory ruling under Conn. Gen. Stat. § 4-176(a).

I. Whether the April 1, 2013 ABI Waiver Operating Policy Was Properly Adopted Under Conn. Gen. Stat. § 17b-10(b) (Questions 1-11, 39-49, 67)

In questions 1-11 and 39-49 of the Request, the Petitioners assert that sections 17b-260a-1 through 17b-260a-17 of the Regulations of Connecticut State Agencies, (the "2013 ABI Waiver Operating Policy"), were not properly adopted by the Department. In particular, through these questions, the Petitioners allege that the 2013 ABI Waiver Operating Policy was not properly adopted for the following reasons: the Department did not comply with the public notice requirements contained in Conn. Gen. Stat. §§ 4-168(a) and 17b-10(b); there was a typographical error in the Notice of Intent that was published in the Connecticut Law Journal; the Department did not submit the proposed regulations to the Legislative Regulation Review Committee ("LRRC") within one hundred and eighty (180) days, and there was no new policy necessary to conform to a requirement of an approved federal waiver, as required for the Department to begin operating under the proposed regulations as an operating policy under Conn. Gen. Stat. § 17b-10(b).

The issues addressed in these questions are nearly identical to those raised in the Petitioners' December 9, 2014 Petition for Declaratory Ruling, and which were addressed and conclusively determined in favor of the Department in its May 28, 2015 Declaratory Ruling. See Exhibit A. As the Department concluded in its May 28, 2015 Declaratory Ruling, "the [2013] ABI Waiver Regulations were promulgated as new policies necessary to conform to the requirements of that waiver," and "have been properly noticed and are in effect while the Department is in the process of final adoption." Exhibit A at 5. As these issues were thoroughly

addressed in the May 28, 2015 Declaratory Ruling, the Department will not readdress these issues here.

II. Whether Section 17b-260a-16 of the 2013 ABI Waiver Operating Policy Violates or Terminates Provider Agreements Signed by the Petitioners, and Whether the Petitioners Must Abide by Section 17b-260a-16 the ABI Waiver Operating Policy (Questions 12-30, 69, 70, 92, 101, 104)

In Questions 12-30 of the Request, the Petitioners ask whether the Department's implementation of section 17b-260a-16 of the 2013 ABI Waiver Operating Policy, which includes more specific documentation requirements than are contained in Provider Agreements signed by the Petitioners, constitutes a violation of the Provider Agreements and thereby terminates such Provider Agreements. In addition, the Petitioners question whether they must abide by the documentation provisions contained in section 17b-260a-16 of the 2013 ABI Waiver Operating Policy.

By way of background, the Petitioners are required to sign Provider Agreements with the Department in order to become participating providers in the Department's ABI Waiver Program and receive payments for providing covered services. At the time of filing the Request, the Petitioners had signed at least three different versions of the Provider Agreements over a period of years, both before and after the implementation of section 17b-260a-16, each of which contained virtually identical language with respect to documentation requirements. Pursuant to such Provider Agreements, the Petitioners agreed to "maintain records that fully disclose services and goods rendered and/or delivered to ABI Waiver participants. These records will be made available to authorized representatives of the Department upon request." Exhibits B, C, D.

Section 17b-260a-16 of the 2013 ABI Waiver Operating Policy contains the following documentation and reporting requirements.

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

(1) Individual's name and the signature of the individual or their legal representative;
(2) provider's name and signature;
(3) dates of service;
(4) start time for each visit;
(5) end time for each visit; and
(6) a brief description of duties performed.

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

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

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

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

First, the Department denies that it has violated or voided the Petitioners' Provider Agreements, and denies that the Provider Agreements are legally binding contracts with the Department, as they lack key terms necessary to form a legally binding contract, most notably a price term. In addition, the Department denies that the documentation responsibilities contained in section 17b-260a-16 are more onerous than they were under the Provider Agreements. Rather, they are more specific. As addressed in section I, *supra*, the ABI Waiver Operating Policy was properly adopted in accordance with Conn. Gen. Stat. § 17b-10(b), and all ABI Waiver providers, including the Petitioners, are subject to these provisions. There is no language in the Provider Agreements cited by the Petitioners that would invalidate such agreements upon the adoption of regulations or operating policies. Similarly, there is nothing in the Provider

Agreements to indicate that providers are exempt from applicable state and federal laws governing Medicaid programs, including home and community-based waivers. Accordingly, the Petitioners are subject to the requirements contained in any applicable Provider Agreements, as well as applicable state and federal law, including all applicable sections of the ABI Waiver Operating Policy.

The Petitioners appear to take particular exception to the documentary requirements contained in section 17b-260a-16(a)(1), which require the signature of the individual or their legal representative in order to document services submitted by the provider for Medicaid reimbursement. While the petitioners have argued that, in certain instances, such signature may be difficult to obtain at each visit in the context of providing cognitive behavioral services, the Department notes that, by July 1, 2016, this issue will be moot. On July 1, 2016, the Department's newest ABI Waiver Operating Policy (the "2016 ABI Waiver Operating Policy") will become effective under Conn. Gen. Stat. § 17b-10(b), and supersede the 2013 ABI Waiver Operating Policy.[3] In section 17b-260a-17(a)(7) of the 2016 ABI Waiver Operating Policy, the Department has amended the language in section 17b-260a-16(a) of the 2013 ABI Waiver Operating Policy to include a caveat that signatures are required "[u]nless otherwise described in the provider's applicable Medicaid Provider Enrollment Agreement and any addenda thereto." The Petitioners signed a new Medicaid Provider Enrollment Agreement, which contains an ABI Waiver-specific addendum.[4] Such addendum specifically states that providers such as the Petitioners need only obtain the appropriate signatures once, and maintain that signature on file. See Exhibit E, Addendum ¶ 24a. Accordingly, pursuant to the newest provider agreement and

[3] The proposed regulations and notice of intent to operate under them as an Operational Policy pursuant to Conn Gen. Stat § 17b-10(b) were posted on the eRegulations System on June 14, 2016.
[4] The Petitioners have indicated in correspondence to the Department dated June 15, 2016 that their signatures on such documents have been given "under protest" and "under duress "

the 2016 ABI Waiver Operating Policy, the Petitioners will no longer be obligated to obtain signatures in order to document each billed service.

III. Whether the Provider Documentation Requirements Contained in section 17b-260a-16 Result in a Reclassification of the Petitioners into Employees of the State of Connecticut (Questions 31-38, 68, 71-72, 77)

In Questions 31-38 of the Request, the Petitioners query whether they have become employees of the State of Connecticut by virtue of the adoption of certain provisions of section 17b-260a-16 of the 2013 ABI Waiver Operating Policy. In particular, the Petitioners allege that, because the Operating Policy requires providers to obtain signatures, record the start and end time of each visit, and provide a brief description of the duties performed, the Department is "exercising behavioral control" over the Petitioners, and has "reclassified" the Petitioners from self-employed entities into employees of the Department and the State of Connecticut.

The Department's insistence that participating providers in the ABI Waiver program maintain documentation, including the start and end time of each visit, sufficient to support their claims for reimbursement from the state and federal government does not convert providers into employees of the state. The Department's Operating Policy defines the conditions of participation in the ABI waiver program, and does not in any way meet the requirements for the creation of an employment relationship. Similarly, the Department's December 1, 2015 amendments to its ABI and ABI II waivers with the Centers for Medicare & Medicaid Services ("CMS"), which set out different reimbursement rates for cognitive behavioral service providers depending on whether or not the services had been provided in-person, and which stated that cognitive behavioral services providers must meet with their clients in-person at least once every three months in order to be reimbursed by the Department, do not convert such providers into employees of the Department.

The Petitioners' are self-employed providers who, as part of their business model, have chosen to participate in the state's Medicaid program. The Petitioners' practice need not be limited to Medicaid recipients. The Department has thousands of participating providers. None of them are considered state employees by virtue of choosing to participate in the Medicaid program, and agreeing to follow the rules and regulations required for participation and reimbursement for services rendered to individuals enrolled in the Department's Medicaid programs. To the extent that the Petitioners may seek additional information or clarification regarding such issues, including the definition of an employee under Connecticut unemployment compensation laws, particularly Conn. Gen. Stat. § 31-222(a)(1)(B), they may direct such questions to the Department of Labor. In addition, to the extent the Petitioners may seek additional information regarding qualifying for the rights afforded to state employees, they may refer to Chapter 67 of the Connecticut General Statutes, and direct questions to the Department of Administrative Services.

IV. Issues Related to Auditing of Providers and Conducting Records Reviews of Providers, Including the Petitioners (Questions 50-67, 76, 78-91, 95-100, 102, 103, 105, 106)

A. Regulations Applicable to Provider Audits Conducted Pursuant to Conn. Gen. Stat. § 17b-99

The Petitioners contest the Department's ability to conduct audits under Conn. Gen. Stat. § 17b-99[5] Conn. Gen. Stat. § 17b-99 contains the requirements for audits performed by the Department with respect to service providers in programs operated or administered by the Department. Prior to July 1, 2015, Conn. Gen Stat. § 17b-99(d)(11) stated that the Department "shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the

[5] The Petitioners also make several queries with respect to the Department's ability to negotiate, and reach a settlement, with providers facing financial findings under Conn Gen Stat. § 17b-99 There is no language in Conn Gen Stat § 17b-99 that would prohibit the Department from reaching such a negotiated compromise.

provisions of this subsection and to ensure the fairness of the audit process, including, but not limited to, the sampling methodologies associated with the process." Consistent with these obligations, the Department presented proposed audit regulations to the LRRC. Despite the Legislative Commissioner's Office's recommendation that such regulations be approved, the LRRC rejected the proposed regulations without prejudice. However, as of July 1, 2015, nearly six months before the Petitioners filed their Request, the legislature repealed the requirement that the Department adopt regulations with respect to the Conn. Gen. Stat. § 17b-99 audit process P.A. 15-5, 2015 June Sp. Sess., § 400. Accordingly, the Department is not required to promulgate audit regulations, and providers, including the Petitioners, may not rely on the absence of audit regulations to contest the Department's ability to conduct provider audits performed in accordance with Conn. Gen. Stat. § 17b-99.

The Petitioners also query whether the provider documentation requirements of section 16 of the ABI Waiver Operating Policy may be used by the Department in the context of a provider audit under Conn. Gen. Stat. § 17b-99. As addressed in Section I, *supra*, the ABI Waiver Operating Policy was properly adopted under Conn. Gen. Stat. § 17b-10(b), and thus it has the force of law. Accordingly, the Department may rely on the ABI Waiver Operating Policy with respect to provider audits conducted under Conn Gen. Stat. § 17b-99. However, as discussed in subsection D, *infra*, the Department has never conducted such an audit of the Petitioners.

B. Alleged Falsification of ABI Waiver Applications to CMS

The Petitioners assert that the Department has, since 2006, "falsified" its ABI Waiver applications and renewal applications to CMS with respect to its methods of ensuring the integrity of payments that have been made for waiver services, and by doing so has "committed

Medicaid Fraud."[6] As the basis for these accusations, the Petitioners state, erroneously, that the Department attested in each application or renewal application that "'audit protocols' exist and are in effect for the ABI Waiver, despite [the Department's] repeated failures to adopt 'audit protocols' by Connecticut General Statutes 17b-99." As best as the Department can decipher, the Petitioners are alleging that, because the Department has never adopted audit regulations, presumably under the pre-July 1, 2015 version of Conn. Gen. Stat. § 17b-99(d)(11), the Department cannot audit Medicaid providers, and was prohibited from referencing the existence of, or describing any facets of the auditing program to CMS. Alternatively, the Petitioners may also be arguing that, due to the absence of audit regulations, the Department was prohibited from indicating to CMS that "audit protocols" exist. Even if such a conclusion was correct, which the Department in no way concedes, the Department has never stated in any application or renewal application that "audit protocols" or "audit regulations" exist. The arguments put forth by the Petitioners with respect to alleged Medicaid fraud and falsification of waiver applications are completely without merit.

The Department operates its audit program under § 17b-99 in accordance with various federal regulations requiring the Department to ensure the financial integrity of payments made under the Medicaid program, including the ABI Waiver. See, e.g., Section 1915(c)(2)(A) of the Social Security Act, 42 U.S.C. § 1396n(c)(2)(A); 42 C.F.R. § 441.302(b). In its applications and renewal applications filed with CMS with respect to the ABI I and ABI II Waivers, the Department is required to complete Appendix I-1: Financial Integrity and Accountability. Appendix I-1 requires the Department to "[d]escribe the methods that are employed to ensure the integrity of payments that have been made for waiver services " See also, 42 C.F.R. §

[6] As with all issues addressed in this Declaratory Ruling, the Department reserves its right to contest that this is a subject properly addressed in a request for a declaratory ruling under Conn Gen Stat § 4-176(a)

441.303(b). As demonstrated in Exhibits 51-54 of the Petitioners' Request, the Department answered as follows:

> The DSS Office of Quality Assurance (QA) conducts financial audits of Medicaid providers and issues exceptions when appropriate for issues of non-compliance with the State's policy requirements. The Office of Quality Assurance activities extend to all DSS programs, and office staff persons are located in the central and regional DSS offices. Functions are grouped into three major areas of focus—audits, quality control, and fraud and recoveries.
>
> All waiver providers are subject to audits performed by the QA. Overall audit demands and audit resources available to DSS QA impact the frequency of audit of waiver providers. These audits include ad hoc reviews when [the Department's fiscal intermediary] or DSS Social Work Services staff alert QA to potential issues.
>
> (ABI I Renewal Application, October 6, 2006, Petitioners' Exhibit 51)

In more recent versions, the Department has added the following additional paragraph:

> Audits of payments to providers are most commonly performed on a universe of claim payments within a two year period. A random sample of 100 claims is chosen. The auditor reviews supporting documentation maintained by the provider and claim information maintained by the department. The purpose of the review is to determine if services and associated payments were made in accordance with applicable state regulations. Errors identified in the sample are extrapolated to the universe of paid claims to arrive at a financial audit adjustment.
>
> (ABI I Renewal Application, October, 2012, Petitioners' Exhibit 54)

Simply put, there is nothing in the Department's waiver applications or renewal applications that in any way indicates that the Department has adopted audit regulations. The Department correctly stated that its Office of Quality Assurance performs audits. The responses tendered by the Department are completely accurate, and in no way deceptive, false, or misleading as indicated by the Petitioners. Moreover, the adoption, or lack thereof, of audit regulations or protocols under Conn. Gen. Stat. § 17b-99 has no bearing on whether the Department may conduct provider audits. As stated above, the allegations put forth by the

Petitioners that the Department has committed Medicaid fraud by falsifying its ABI Waiver applications and renewal applications are entirely without merit.

C. The Department's June 16, 2014 Review of Petitioners' Records

The Petitioners question the Department's authority to engage in an alleged "audit" of the Petitioners on June 16, 2014, and the relevant provider documentation requirements that would pertain to such an "audit." As has been previously explained in multiple letters to the Petitioners' legal counsel, the Department exercised its authority to review the Providers' records under both (1) its 2004 Provider Agreement with the Petitioners, which required the Petitioners to "maintain records that fully disclose services and goods rendered and/or delivered to ABI Waiver participants...[and] make [the records] available to authorized representatives of the Department upon request," and (2) section 17b-260a-16 of the ABI Waiver Operating Policy. See Exhibits F and G. The purpose of the records review was to review the documentation that supported the services the Petitioners claimed to have provided, and which were paid by the Department, under the ABI Waiver program While the terms of the documentation requirements contained in the Provider Agreement applied to all claims, the requirements contained in section 17b-260a-16 of the ABI Waiver Operating Policy applied only to services provided on or after April 1, 2013, the effective date of the ABI Waiver Operating Policy. The Department did not conduct an audit of the Petitioners under Conn. Gen. Stat. § 17b-99, and did not make any financial findings.

D. Review of Credentials and Qualifications by Allied Community Resources, Inc.

The Petitioners also question whether the Department's fiscal intermediary, Allied Community Resources, Inc. ("Allied"), will be conducting an "audit" of providers under Conn. Gen. Stat. § 17b-99, and whether any credentialing requirements reviewed by Allied have the

force of law. Allied does not conduct any audits of providers under the auspices of Conn. Gen. Stat. § 17b-99. Rather, pursuant to its contract with the Department, Allied reviews ABI providers' policies, practices and procedures with respect to providing ABI Waiver services, and reports such information to the Department. In particular, Allied verifies that providers possess the credentials and qualifications required by the Department, as documented in the ABI Waiver Operating Policy and the approved federal ABI waivers, as well as other established standards, including financial solvency. Any review of the Petitioners' or other ABI waiver providers' files by Allied will be conducted in accordance with applicable provider agreements, regulations and operating policies, but will not be an audit under Conn. Gen. Stat. § 17b-99. In addition, Allied does not make any financial findings with respect to its evaluations of ABI waiver providers.

V. Amendments to Cognitive Behavior Services Effective December 1, 2015 (Questions 73-75, 93, 94, 101)

The Petitioners poses various questions regarding the Department's amendment of its approved federal waivers with respect to the rates of reimbursement and units of service for cognitive behavioral services rendered under the ABI Waiver program. By way of background, prior to December 1, 2015, all cognitive behavioral services were reimbursed at one hourly rate, and in whole one-hour units of service. Thus, a provider was able to bill for the full hourly unit without having provided an hour of services. One common example of this practice involved providers utilizing "Skype" to communicate with a client for a few minutes, and then billing the Department for a full unit of service.

The Department invited all participating providers of cognitive behavioral services to meet and discuss potential modifications to the service definition and payment rates. The meeting and follow-up communications resulted in a consensus for a modification of the service definition and the development of an additional procedure code for the service. In particular, a

new procedure code (1448P) was assigned for cognitive behavioral services that were not provided face-to-face with the client, including time spent developing the cognitive behavioral plan, as well as phone or other secure electronic forms of communication, including Skype. Cognitive behavioral services that were provided on a face-to-face basis, specifically with the provider and participant in the same room, retained the original procedure code (1548P). In order to encourage cognitive-behavioral providers to engage their clients in person, the reimbursement rate for face-to-face services was increased from its previous rate, and a lower reimbursement rate for non-face-to-face services was introduced. In addition, in order to ensure that providers were compensated in a manner that accurately reflected their time spent servicing the client, the new non-face-to-face rate was based on quarter hour increments

A. Were the Amendments to the Cognitive Behavioral Service Properly Implemented and Legally Enforceable?

In order to implement the changes to the cognitive behavioral services definition, procedure code and reimbursement rate, the Department properly followed all state and federal requirements with respect to the waiver amendment process. As the Department previously explained to the Petitioners via email correspondence on December 2, 2015, the "Department administers the ABI waiver program in accordance with the terms of the waiver approved by both the Connecticut General Assembly and CMS. [The Department is] required to do so as a condition of receiving federal matching funds. There is no requirement that every operational detail of the waiver be memorialized in state regulations or in the ABI provider agreement. ABI providers have been provided with the information necessary to comply with the new waiver provisions." Exhibit H.

In order to meet is state and federal requirements for amending the waivers to include the changes to cognitive behavioral services, the Department first published notice in the

implementation of a quarter hour unit increment, the Department has violated, or has caused the Petitioners to void, their prior Provider Agreements. In particular, the Petitioners note that, upon implementing the new two-tiered procedure code and quarter hour service increment on December 1, 2015, the Department did not modify existing or future service plans for ABI Waiver participants to dictate the exact number of units the providers would be authorized to provide face-to-face as opposed to non-face-to-face Rather, the service plans make reference only to the original procedure code and hourly unit increment. As explained to the Petitioners in an email from the Department dated December 1, 2015, the effective date of the amendments, "the service plan [for each individual] will not differentiate face[-]to[-]face versus non[-]face[-]to[-]face hours. As a provider, you can determine that breakdown as long as the billing doesn't exceed the authorized hours in the service plan. Please note the significant increase in the rate for providing the in person service." Exhibit J.

The Petitioners, having previously argued that the Department has improperly exercised "behavioral control" over them, now complain that the Department has afforded them too much discretion to determine the appropriate type of services to provide to their clients. In particular, the Petitioners cite to Paragraph 4 of their prior Provider Agreements, which state that the provider "will adhere to the units and services assigned in accordance with the ABI Waiver participant's service plan to which the agency is named as a service provider." Accordingly, the Petitioners argue that, by requiring the Petitioners to bill and receive reimbursement using the new 1448P procedure code and quarter hour unit increments for non-face-to-face cognitive behavioral services, when an individual's existing service plan only contains a reference to the original 1548P procedure code and hourly unit increment, the Department has violated the

Provider Agreements, voided the agreements, or caused the Petitioners to violate those agreements.

The Department denies that it has violated or voided the Petitioners' Provider Agreements, and denies that the Provider Agreements are legally binding contracts with the Department, as they lack key terms necessary to form a legally binding contract, most notably a price term. The Department properly followed all state and federal requirements in amending the waivers, and implementing the new procedure codes and unit increments. The Petitioners were personally given advanced notice of the impending change, in addition to the public notice and comment period conducted under Conn Gen. Stat § 17b-8 To the extent that the amendments require the Petitioners to modify their billing practices to distinguish between those cognitive behavioral services performed face-to-face as opposed to non-face-to-face, the Petitioners must comply. However, the Department agrees that, where an individual's service plan references only the pre-existing 1548P procedure code, the provider is not in violation of any Provider Agreement, regulation or operating policy when it properly bills the Department using the procedure codes for face-to-face services and non-face-to-face services In order to properly use these procedure codes, the billing must accurately reflect both the type of service actually performed and the proper unit increment, and not exceed the authorized hours in the service plan

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
Roderick L Bremby
by Kathleen M Brennan, Deputy Commissioner
Roderick L. Bremby
Commissioner

June 22, 2016

EXHIBIT A

STATE OF CONNECTICUT

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Declaratory Ruling

Re: Petition for Declaratory Ruling by Tariq Abdulaziz

The Department of Social Services (the "Department") issues this declaratory ruling pursuant to the authority granted to administrative agencies in section 4-176 of the Connecticut General Statutes and sections 17-311-44 to 17-311-46, inclusive, of the Regulations of Connecticut State Agencies.

Procedural History

On December 9, 2014, Tariq Abdulaziz (the "Petitioner") filed a Petition for Declaratory Ruling. *See* Exhibit A, Petition for Declaratory Ruling. The questions set forth in the Petition for Declaratory Ruling are as follows:

1. Whether the regulations proposed by said Agency pursuant to Connecticut General Statutes §4-168, and being §17b-260a and §17b-260b were properly adopted pursuant to the Connecticut Uniform Administrative Procedure Act.

2. Whether the regulations proposed by said Agency, pursuant to Connecticut General Statutes §4-168 and being §17b-99, were properly adopted.

3. Whether 17b-10 can be applied to the ABI Medicaid Waiver Program.

On December 30, 2014, the Department agreed to issue a declaratory ruling by May 29, 2015 in accordance with sections 4-176(e)(3) and 4-176(i) of the Connecticut General Statutes. *See* Exhibit B, Agreement to Issue Declaratory Ruling.

On February 20, 2015, the Petitioner filed two notices of deposition with the Department, in which he sought to depose two of the Department's employees, Lara Stauning and Dorian Long, and requested that they produce certain documents contained in the Schedule A of the notices of deposition. *See* Exhibit C, Notices of Deposition.

On March 4, 2015, the Department issued an Order in which it stated that no discovery, including the taking of a deposition, was permitted in relation to the Petition for Declaratory Ruling. *See* Exhibit D, Order dated March 4, 2015. The Department explained to the Petitioner that the declaratory ruling would be issued without any type of proceeding, per section 4-176(e)(3) of the Connecticut General Statutes, and even if there were a proceeding, the Connecticut Supreme Court has ruled that absent an express statutory or regulatory provision, there is no right to discovery in administrative proceedings. *See Pet v. Dep't of Health Servs.*,

207 Conn. 346, 357, 542 A.2d 672 (1988). Neither statutes nor the Department's regulations grant a party the right to discovery, including the taking of a deposition, in an administrative proceeding or in relation to a petition for a declaratory ruling.

On March 31, 2015, the Petitioner filed what he called an "Amended Petition for Declaratory Ruling." *See* Exhibit E, Amended Petition for Declaratory Ruling. The following questions were presented, in addition to the original three questions presented on December 9, 2014:

4. Whether the Department of Social Services (DSS), despite the non-adoption of regulations governing the Acquired Brain Injury/Traumatic Brain Injury Waiver Program (ABI Waiver), developed and applied certain published regulations in 1999 (1999 Operation Policy) and certain Social Work Policies.

5. Whether the Department of Social Services (DSS), in developing and applying said 1999 non-adopted regulations, distributed them to Licensing Regulation and Review Committee, the Office of Attorney General or the Secretary of State.

6. Whether the Department of Social Services (DSS) in applying said 1999 non-adopted regulations, impacted providers record keeping requirements and defined who is responsible for determining how services are provided to customers, without ever going through the regulatory adoption process.

7. Whether the Department of Social Services (DSS) in promulgating proposed regulations Connecticut General Statutes §17b-260a-1 to §17b-260a-17, with a Notice of Intent (NOI) published on March 26, 2013, in the Connecticut Law Journal with an effective date of April 1, 2013, despite reference errors as herein referred, failed to include in said NOI any reference to previous and current policies in effect and governing the ABI Waiver Program.

8. Whether the Department of Social Services (DSS) applied policies developed and/or in use by the Department of Social Work since 2009, but failed to publicize them to the general public; distribute them to consumers, providers, Licensing Regulation and Review Committee, the Attorney General or Secretary of State.

Ruling

Question One: Whether the regulations proposed by said Agency pursuant to Connecticut General Statutes §4-168, and being §17b-260a and §17b-260b were properly adopted pursuant to the Connecticut Uniform Administrative Procedure Act.

Sections 17b-260a and 17b-260b are statutes, not regulations. It will be assumed that the Petitioner is asking whether sections 17b-260a-1 to 17b-260a-17, inclusive, of the Regulations of Connecticut State Agencies (the "ABI Waiver Regulations") were properly adopted pursuant to the Connecticut Uniform Administrative Procedure Act ("UAPA").

The Petitioner asserts that the ABI Waiver Regulations were not properly adopted for the following reasons: A) the Department did not comply with the requirement of Connecticut General Statute §17b-10(b) to publish notice of intent to adopt the ABI Waiver Regulations within twenty day after adopting the policy; B) the Department did not comply with the requirement of Connecticut General Statutes §4-168(a) to publish notice of intent at least thirty days prior to adopting the ABI Waiver Regulations; C) the ABI Waiver Regulations have not been properly noticed because of a typographical error citing to §17b-260b, rather than §17b-260a, in the Connecticut Law Journal; and D) the Department did not submit the ABI Waiver Regulations to the Legislative Regulation Review Committee ("LRRC") within one hundred eighty (180) days of the notice's publication in the Connecticut Law Journal

The ABI Waiver Regulations have been properly adopted as follows:

A) The Department is operating under the ABI Waiver Regulations as a policy, in accordance with section 17b-10(b) of the Connecticut General Statutes. *See* Exhibit F, §17b-10(b) of the Connecticut General Statutes, in effect until June 30, 2013.

Section 17b-10(b) of the Connecticut General Statutes enables the Department to operate under a policy while the Department is in the process of adopting the policy as a regulation. *Id.* Until June 30, 2013, it provided that the Department

> shall adopt as a regulation in accordance with the provisions of chapter 54, any new policy necessary to conform to a requirement of an approved federal waiver application initiated in accordance with section 17b-8... but the department may operate under such policy while it is in the process of adopting the policy as a regulation, provided the Department of Social Services prints notice of intent to adopt the regulation in the Connecticut Law Journal within twenty days after adopting the policy. Such policy shall be valid until the time final regulations are effective. *Id.*[1]

The ABI Waiver Regulations were promulgated as new policies necessary to conform to the requirement of an approved federal waiver. The statute in effect at the time was clear that, as long as the Department printed notice of its intent to adopt the policy as a regulation in the Connecticut Law Journal within twenty days after adopting the policy, the Department could operate under such policy until the final regulations become effective. *Id.*

In fact, the Department gave more notice than it was required to give. The Notice of Intent to Adopt Regulations ("NOI") was published in the Connecticut Law Journal on March 26, 2013, five days before the policy went into effect on April 1, 2013. *See* Exhibit G, Notice of Intent to Adopt Regulations. The Department, therefore, complied fully with section 17b-10(b)

[1] This section is virtually identical to the current version of section 17b-10(b) of the Connecticut General Statutes. The only difference is that that the Department is now required to post the policy on the eRegulations System prior to adopting the policy, rather than printing notice in the Connecticut Law Journal within twenty days after adopting the policy.

of the Connecticut General Statutes, which requires that notice be published no later than 20 days after adopting the policy.

B) Again, because the ABI Waiver Regulations were a new policy "necessary to conform to a requirement" of the approved ABI Waiver, the Department issued an NOI in accordance with section 17b-10(b) of the Connecticut General Statutes in effect at the time. *See* Exhibit F. As described in the previous response, the Department complied with the notice requirement in section 17b-10(b) of the Connecticut General Statutes.

C) The ABI Regulations have been properly noticed, even though there is a typographical error in the NOI that was published in the Connecticut Law Journal on March 26, 2013. The NOI cites to section 17b-260b, rather than to section 17b-260a of the Connecticut General Statutes as the statutory authority for the proposed regulations. *See* Exhibit G. Nevertheless, there is no question that the NOI is announcing the Department's intent to adopt regulations for the ABI waiver program. There are multiple references to the ABI waiver program in the opening paragraph of the NOI and in the Statement of Purpose. *Id.* Even with the incorrect statutory citation, therefore, there can be no confusion about the NOI's purpose. The Department provided sufficient notice to the public of its intention to adopt regulations concerning the ABI waiver program, and that the implementation date for the policy was April 1, 2013. *Id.* The typographical error, therefore, does not invalidate the policy under which the Department is operating.

D) The Department acknowledges that it did not submit the ABI Waiver Regulations to the LRRC within 180 days after publication of the NOI, nor did it notify the LRRC of the reasons for its noncompliance and the date by which it would submit the proposed regulations. *See* Exhibit F. The Department's failure to comply with this provision, however, is not a basis upon which to invalidate the policy under which the Department is operating.

The Connecticut Supreme Court has provided guidance concerning whether the time frame in a statute is mandatory in which case the failure to comply with it invalidates an agency's action:

> The test to be applied in determining whether a statute is mandatory or directory is whether the prescribed mode of action is the essence of the thing to be accomplished, or in other words, whether it relates to a matter of substance or a matter of convenience.... If it is a matter of substance, the statutory provision is mandatory. If, however, the legislative provision is designed to secure order, system and dispatch in the proceedings, it is generally held to be directory, especially where the requirement is stated in affirmative terms unaccompanied by negative words.... Such a statutory provision is one which prescribes what shall be done but does not invalidate action upon a failure to comply." (Citations omitted; internal quotation marks omitted.) *Jones v. Mansfield Training School*, 220 Conn. 721, 727, 601 A.2d 507 (1992). A reliable guide in determining whether a statutory provision is directory or mandatory is whether the provision is accompanied by language that expressly invalidates any action taken after noncompliance with the

provision. *Leo Fedus & Sons Construction Co. v. Zoning Board of Appeals,* 225 Conn. 432, 440, 623 A.2d 1007 (1993).

Katz v Comm'r of Revenue Servs., 234 Conn. 614, 617, 662 A.2d 762, 764 (1995). There is nothing in section 17b-10 of the Connecticut General Statutes indicating that, if the Department failed to comply with the 180-day period, its regulation would become invalid. Accordingly, although the legislature may have intended for these matters to proceed expeditiously, there is nothing in the statute to indicate that it intended the draconian remedy of invalidating the operational policy, which has the effect of a regulation.

For all of the reasons set forth above, the ABI Waiver Regulations have been properly noticed and are in effect while the Department is in the process of final adoption.

Question Two: Whether the regulations proposed by said Agency, pursuant to Connecticut General Statutes §4-168 and being §17b-99, were properly adopted.

Section 17b-99 is a statute, not a regulation. It will be assumed that the Petitioner is asking whether proposed sections 17b-99(d)-1 to 17b-99(d)-6, inclusive, were properly adopted.

There are currently no regulations in effect for section 17b-99 of the Connecticut General Statutes. Although the Department has presented a proposed regulation to implement this section to the LRRC, the LRRC rejected it without prejudice, despite the Legislative Commissioner's Office's recommendation for approval. Accordingly, a declaratory ruling cannot be issued on the validity of a regulation that has not yet been adopted.

Contrary to the Petitioner's claim, the Department does not rely on regulations to extrapolate findings of overpayments against providers. Rather, section 17b-99(d) (3) of the Connecticut General Statutes authorizes the Department to extrapolate findings of overpayment under certain circumstances. The Department acts in accordance with the statute when it extrapolates overpayments. *See* Conn. Gen. Stat. §17b-99.

Question Three: Whether 17b-10 can be applied to the ABI Medicaid Waiver Program.

Yes, section 17b-10(b) of the Connecticut General Statutes is applicable to the promulgation of regulations under the ABI Waiver Program. As stated above, section 17b-10(b) of the Connecticut General Statutes provides that the Department shall adopt as a regulation, in accordance with the provisions of chapter 54, any new policy necessary to conform to a requirement of an approved federal waiver application initiated in accordance with section 17b-8. *See* Exhibit F.

The ABI Waiver Program operates under an approved federal waiver which was initiated in accordance with section 17b-8 of the Connecticut General Statutes. The ABI Waiver Regulations were promulgated as new policies necessary to conform to the requirements of that waiver. Section 17b-10(b) of the Connecticut General Statutes, therefore, is applicable to regulations promulgated pursuant to the ABI Waiver.

Questions Four – Eight:

The Department has determined that questions four through eight do not constitute questions that meet the standard for questions that are properly answered through issuance of a declaratory ruling.

Section 4-176(a) of the Connecticut General Statutes provides that any person may petition a state agency for a declaratory ruling "as to the validity of any regulation, or the applicability to specified circumstances of a provision of the general statutes, a regulation, or a final decision on a matter within the jurisdiction of the agency." *See* Conn. Gen. Stat. §4-176(a). These are the "ground rules" or standards that a petitioner must meet for bringing a petition for a declaratory ruling before a state agency. *Peruta v. Comm'r of Pub. Safety*, 128 Conn. App. 777, 785, *cert. denied*, 302 Conn. 919 (2011).

In Peruta, the Appellate Court reviewed the trial court's granting of the Department of Public Safety's motion to dismiss the plaintiff's action for declaratory judgment for lack of subject matter jurisdiction. The plaintiff in that case emailed nine questions to the Department of Public Safety, and later delivered a document with the same questions.[2] The Department of Public Safety's legal affairs unit sent the plaintiff a letter stating that it was "unable to provide answers to his questions" and suggested that he seek the advice of an attorney. The plaintiff then filed the declaratory judgment action.

The Superior Court had granted the Department of Public Safety's motion to dismiss, finding that the Plaintiff had failed to exhaust his administrative remedies by not first requesting a declaratory ruling from the Department of Public Safety. *Id.* at 779. It ruled that the email the Plaintiff sent to the Department of Public Safety with nine questions regarding the carrying of a firearm was not a valid petition for a declaratory ruling. *Id.*

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[2] In his e-mail, the plaintiff asked the following questions: (1) "What state statute(s), regulation(s), policies or case law(s) mandates concealment of a firearm while being carried by an individual in possession of a valid license to carry same?"; (2) "What state statute(s), regulation(s), policies or case law(s) prevents the wearing of an exposed firearm while being carried by an individual in possession of a valid license to carry same?"; (3) "What state statute(s), regulation(s), policies or case law(s) establish the standards for concealment of a firearm while being carried by an individual in possession of a valid license to carry same?"; (4) "What state statute(s), regulation(s), policies or case law(s) establishes the simple act of carrying of a holstered firearm, by an individual in possession of a valid permit/license to carry same, into a restaurant as an element of a crime?" (5) "What state statute(s), regulation(s), policies or case law(s) establishes the simple act of carrying of a holstered firearm, by an individual in possession of a valid permit/license to carry same, into an establishment that serves alcoholic beverages, (such as a bar or restaurant), as an element of a crime?"; (6) "Is there any existing criminal case law where the simple act of carrying of a concealed holstered firearm, (by an individual in possession of a valid permit/license to carry same), into a restaurant meets the necessary elements contained in [General Statutes §] 53a–181—Breach of peace in the second degree?"; (7) "Is there any existing criminal case law on the simple act of carrying of an exposed, holstered firearm, (by an individual in possession of a valid permit/license to carry same), into a restaurant meets the necessary elements contained in [§] 53a–181—Breach of the peace in the second degree?"; (8) "What state statute(s), regulation(s), policies, case law(s) or situations grant or provide the authority to a local police officer or department to seize and/or confiscate a pistol permit from the holder of same?"; (9) "What state statute(s), regulation(s), policies, case law(s) or situations grant or provide the authority to a local police officer to determine 'MATURE JUDGMENT' as the phrase pertains to carrying a firearm by a person permitted or licensed to do so?"

The Appellate Court affirmed the trial court's decision, ruling that the Plaintiff's email was not a petition for a declaratory ruling -- it needed to "set forth specific circumstances and seek to have the department apply a regulation, statute or final decision on a matter in its jurisdiction to those specific circumstances," and it failed to do that. *Id.* at 785- 786.

The Court stated:

> [T]hrough a series of nine questions, the plaintiff asked the department to *identify* and to provide the source of legal authority preventing, in whole or in part, a valid permit holder from carrying a firearm in the state, openly or exposed, and from doing so in a 'restaurant' or 'an establishment that services alcoholic beverages....' The plaintiff did not seek to have the department apply or examine a regulation or statute with respect to a specified set of circumstances."

Id. at 785-86 (emphasis in original).

Similar to the questions at issue in Peruta, questions four through eight posed by the Petitioner in his Amended Petition for Declaratory Ruling simply ask for information. They do not question the validity of a regulation nor do they seek to have the Department apply or examine a regulation or statute with respect to a specified set of circumstances. Accordingly, the Department is deciding not to issue a declaratory ruling on questions four through eight because these questions do not constitute a petition for a declaratory ruling. *See* Conn. Gen. Stat. 4-176(e)(5)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

Roderick L. Bremby
Commissioner of Social Services

May 28, 2015

Certificate of Mailing Form

Declaratory Ruling – Tariq Abdulaziz

I certify that a copy of the above referenced Declaratory Ruling was sent to the following person(s) on:

May 29, 2015.

[ ] Hand Delivered
[X] Mailed
[ ] Other (specify)

Petitioner:

Tariq Abdulaziz
23 Kate Way
Windsor Locks, CT 06096

Petitioner's Attorney:

I. David Marder
76 South Frontage Road
Vernon, CT 06066

Joseph A. Smiga

5/29/15
Date

EXHIBIT B

ABI WAIVER PROVIDER REGISTRY APPLICATION

The ABI Waiver Program provides 21 home and community-based services to eligible individuals with an acquired brain injury. Providers must be enrolled in the Department's ABI Provider Registry in order to receive payment. In order to be included in the Registry, providers must meet the Department's specific qualifications for each service. This is an application to be included in the ABI Provider Registry. Instructions for completion of this application are on the attached page. Please refer to the Department's ABI Provider Manual for a description of provider qualifications, as well as services, rates, billing and general program information.
ALL PAPERWORK MUST BE SUBMITTED PRIOR TO ATTENDING THE TRAINING.

A. *PROVIDER INFORMATION*

1. AGENCY: ☑ OR INDIVIDUAL: ☐
2. PROVIDER NAME Neuro Strategies, Inc.
   2a. CONTACT (if agency provider) TARIQ ABDULAZIZ
3. ADDRESS 75 Hockanum Blvd (street) Unit 217
   Vernon (city) CT. (state) 06066 (zip)
4. MAILING ADDRESS (if different) (Same)
5. TELEPHONE: 860 377-0641 6. FAX: 860 870-5737 7. Email: neurostrategies@earthlink.net
8. ☐ SSN (if individual): " " OR ☑ FEIN (if agency): 22-0712098
9. SERVICE AREA (see instructions) Statewide ☑ OR NorthCentral ☐ SouthCentral ☐ NorthWest ☐ SouthWest ☐ Eastern ☐
10. PLEASE DO NOT INCLUDE MY NAME ON THE REGISTRY DISTRIBUTED TO THE DSS OFFICES: ☑

B. *PROVIDER SPECIALTY and QUALIFICATIONS (check all that apply)*

Column 1 CHECK (✓) SERVICE TYPE	Column 2 A.B.I. WAIVER SERVICES	Column 3 PROVIDER TYPE	Column 4 BRIEFLY DESCRIBE THE PROVIDER QUALIFICATION DOCUMENTATION YOU ARE SUBMITTING
	Case Management		
	Chore Services		
✓	Cognitive Behavioral Programs		
	Community Living Support Services		
	Companion Services		
	Environmental Accessibility Adaptations		
	Home-Delivered Meals		
	Homemaker Services		
✓	Independent Living Skills Training & Devel.		
	Personal Care Assistance		
	Personal Emergency Response Systems		
✓	Pre-Vocational Services		
	Respite Services		
	Specialized Medical Equipment and Supplies		
	Substance Abuse Programs		
	Supported Employment		
	Transitional Living Services		
	Transportation		
	Vehicle Modification Services		

PROVIDER AGREEMENT

1. ALL OF THE STATEMENTS MADE BY ME ON THIS APPLICATION AND ALL INFORMATION CONTAINED IN MY SUPPORTING PROVIDER QUALIFICATION DOCUMENTATION IS TRUE AND CORRECT.

2. I ACKNOWLEDGE THAT I CAN PERFORM ALL STANDARDS AND DUTIES FOR THE SERVICES I AM APPLYING FOR, AS STATED IN THE PROVIDER MANUAL.

3. I WILL IMMEDIATELY NOTIFY THE DEPARTMENT IF ANY INFORMATION PROVIDED BY ME ON THIS APPLICATION CHANGES.

4. I WILL MAINTAIN CURRENT STANDING WITH RESPECT TO ANY LICENSE AND/OR CERTIFICATION REQUIREMENTS ESTABLISHED BY THE DEPARTMENT FOR MY ABI PROVIDER TYPE AND SERVICE SPECIALTY.

5. I WILL IMMEDIATELY NOTIFY THE DEPARTMENT IF SUCH LICENSES AND/OR CERTIFICATIONS EXPIRE, ARE REVOKED, SUSPENDED OR OTHERWISE TERMINATED FOR ANY REASON.

6. I WILL PROVIDE ALL SERVICES IN ACCORDANCE WITH THE TERMS OF THE ABI WAIVER PARTICIPANT'S APPROVED SERVICE PLAN.

7. THE RATE PAID BY THE DEPARTMENT FOR THE PERFORMANCE OF ABI WAIVER SERVICES IS THE COMPLETE PAYMENT IN FULL FOR ALL SERVICE(S), GOODS OR PRODUCTS DELIVERED TO ELIGIBLE ABI WAIVER PARTICIPANTS.

8. EXCEPT FOR AUTHORIZED CO-PAYMENTS MADE BY ELIGIBLE WAIVER PARTICIPANTS, THE DEPARTMENT'S PAYMENTS TO ME FOR THE PERFORMANCE OF ABI SERVICES CONSTITUTE SOLE AND COMPLETE PAYMENT IN FULL.

9. I WILL MAINTAIN RECORDS THAT FULLY DISCLOSE SERVICES AND GOODS RENDERED AND/OR DELIVERED TO ABI WAIVER PARTICIPANTS. THESE RECORDS WILL BE MADE AVAILABLE TO AUTHORIZED REPRESENTATIVES OF THE DEPARTMENT UPON REQUEST.

10. I ACKNOWLEDGE THAT I MAY BE SUSPENDED OR TERMINATED FROM THE ABI PROVIDER REGISTRY IF I AM FOUND BY THE DEPARTMENT TO HAVE ENGAGED IN FRAUDULENT OR ABUSIVE PROGRAM SERVICES.

11. I AGREE TO NOT USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) OTHER THAN AS PERMITTED OR AS REQUIRED BY LAW AND TO USE APPROPRIATE SAFEGUARDS TO PREVENT IMPROPER USE OR DISCLOSURE OF PHI.

12. I AM OVER 18 YEARS OF AGE.

TARIQ M. ABDULAZIZ
PROVIDER NAME (please print individual or agency name)

01/15/04
AUTHORIZED SIGNATURE (individual or agency rep.) DATE

ALL PAPERWORK MUST BE SUBMITTED PRIOR TO ATTENDING THE TRAINING

3 of 8

EXHIBIT C

ALLIED COMMUNITY Resources

FMS-Provider Services
PO Box 479, East Windsor, CT 06088-0479
Phone: 860-627-9500 Toll Free: 877-722-8833
Fax: 860-627-0230

DSS ABI MEDICAID WAIVER PROGRAM
PROVIDER SERVICES APPLICATION - AGENCY

Provider Information:

Agency Name: NeuroStrategies Inc

Agency Contact Name: Tang Abdulaziz

Agency Address: 23 Kate O Way Windsor Locks, CT. 06096

Mailing Address (if different): SAME

Telephone: 8603770641 **Agency Contact Email:** tangabdulaziz@neurostrategies.info

Fax: 8608311044 **Cell Phone:** 860 377 0641

FEIN # 02-07 13098 **SS # (if applicable):** ___-___-___

☐ Please check here if you **DO NOT** want your name included on the ABI Provider Directory which is distributed to DSS Offices and participants on the ABI Waiver Program.***Please note that you will not be contacted by potential employers if you choose not to have your name listed on the directory***

See attached list of Agency provider services. Please ✓ each service you would like your agency to be considered for and determine if your agency meets the requirements in order to be considered for these services in the column to the right of each service.

See attached list of Connecticut towns and regions. Please indicate individual towns or regions of the state in which you will provide services.

DSS ABI MEDICAID WAIVER AGENCY PROVIDER DIRECTORY AGREEMENT

1. The agency is qualified to perform all the standards and duties for the services for which I am applying.
2. The agency will immediately notify the Fiduciary Agent- **Allied Community Resources (ACR),** if any information provided by me on this application changes.
3. The agency will maintain current standing with respect to any license and/or certification requirement established by the **Department of Social Services (DSS)** for the service specialty. The agency understands that copies of updated contracts, licenses, and accreditations as they become renewed or extended, will be requested. The agency will immediately notify ACR if such licenses and/or certifications expire, are revoked, suspended or otherwise terminated for any reason.
4. The agency will adhere to the units and services assigned in accordance with the ABI Waiver participant's service plan to which the agency is named as a service provider.
5. If the program participant is hospitalized or in a skilled nursing facility, the agency understands that it **MAY NOT** provide services, submit invoices, and receive payment during this time.

6. The rate paid by DSS for the performance of ABI Waiver Services is the complete payment in full for all service(s) or products delivered to eligible ABI Waiver participants. Payments to the agency for the performance of ABI services or delivery of goods constitute sole and complete payment in full.
7. The agency will maintain records that fully disclose services and goods rendered and/or delivered to ABI Waiver participants. These records will be made available to authorized representatives of DSS upon request.
8. The agency acknowledges that it may be suspended or terminated from the ABI Provider Directory if it is found by DSS to have engaged in fraudulent or abusive program services.
9. The agency agrees to not use or disclose protected health information (PHI) other than as permitted or as required by law and to use appropriate safeguards to prevent improper use or disclosure of PHI.
10. The agency understands that **NONE** of its employees may provide services to any ABI Waiver participant and receive payment **until the agency has been notified in writing by ACR** that the agency and its employees are approved providers on the ABI Medicaid Waiver Program and that the agency has been named to a program participant's service plan by DSS.
11. The agency understands that in order to add an existing provider as an employee of the agency, ACR must be notified in writing and the proper paperwork must be submitted and reviewed for completeness by ACR **BEFORE** the employee may begin working. The agency understands that employee approvals will **NOT** be backdated.
12. The agency understands that the employees and representatives (if applicable) may not provide services both privately and as an agency employee to the same waiver participant as this creates a conflict of interest. ***This is against program rules and is strictly prohibited.*** A Conflict of Interest form is required for any individual who is approved as an agency employee if he/she is currently a private provider.
13. This is a State and Federal Government program. Altering invoices or falsely claiming hours worked or services rendered is considered fraud. The agency will be subject to prosecution for fraud to the fullest extent of the law. The agency may be subject to prosecution for fraud on both a State and Federal level.
14. The agency understands that this program does not provide Worker's Compensation Coverage.
15. The agency understands that any employee **may not** work for a participant on the ABI Medicaid Waiver Program if he/she is a relative of the participant's conservator, if applicable.
16. Neither the agency nor its employees are employed by Allied Community Resources.
17. The agency understands that failure to comply with the above statements may result in the revocation of the agency's approval status from the ABI Medicaid Waiver Program.
18. The agency understands that if the agency name or the names of any of its officers appear on the OIG (Office of Inspector General) list of excluded entities/individuals, the agency is prohibited from becoming a paid provider under any DSS Program.

AS THE AGENCY'S REPRESENTATIVE, I HAVE READ AND ACCEPT THE TERMS OF THE PROVIDER AGREEMENT AS STATED ABOVE. ALL OF THE STATEMENTS MADE BY ME ON THIS APPLICATION AND ALL INFORMATION CONTAINED IN ANY SUPPORTING QUALIFICATION DOCUMENTATION ARE TRUE AND CORRECT.

NewoStrategies Inc
Agency Name

Tariq Abdulazz — 10/28/14
Agency Representative Name (please print) **Agency Representative Signature** **Date**

F188-V 08/16/12

EXHIBIT D

ALLIED COMMUNITY Resources

FMS-Provider Services
PO Box 479, East Windsor, CT 06088-0479
Phone: 860-627-9500 Toll Free: 877-722-8833
Fax: 860-627-0230

DSS ABI MEDICAID WAIVER PROGRAM
PROVIDER SERVICES APPLICATION - AGENCY

Agency Name: NEURO STRATEGIES, INC

Agency Address: 23 KATE WAY Windsor Locks, CT. 06096

Mailing Address (if different): SAME

Telephone: 860 377-0641 **Fax:** 860-831-1440

Agency Contact Name: Tariq Abdulaziz, Ph.D., M.S., M.S., MBA

Agency Contact Email: Neurostrategies.ct@gmail.com

FEIN # 02-0713098 **or SSN (if applicable):** ___-___-___

See attached list of Agency provider services. Please ✓ each service you would like your agency to be considered for and determine if your agency meets the requirements in order to be considered for these services in the column to the right of each service.

See attached list of Connecticut towns and regions. Please indicate individual towns or regions of the state in which you will provide services.

DSS ABI I & II MEDICAID WAIVER PROVIDER AGREEMENT

1. The agency is qualified to perform all the standards and duties for the services for which it is applying.
2. The agency will immediately notify the Fiduciary Agent, **Allied Community Resources (ACR)**, if any information provided me on this application changes.
3. The agency will maintain current standing with respect to any license and/or certification requirement established by the **Department of Social Services (DSS)** for the service specialty. The agency understands that copies of updated contracts, licenses, and accreditations as they become renewed or extended, may be requested. The agency will immediately notify ACR if such licenses and/or certifications expire, are revoked, suspended or otherwise terminated for any reason.
4. The agency will adhere to the units and services assigned in accordance with the ABI Waiver participant's service plan to which the agency is named as a service provider.
5. If the program participant is hospitalized or in a skilled nursing facility, the agency understands that it **MAY NOT** provide services, submit invoices, and receive payment during this time.
6. The rate paid by DSS for the performance of ABI Waiver Services is the complete payment in full for all service(s) or products delivered to eligible ABI Waiver participants. Payments to the agency for the performance of ABI services or delivery of goods constitute sole and complete payment in full.
7. The agency will maintain records that fully disclose services and goods rendered and/or delivered to ABI Waiver participants. These records will be made available to authorized representatives of DSS upon request.

8. The agency acknowledges that it may be suspended or terminated from the ABI Provider Directory if it is found by DSS to have engaged in fraudulent or abusive program services.
9. The agency agrees to not use or disclose protected health information (PHI) other than as permitted or as required by law and to use appropriate safeguards to prevent improper use or disclosure of PHI.
10. The agency understands that **NONE** of its employees may provide services to any ABI Waiver participant and receive payment **until the agency has been notified in writing by ACR** that the agency and its employees are approved providers on the ABI Medicaid Waiver Program and that the agency has been named to a program participant's service plan by DSS.
11. The agency understands that in order to add an existing provider as an employee of the agency, ACR must be notified in writing and the proper paperwork must be submitted and reviewed for completeness by ACR **BEFORE** the employee may begin working. The agency understands that employee approvals will **NOT** be backdated.
12. The agency understands that the employees and representatives (if applicable) may not provide services both privately and as an agency employee to the same waiver participant as this creates a conflict of interest. ***This is against program rules and is strictly prohibited.*** A Conflict of Interest form is required for any individual who is approved as an agency employee if he/she is currently a private provider.
13. This is a State and Federal Government program. Altering invoices or falsely claiming hours worked or services rendered is considered fraud. The agency will be subject to prosecution for fraud to the fullest extent of the law. The agency may be subject to prosecution for fraud on both a State and Federal level.
14. The agency understands that this program does not provide Worker's Compensation Coverage.
15. The agency understands that any employee **may not** work for a participant on the ABI Medicaid Waiver Program if he/she is a relative of the participant's conservator, if applicable.
16. Neither the agency nor its employees are employed by Allied Community Resources.
17. The agency understands that failure to comply with the above statements may result in the revocation of the agency's approval status from the ABI Medicaid Waiver Program.
18. The agency understands that if the agency name or the names of any of its officers appear on the OIG (Office of Inspector General) List of Excluded Individuals and Entities, the agency is prohibited from becoming a paid provider under any DSS Program.

AS THE AGENCY'S LEGALLY AUTHORIZED REPRESENTATIVE, I HAVE READ AND ACCEPT THE TERMS OF THE PROVIDER AGREEMENT AS STATED ABOVE. ALL OF THE STATEMENTS MADE BY ME ON THIS APPLICATION AND ALL INFORMATION CONTAINED IN ANY SUPPORTING QUALIFICATION DOCUMENTATION ARE TRUE AND CORRECT.

TARIQ M. ABOUNAZIZ
Agency Legally Authorized Representative Name (please print)

[signature] 10/30/2015
Agency Legally Authorized Representative Signature **Date**

EXHIBIT E

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

Medical Care Administration

Provider Enrollment Agreement

NEUROSTRATEGIES, INC

(Name of Applicant)

(hereinafter the "Provider") wishes to participate in the Connecticut Medical Assistance Program. For purposes of this Provider Enrollment Agreement (hereinafter the "Agreement"), the term "Connecticut Medical Assistance Program" means any and all of the health benefit programs administered by the State of Connecticut Department of Social Services (hereinafter "DSS"). The Provider represents and agrees as follows:

General Provider Requirements

1. To comply continually with all enrollment requirements established under rules adopted by DSS or any successor agency, as they may be amended from time to time.
2. To abide by and comply with all federal and state statutes, regulations, and policies pertaining to Provider's participation in the Connecticut Medical Assistance Program, as they may be amended from time to time.
3. To continually adhere to professional standards governing medical care and services and to continually meet state and federal licensure, accreditation, certification or other regulatory requirements, including all applicable provisions of the Connecticut General Statutes and any rule, regulation or DSS policy promulgated pursuant thereto and certification in the Medicare program, if applicable.
4. To furnish all information requested by DSS specified in the Provider Enrollment Agreement and the Application Form, and, further, to notify DSS or its designated agent, in writing, of all material and/or substantial changes in information contained on the Application Form.

   To furnish material and/or substantial changes in information including changes in the status of Medicare, Medicaid, or other Connecticut Medical Assistance program eligibility, provider's license, certification, or permit to provide services in/for the State of Connecticut, and any change in the status of ownership of the Provider, if applicable.
5. To provide services and/or supplies covered by Connecticut's Medical Assistance Program to eligible clients pursuant to all applicable federal and state statutes, regulations, and policies.
6. To maintain a specific record for each client eligible for the Connecticut Medical Assistance Program benefits, including but not limited to name; address; birth date; Social Security Number; DSS identification number; pertinent diagnostic information including x-rays; current treatment plan; treatment notes; documentation of dates of services and services provided; and all other information required by state and federal law.
7. To maintain all records for a minimum of five years or for the minimum amount of time required by federal or state law governing record retention, whichever period is greater. In the event of a dispute concerning goods and services provided to a client, or in the event of a dispute concerning reimbursement, documentation shall be maintained until the dispute is completely resolved or for five years, whichever is greater.

   The Provider acknowledges that failure to maintain all required documentation may result in the disallowance and recovery by DSS of any amounts paid to the Provider for which the required documentation is not maintained and provided to DSS upon request.

8. To maintain, in accordance with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d to 1320d-8, inclusive, and regulations promulgated thereto, as they may be amended from time to time, the confidentiality of a client's record, including, but not limited to:

   a. client's name, address, and Social Security number;

   b. medical services provided;

   c. medical data, including diagnosis and past medical history;

   d. any information received for verifying income eligibility; and

   e. any information received in connection with the identification of legally liable third party resources.

   Disclosure of clients' personal, financial, and medical information may be made under the following circumstances:

   f. to other providers in connection with their treatment of the client;

   g. to DSS or its authorized agent in connection with the determination of initial or continuing eligibility, or for the verification or audit of submitted claims;

   h. in connection with an investigation, prosecution, or civil, criminal, or administrative proceeding related to the provision of or billing for services covered by the Connecticut Medical Assistance Program;

   i. as required to obtain reimbursement from other payer sources;

   j. as otherwise required by state or federal law; and

   k. with the client's written consent to other persons or entities designated by the client or legal guardian, or, in the event that the client is a minor, from the client's parents or legal guardian.

   Upon request, disclosure of all records relating to services provided and payments claimed must be made to the Secretary of Health and Human Services, to DSS; and/or to the State Medicaid fraud control unit, in accordance with applicable state and federal law.

   In the event that the Provider authorizes a third party to act on the Provider's behalf, the Provider shall submit written verification of such authorization to DSS

9. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract, and, in accordance with 42 C.F.R. § 455.105 and § 431.115 et seq., to provide upon request of the Secretary of Health and Human Services and/or DSS, full and complete information about the ownership of any subcontractor or any significant business transaction.

   No subcontract, however, terminates the legal responsibility of the Provider to DSS to assure that all activities under the contract are carried out. Provider shall furnish to DSS upon request copies of all subcontracts in which monies covered by this Agreement are to be used. Further, all such subcontracts shall include a provision that the subcontractor will comply with all pertinent requirements of this Agreement.

10 To abide by the DSS' Medical Assistance Program Provider Manual(s), as amended from time to time, as well as all bulletins, policy transmittals, notices, and amendments that shall be communicated to the Provider, which shall be binding upon receipt unless otherwise noted. Receipt of amendments, bulletins and notices by Provider shall be presumed when the amendments, bulletins, and notices are mailed or emailed to the Provider's current address or email address that is on file with DSS or its fiscal agent, or posted to the Connecticut Medical Assistance Program web site.

11. To make timely efforts to determine clients' eligibility, including verification of third-party payor resources, and to pursue insurance, Medicare and any other third party payor prior to submitting claims to the Connecticut Medical Assistance Program for payment.

Provider further acknowledges the Connecticut Medical Assistance Program as payor of last resort. Provider agrees to exhaust clients' medical insurance resources prior to submitting claims for reimbursement and to assist in identifying other possible sources of third party liability, which may have a legal obligation to pay all or part of the medical cost of injury or disability.

12. To comply with the advance directives requirements set forth specified in 42 C.F.R. Part 489, Subpart I, and 42 C.F.R. § 417 436(d), if applicable.

Billing/Payment Rates

13. To submit timely billing in a form and manner approved by DSS, as outlined in the Provider manual, after first ascertaining whether any other insurance resources may be liable for any or all of the cost of the services rendered and seeking reimbursement from such resource(s).

14. To comply with the prohibition against reassignment of provider claims set forth in 42 C.F.R. § 447.10

15. To submit only those claims for goods and services that are covered by the Connecticut Medical Assistance Program and that are documented by Provider as being:
    a. for medically necessary goods and services;
    b for medically necessary goods and services actually provided to the person in whose name the claim is being made;
    c. for compensation that Provider is legally entitled to receive; and
    d. in compliance with DSS requirements regarding timely filing.

16. To accept payment as determined by DSS or its fiscal agent in accordance with federal and state statutes and regulations and policies as payment in full for all services, goods, and products covered by Connecticut Medical Assistance Program and provided to program clients. The Provider agrees not to bill program clients for services that are incidental to covered services, including but not limited to, copying medical records and completing school and camp forms and other forms relating to clients' participation in sports and other activities. The Provider further agrees not to bill clients or any other party for any additional or make-up charge for services covered by the Connecticut Medical Assistance Program, excluding any cost sharing, as defined in section 17b-290(6) of the Connecticut General, and as permitted by law, even when the Program does not pay for those covered services for technical reasons, such as a claim not timely filed or a client being managed-care eligible, or a billed amount exceeding the program allowed amount. The provider may charge an eligible Connecticut Medical Assistance Program client, or any financially responsible relative or representative of that individual, for goods or services that are not covered under the Connecticut Medical Assistance Program, only when the client knowingly elects to receive the goods or services and enters into an agreement in writing for such goods or services prior to receiving them.

    The Provider shall refund to the payor any payment made by or on behalf of a client determined to be eligible for the Connecticut Medical Assistance Program to the extent that eligibility under the program overlaps the period for which payment was made and to the extent that the goods and services are covered by Connecticut Medical Assistance Program benefits.

17. To timely submit all financial information required under federal and state law.

18. To refund promptly (within 30 days of receipt) to DSS or its fiscal agent any duplicate or erroneous payment received, including any duplication or erroneous payment received for prior years or pursuant to prior provider agreements.

19. To make repayments to DSS or its fiscal agent, or arrange to have future payments from the DSS program(s) withheld, within 30 days of receipt of notice from DSS or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made. This obligation includes repayment of an overpayment received for prior years or pursuant to prior provider agreements. The Provider is liable for any costs incurred by DSS in recouping any overpayment.

20. To promptly make full reimbursement to DSS or its fiscal agent of any federal disallowance incurred by DSS when such disallowance relates to payments previously made to Provider under the Connecticut Medical Assistance Program, including payments made for prior years or pursuant to prior provider agreements.

21. To maintain fiscal, medical and programmatic records which fully disclose services and goods rendered and/or delivered to eligible clients. These records and information, including, but not limited to, records and information regarding payments claimed by the Provider for furnishing goods and services, will be made available to authorized representatives upon request, in accordance with all state and federal statutes and regulations.

22 To cooperate fully and make available upon demand by federal and state officials and their agents all records and information that such officials have determined to be necessary to assure the appropriateness of DSS payments made to Provider, to ensure the proper administration of the Connecticut Medical Assistance Program and to assure Provider's compliance with all applicable statutes and regulations and policies. Such records and information are specified in federal and state statutes and regulations and the Provider Manual and shall include, without necessarily being limited to, the following:

a. medical records;

b. original prescriptions for and records of all treatments, drugs and services for which vendor payments have been made, or are to be made under the Connecticut Medical Assistance Program, including the authority for and the date of administration of such treatment, drugs, or services;

c. any original documentation determined by DSS or its representative to be necessary to fully disclose and document the medical necessity of and extent of goods or services provided to clients receiving assistance under the provisions of the Connecticut Medical Assistance Program;

d. any other original documentation in each client's record which will enable the DSS or its agent to verify that each charge is due and proper;

e financial records maintained in accordance with generally accepted accounting principles, unless another form is specified by DSS; and

f. all other records as may be found necessary by DSS or its agent in determining Provider's compliance with any federal or state law, rule, regulation, or policy.

23. That any payment, or part thereof, for Connecticut Medical Assistance Program goods or services, which represent an excess over the appropriate payment, or any payment owed to DSS because of a violation due to abuse or fraud, shall be immediately paid to DSS. Any sum not so repaid may be recovered by DSS in accordance with the provisions below or in an action by DSS brought against the Provider.

24. To pay any applicable application fee, as required under federal law.

Audits and Recoupment

25. That in addition to the above provisions regarding billing and payment, Provider agrees that:

a amounts paid to Provider by DSS shall be subject to review and adjustment upon audit or due to other acquired information or as may otherwise be required by law;

b whenever DSS makes a determination, which results in the Provider being indebted to the DSS for past overpayments, DSS may recoup said overpayments as soon as possible from the DSS's current and future payments to the Provider. DSS's authority to recoup overpayments includes recoupment of overpayments made for prior years or pursuant to prior provider agreements. A recomputation based upon such adjustments shall be made retroactive to the applicable period;

c. in a recoupment situation, DSS may determine a recoupment schedule of amounts to be recouped from Provider's payments after consideration of the following factors:

(1) the amount of the indebtedness;

(2) the objective of completion of total recoupment of past overpayments as soon as possible;

(3) the cash flow of the Provider; and

(4) any other factors brought to the attention of DSS by the Provider relative to Provider's ability to function during and after recoupment,

d. whenever Provider has received past overpayments, the DSS may recoup the amount of such overpayments from the current and future payments to Provider regardless of any intervening change in ownership;

e. if Provider owes money to DSS, including money owed for prior years or pursuant to prior provider agreements, DSS or its fiscal agent may offset against such indebtedness any liability to another provider which is owned or controlled by the same person or persons who owned or controlled the first provider at the time the indebtedness to DSS was incurred. In the case of the same person or persons owning or controlling two or more providers but separately incorporating them, whether the person or persons own or control such corporations shall be an issue of fact. Where common ownership or control is found, this subsection shall apply notwithstanding the form of business organizations utilized by such persons e.g. separate corporations, limited partnerships, etc.; and

f. DSS's decision to exercise, or decision not to exercise, its right of recoupment shall be in addition to, and not in lieu of, any other means or right of recovery the DSS may have.

Fraud and Abuse; Penalties

26. To cease any conduct that DSS or its representative deems to be abusive of the Connecticut Medical Assistance Program and to promptly correct any deficiencies in Provider's operations upon request by DSS or its fiscal agent.

27 To comply with state and federal law, including, but not limited to, sections 1128, 1128A, 1128B, and 1909 of the Social Security Act (hereinafter the "Act") (42 U.S.C. §§ 1320a-7, 1320a-7a, 1320a-7b,1396h) and Connecticut General Statutes sections 17b-301a to 17b-301p, inclusive, which provide state and federal penalties for violations connected with the Connecticut Medical Assistance Program.

Provider acknowledges and understands that the prohibitions set forth in state and federal law include, but are not limited to, the following:

a. false statements, claims, misrepresentation, concealment, failure to disclose and conversion of benefits;

b. any giving or seeking of kickbacks, rebates, or similar remuneration;

c. charging or receiving reimbursement in excess of that provided by the State; and

d. false statements or misrepresentation in order to qualify as a provider.

28. That termination from participation in the Connecticut Medical Assistance Program will result if the Provider is terminated on or after January 1, 2011 under Title XVIII of the Act (Medicare) or any other state's Title XIX (Medicaid) program or Title XXI (CHIP); is convicted of a criminal offense related to that person's involvement with Medicare, Medicaid or Title XXI programs in the last ten years; or if the Provider fails to submit timely and accurate information and cooperate with any screening methods required by law.

29. That suspension may result if the Provider is sanctioned by DSS for having engaged in fraudulent or abusive program practices or conduct, as set forth in state or federal law.

30. That, in accordance with federal law, DSS must temporarily suspend all Medicaid payments to a Provider after it determines there is a credible allegation of fraud for which an investigation is pending, unless DSS has good cause to not suspend payments or to suspend only in part.

31. To comply with the provisions of section 1902(a)(68) of the Act (42 U.S.C. § 1396a(a)(68)) and sections 17b-262-770 to17b-262-773, inclusive, of the Regulations of Connecticut State Agencies, as they may be amended from time to time.

Nondiscrimination

32. To abstain from discrimination or permitting discrimination against any person or group of persons on the basis of race, color, religious creed, age, marital status, national origin, ancestry, sex, gender identity or expression, sexual orientation, mental retardation, mental or physical disability, including, but not limited to, blindness or payor source, in accordance with the laws of the United States or the State of Connecticut.

Provider further agrees to comply with:

a. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000d, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the regulations, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services;

b. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 et seq., (hereafter the "Rehabilitation Act") as amended, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of the Rehabilitation Act and the regulations, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services;

c. Title IX of the Educational Amendments of 1972, 20 U.S.C. § 1681, et seq., as amended, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the regulations, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any educational program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services; and

d. the civil rights requirements set forth in 45 C.F.R. Parts 80, 84, and 90.

Termination

33. That this Agreement may be voluntarily terminated as follows:

a. by DSS or its fiscal agent upon 30 days written notice;

b. by DSS or its fiscal agent upon notice for Provider's breach of any provision of this Agreement as determined by DSS; or

c. by Provider, upon 30 days written notice, subject to any requirements set forth in federal and state law. Compliance with any such requirements is a condition precedent to termination.

Disclosure Requirements

34. To comply with all requirements, set forth in 42 C.F.R. §§ 455.100 to 455.106, inclusive, as they may be amended from time to time. These requirements include, but are not limited to, the full disclosure of the following information upon request:

a. the name, address, social security number and date of birth of any provider or any individual or managing employee (or tax identification number in the case of a corporation) with an ownership

or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more;

b. whether any such person is related to another as spouse parent, child, or sibling;

c. the name of any other disclosing entity in which such a person also has an ownership or control interest;

d. the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000.00 during the 12-month period ending on the date of the request;

e. any significant business transactions between Provider and any subcontractor during the 5-year period ending on the date of the request;

f. the name of any person having an ownership or control interest in Provider, or as an agent or managing employee of Provider, who has been convicted of a civil or criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or other Connecticut Medical Assistance Programs since the inception of these programs; and

g. any other information requested in the Provider Enrollment application.

Provider further agrees to furnish, without a specific request by DSS, the information referenced above at the time of Provider's certification survey, as applicable, and also, without a specific request, disclose the identity of any person with ownership or control interest who has been convicted of a civil or criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other Connecticut Medical Assistance Programs prior to entering into or renewing this Agreement in accordance with 42 C.F.R. Part 455.

35. That the following penalties, as set forth in 42 C.F R. §§455.104 to 455.106, inclusive, are applicable to Providers failing to make that section's required disclosures:
    a. DSS will not approve an Agreement and must terminate an existing Agreement if the Provider fails to disclose ownership or control information;
    b. DSS may refuse to enter into or renew an Agreement with a Provider if any person with ownership or interest control, or who is an agent or a managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX Services Program;
    c. DSS may refuse to enter into or terminate an Agreement if it determines that a Provider did not fully and accurately make the required disclosures concerning such convictions.

Miscellaneous

36. That the Agreement, upon execution, supersedes and replaces any Agreement previously executed by the Provider. This Agreement does not impair Provider's obligation to repay to DSS any money owed to DSS pursuant to prior Agreements or the ability of DSS to recoup such amounts from payments made pursuant to this Agreement.
37. The Provider acknowledges that there is no right to renew this Agreement.
38. The Provider will examine publicly available data, including but not limited to the U.S. Department of Health and Human Services Office of Inspector General (hereinafter "OIG"), or any successor agency's, List of Excluded Individuals/Entities Report and the OIG Web site, to determine whether any potential or current employees, contractors or suppliers have been suspended or excluded or terminated from any healthcare program and shall comply with, and give effect to, any such suspension, exclusion, or termination or accordance with the requirements of state and federal law. The Provider shall search the HHS-OIG Web site on a monthly basis, or at such intervals as specified by the OIG or DSS, to capture sanctions that have occurred since the Provider's last

search The Provider shall also routinely search the Administrative Actions List on the DSS website. The Provider shall immediately report to the OIG and to DSS any sanction information discovered in its search and report what action has been taken to ensure compliance with state and federal law. The Provider shall be subject to civil monetary penalties if it employs or enters into contracts with excluded individuals or entities.

39. If the provider uses electronic signatures, the provider certifies that the provider's policies meet the DSS requirements for acceptance, issuance, and use of electronic signatures.

The effective date of this Agreement and the period of time during which this Agreement shall be in effect, unless terminated by either party prior to the stated ending date, shall be written on the letter DSS sends to the Provider, through its Fiscal Agent Contractor, approving the Provider for participation in the Connecticut Medical Assistance Program. This approval letter shall be incorporated into and made part of this Agreement. If the Provider fails to complete an application for re-enrollment by the time the current Agreement has expired, DSS may stop making payments to the Provider, although DSS will retroactively make payments for services provided under the Connecticut Medical Assistance Program for up to six months from the date the re-enrollment was due.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 U.S.C. § 1320a-7b MAY BE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.

NEUROSTRATEGIES, INC.

Provider Entity Name (doing business as)

TARIQ M ABDULAZIZ

Name of Provider or Authorized Representative (type/print name)

TARIQ M ABDULAZIZ

Signature of Provider or Authorized Representative

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
Division of Health Services
Addendum to Provider Enrollment Agreement for Acquired Brain Injury Waiver Providers

The Provider wishes to participate in the Connecticut Medical Assistance Program as an Acquired Brain Injury (ABI) or Acquired Brain Injury II (ABI II) waiver provider. The Connecticut Medical Assistance Program is administered by

the State of Connecticut Department of Social Services ("DSS"). Except as otherwise specifically provided in this Addendum to Provider Enrollment Agreement (the "Addendum"), all provisions of the Provider Enrollment Agreement (the "Agreement") shall remain in full force and effect. This Addendum is deemed incorporated by reference into the Agreement as if fully set forth therein and DSS may enforce this Addendum pursuant to all applicable authority, including, but not limited to, all authority specified in the Agreement In addition to all representations and agreements made in the Agreement, the Provider also represents and agrees as follows

1 The Provider shall comply with all federal and state statutes, regulations, and policies, including operational policies adopted under section 17b-10 of the Connecticut General Statutes, pertaining to the Provider's participation in the ABI waiver program, as they may be amended from time to time.

2. The Provider shall comply with all applicable DSS standards and the service authorizations entered by the applicable care manager selected by DSS to manage care provided by the Provider for a client (the "Care Manager")

3. The Provider shall provide sufficient supervision of its employees and contractors to ensure the quality of care delivered and compliance with DSS and the Care Manager's care standards. The Provider shall maintain evidence of such supervision in each client's file and shall describe the supervision in periodic reports submitted to the Care Manager

4 For services provided in the client's home, the client shall be present in the home at the time the service is provided, except for minor home modification services that DSS or the Care Manager allows Provider to perform when the client is not present. Service providers may leave the client's home to perform errands for the client, to accompany the client on errands or to appointments, or to provide opportunities for the client to take part in community activities.

5 The Provider shall submit a written report of any incidents of client abuse or neglect to the department or Care Manager

6 The Provider shall maintain current standing with respect to any license, accreditation, or certification requirement established by DSS, and provide documentation of such standing as requested by DSS The Provider shall immediately notify DSS' fiscal agent if such license, accreditation, or certification expires, or is revoked, suspended, or terminated for any reason.

7 Providers accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF") may credential their own employees All non-CARF accredited Providers shall have their employees credentialed by DSS' fiscal agent

8 The Provider may not provide services both privately and as an agency employee to the same waiver client, as this may create a conflict of interest

9 In addition to DSS' or its fiscal agent's right to suspend the Provider or voluntarily terminate the Agreement under Paragraphs 29 and 33 of the Agreement, DSS may immediately suspended the Provider or terminate the Agreement upon a finding by DSS that the Provider has engaged in fraudulent or abusive program practices, or has otherwise endangered the health, safety or welfare of a client

Care Planning and Referral Process; Service Authorizations

10 The Care Manager is responsible for developing a written Individualized plan that describes the type, amount, frequency and duration of services to be provided to the client in consultation with the client, the client's family or the client's authorized representative (the "Plan of Care"). The Provider shall cooperate with the Care Manager in its development of the Plan of Care DSS is not required to purchase, and the Care Manager is not required to authorize, any specific service(s) or dollar amount of service(s) from the Provider

11. The Care Manager, not the Provider, is responsible for communicating with a client regarding the Plan of Care, including proposed changes to such Plan of Care The Provider shall not discuss details regarding the Plan of Care with a client including, but not limited to, the Provider's desire to change or terminate services, without the Care Manager's prior approval.

12 The Provider shall obtain prior approval from the Care Manager before implementing any proposed change to the Plan of Care. The Provider shall not provide any additional or different services to a client other than those specified in the Plan of Care and the service authorization without the Care Manager's prior approval

13 The Care Manager shall provide service authorizations as necessary to implement each client's Plan of Care. The Provider shall comply with the Care Manager's service authorizations, including requirements regarding the frequency and duration of services The Provider shall notify the Care Manager of the exact start date of services before receiving the service authorization. By accepting the service authorization and initiating service, the Provider agrees to follow all provisions in the service authorization and the Plan of Care. The Care Manager may, upon the consent of the client or the client's authorized representative, discontinue services with the Provider and start services with a new provider at any time

14 If the Care Manager verbally or informally authorizes the Provider to perform certain services not included in a current service authorization, the Provider may perform such services for a maximum of ten (10) business days without a formal service authorization. The Provider may continue performing the services after such time period only if the Care Manager formally validates the service authorization

15. The Provider shall retain in the client's file all service authorizations and modifications entered by the Care Manager in the website portal.

Scheduling Changes; Modifications to Service Authorizations

16 Providers of adult day care services shall notify the Care Manager of scheduling changes for any reason as soon as they are known, including, but not limited to, changes due to inclement weather or the unavailability of the Provider's staff

17 When the Provider cannot provide a service as specified in the service authorization for any reason, including, but not limited to, hospitalization of the client, unavailability or absence of the Provider's staff, and unavailability of the client (a "service interruption"), the Provider shall notify the Care Manager as soon as possible prior to the scheduled service The Provider shall document such service interruption and the Provider's notification to the Care Manager in the client's file

18 The Care Manager shall notify the Provider of any service interruptions that are known to the Care Manager The Provider shall document any such notifications in the client's file including the name of the Care Manager's staff person who contacted the Provider; the date of the contact; and the effective date of the service interruption The Care Manager shall notify the Provider if service is resumed and if there is any change to the original service authorization

19 Except for Personal Emergency Response Systems or modifications to the client's home that need to be completed before a client returns from a hospital or institution, the Provider shall not bill and DSS shall not pay the Provider for any services provided while a client is hospitalized or institutionalized unless the Provider obtains the Care Manager's prior written approval to provide such services, as documented in a modified service authorization

20 When the Care Manager discontinues the Provider's provision of services to a client for any reason, it shall notify the Provider immediately and confirm such discontinuation not more than ten (10) business days after the verbal or informal notification by discontinuing the service authorization.

21 If a Provider wishes to discontinue providing services to a client, Provider shall notify the Care Manager in writing not less than fourteen (14) days before the proposed date of discontinuation

22. If the Provider requests additional service time or a change from the services specified in the service authorization, the Provider shall obtain the Care Manager's consent before implementing the change

Provider's Documentation of Services

23 The Provider shall maintain a separate file for each client Such file shall contain, at a minimum timesheets signed by the client and by Provider's employee(s), client signature approval, the Care Manager's service authorizations, provider reports, written notes and any other documentation specific to the client's Plan of

Care, service goals and any other materials required by the Provider's licensure, certification, or internal protocols. An electronic visit verification may be utilized to replace signed time and activity sheets

24 The Provider shall maintain the following documentation for each service as specified below, including the complete date information (month, day and year) on all documents

a Skilled Nursing, Professional Therapies, and Professional Counseling: Client signature (one time only) on file, and professional notes signed by the responsible professional documenting each visit

b. Home Health Aide, Homemaker, Companion, Chore Services and other hourly services: Daily time sheets signed by the client and the Provider's employee for each visit and the details of each day's activities, or a combined time sheet and activity sheet signed by the client and the Provider's employee. The Provider shall document the exact start and end time of the visit on each sheet.

c. Adult Day Care or ABI Group Day Attendance log indicating a half-day or full-day session, approved and signed by the Director of the adult day care center each day

d. Personal Emergency Response System Signature of client on installation agreement. Personal Emergency Response System providers shall prorate their first month's invoice for monitoring service when installation occurs after the fifteenth (15th) day of the month

e. The requirement for signed time and activity sheets may be replaced upon the implementation of a Department-sponsored electronic visit verification system

25 If a client cannot sign the client's full name or refuses to do so, the Provider may use one of the following substitute signatures:

a an "X" made by the client or signature of authorized representative,

b initials made by the client,

c. the signature of a "live-in" relative,

d. the signature of a responsible friend or neighbor, or

e. a written notation by the caregiver (i e the Provider's employee) that the client is unable to sign

26 The Provider may use electronic timekeeping as an alternative to hard copy timesheets, provided that the electronic timekeeping system meets all requirements established by DSS and the Care Manager Records and documents produced by such system shall demonstrate that the services provided by the caregiver have been provided in the manner and time frame prescribed in the Plan of Care and service authorizations. Such records shall be retrievable by client name or number for complete and historic clinical and billing information While the Provider may also use an electronic recordkeeping system for the Provider's internal daily operation, the Provider shall comply with all requirements regarding the retention of original or source documentation

27 The Provider shall submit the following reports to the Care Manager

a A verbal status report to the Care Manager on each client who receives services from the Provider not later than ten (10) business days after the start of service,

b Periodic verbal status reports to the Care Manager describing any change in a client's condition, including the client's admission to a hospital, nursing home, or travel out of area,

c. A written client services progress report on the results of authorized services to coincide with the frequency of scheduled team meetings until the service is terminated, including the amount and type of services supplied to the client. This requirement does not apply to Personal Emergency Response Systems or Home-Delivered Meals

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS ADDENDUM TO PROVIDER ENROLLMENT AGREEMENT, AND HAVING READ THIS ADDENDUM AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, BOTH INDIVIDUALLY AND ON BEHALF OF THE

PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

NEUROSTRATEGIES, INC.

Provider Entity Name (doing business as)

TARIQ M ABDULAZIZ

Name of Provider or Authorized Representative (type/print name)

TARIQ M ABDULAZIZ

Signature of Provider or Authorized Representative

EXHIBIT F

STATE OF CONNECTICUT

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

May 20, 2014

I. David Marder, Esq.
Marder & DeFelice Law Office, LLC
76 South Frontage Road
Vernon, CT 06066-5518

Dear Attorney Marder,

The purpose of this letter is to respond to your letter, dated May 13, 2014, in which you seek information about the Department of Social Services' (the "Department") authority to review Tariq Abdulaziz's records.

As you know, on April 21, 2014, the Department notified Tariq Abdulaziz, that the Department would be conducting an on-site visit to review records supporting claims paid under the Acquired Brain Injury ("ABI") Medicaid Waiver Program The Department and your client agreed that this review would take place on May 13, 2014. This date was postponed due to your request

In its April 21, 2014 letter, the Department noted that its request to review your client's records was in accordance with item nine of the provider agreement your client signed on January 15, 2004. Item nine states that Tariq Abdulaziz "will maintain records that fully disclose services and goods rendered and/or delivered to ABI waiver participants. These records will be made available to authorized representatives of the Department upon request."

Additionally, section 17b-260a-16 of the Regulations of Connecticut State Agencies, which was noticed on March 26, 2013, and became effective on April 1, 2013, provides as follows:

> (a) Providers are required to retain records to document services submitted for Medicaid reimbursement for at least five years from the date the service or item was provided. Documentation shall include the following:
>
> (1) Individual's name and the signature of the individual or their legal representative;
> (2) provider's name and signature;
> (3) dates of service;
> (4) start time for each visit;
> (5) end time for each visit; and
> (6) a brief description of duties performed.

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

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

At this time, in accordance with the provider agreement your client signed and section 17b-260a-16 of the Regulations of Connecticut State Agencies, the Department is requesting immediate access to your client's records. The Department's Quality Assurance division will contact your client to schedule a time for the record review.

Regarding your client's requests for copies of service plans, it is my understanding that the Department has and will continue to be accommodating to your client's requests. Your client's requests for service plans, however, are not relevant to the records review authorized by the provider agreement and section 17b-260a-16 of the Regulations of Connecticut State Agencies and should not delay the records review.

Sincerely,

Joseph A. Smiga
Staff Attorney, DSS

Enc. ABI Regulations
Provider Agreement

EXHIBIT G

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE • HARTFORD, CONNECTICUT 06105

August 22, 2014

I. David Marder, Esq
Marder & DeFelice Law Office, LLC
76 South Frontage Road
Vernon, CT 06066-5518

Re: NeuroStrategies, Inc. – Tariq Abdulaziz

Dear Attorney Marder,

The purpose of this letter is to respond to your correspondence to me, dated May 22, 2014 and August 6, 2014

In your August 6, 2014 letter, you question social workers' requests for monthly reports for 2013. Such requests should not have been made.

Next, you want to know about the audit standards that apply to the Department's review of your client's records It is not clear what you mean by this question The Department conducted a records review in accordance with the Provider Agreement your client signed on January 15, 2004 and section 17b-260a-16(b) of the regulations, which states that, "[u]pon written request presented to the provider, the department ..may be given immediate access to, and permitted to review and copy any and all records and documentation used to support claims billed to Medicaid." As mentioned in my letter to you, dated May 28, 2014, the purpose for this records review is to review the documentation that supports the services your client claimed to have provided, for which the Department paid.

By signing the Provider Agreement, your client has agreed to maintain records that fully disclose services and goods rendered and/or delivered to ABI Waiver participants. Your client will be held to that standard. Moreover, for services provided on or after April 1, 2013, your client will be held to the standards outlined in section 17b-260a-16(a) of the regulations. This section provides as follows:

> 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.

In your May 22, 2014 letter, you also ask for information about the adoption of the Department's ABI waiver regulations These are new policies necessary to conform to the requirement of an approved federal waiver, and the statute is clear that the Department may operate under them until the time final regulations are effective. *See* Conn. Gen. Stat. § 17b-10(b). The Department published its Notice of its Intent to adopt the regulations on March 26, 2013, five days prior to the policy going into effect on April 1, 2013. The Department, therefore, complied fully with section 17b-10(b) of the Connecticut General Statutes.

Moreover, contrary to the representation in your letter, the Department received only one set of comments to the proposed regulation, and did not get any requests for a hearing. Accordingly, pursuant to section 4-168(a) of the Connecticut General Statutes, there was no reason for the Department to hold a hearing on these proposed regulations.

You point out that there is a typographical error in the Notice of Intent ("NOI"), i e , the NOI cites to section 17b-260b, rather than section 17b-260a, of the Connecticut General Statutes as the statutory authority for the proposed regulations. Nevertheless, it is clear that the NOI is announcing the Department's intent to adopt regulations for the ABI waiver program, as confirmed by multiple references to the ABI waiver program in the opening paragraph of the NOI and in the Statement of Purpose. There is no possibility that, despite the incorrect citation, anyone reading this NOI would misunderstand its meaning The Department provided sufficient notice to the public of its intention to adopt regulations concerning the ABI waiver program, and that the implementation date for the proposed regulation was April 1, 2013.

Finally, you asked for confirmation that "the specifics of the proposed regulations have not yet been developed" indicating that "the providers have not been notified of any such details and given a reasonable amount of time to comply." Providers have been duly notified of the regulatory requirements and have been given ample time to comply; the regulations were noticed over a year ago.

As noted in the Department's response to comments, there are some aspects of the proposed regulation that are still being developed As also noted, once the Department has specified such details, it will notify providers and give them a reasonable amount of time to comply with any new requirements.

Sincerely,

Joseph A. Smiga
Staff Attorney, DSS

Phone 860-424-5760 Information 1-800-462-0134 and TDD/TTY 1-800-842-4524 Fax 860-424-5729
http //www.ct.gov/dss/olcrah

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EXHIBIT H

STATE OF CONNECTICUT

Welcome, Tariq Abdulaziz Help | Preferences | Logout

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RE: follow up information on cognitive behavioral service

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From Brenda Parrella <Brenda.Parrella@ct.gov>

To Tracey Sondik <tmsondik@aol.com>, Susan Smith <psacsmith@cox.net>, gileadhillfive@att.net <gileadhillfive@att.net>, John Stanwood <jstanwood@hfsc.org>, Jennifer Collon <jcollon@escrec.org>, Eugene Piasetsky <nbirs@comcast.net>, Annemarie Murphy <goldpsych@earthlink.net>, kim@clinicalneuropsych.com <kim@clinicalneuropsych.com>, msjphd434@aol com <msjphd434@aol com>, Michelle Brisman <mbrisman@stfranciscare.org>, tbelliveau@hfsc.org <tbelliveau@hfsc.org>, Rachel Sampson <rsampson02@sbcglobal.net>, erin conneely <econneely@sbcglobal.net>, Kathy Bruni <Kathy a Bruni@ct.gov>, Christine Smith <ccsmith221@aol.com>, jameswpier@sbcglobal.net <jameswpier@sbcglobal.net>, barbara.rhein.phd@sbcglobal.net <barbara.rhein.phd@sbcglobal.net>, joseph.struckus@snet.net <joseph.struckus@snet.net>, barbara@4ablsolutions.com <barbara@4ablsolutions.com>, Steven Brown <sbrown@hfsc.org>, bhunter@futures-ct.org <bhunter@futures-ct.org>, Lisa Holme <holme@att.net>, marshallgladstone@hotmail.com <marshallgladstone@hotmail.com>, elaine burns <ctblsn@live.com>, drbrockett@sbcglobal.net <drbrockett@sbcglobal.net>, Layth Haddaf <lhaddad@sagerehab.org>, Kathleen Lord <kathleenlord@sbcglobal.net>, Tariq Abdulaziz <tariqabdulaziz@neurostrategies.info>

CC Kate McEvoy <Kate.McEvoy@ct.gov>, Phyllis Hyman <Phyllis.Hyman@ct.gov>

Date 2 December 2015 16:05

Expires in 20 days

RE: follow up information on cognitive behavioral service

MailGate SC

Dear Mr Abdulaziz

The Department administers the ABI waiver program in accordance with the terms of the waiver approved by both the Connecticut General Assembly and CMS. We are required to do so as a condition of receiving federal matching funds

There is no requirement that every operational detail of the waiver be memorialized in state regulations or in the ABI provider agreement.

ABI waiver providers have been provided with the information necessary to comply with the new waiver provisions

Brenda Parrella

Brenda Parrella

Agency Legal Director

Department of Social Services

55 Farmington Avenue

Hartford, CT 06105

860-424-5104

Brenda.parrella@ct.gov

EXHIBIT I

15. 10. 3005

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Boston Regional Office
JFK Federal Building, Government Center
Room 2325
Boston, Massachusetts 02203

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations / Boston Regional Office

October 22, 2015

RECEIVED
State of Connecticut
OCT 27 2015
Dept. of Social Services
Commissioner's Office

Roderick L. Bremby, Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, Connecticut 06105

Dear Mr. Bremby:

I am pleased to inform you that the State's revised request to amend the home and community-based services (HCBS) waiver for individuals with acquired brain injuries (ABI II) is approved as authorized under the provisions at Section 1915(c) of the Social Security Act (the Act). The HCBS waiver serves Medicaid eligible individuals who meet the State's criteria for the level of care in nursing facilities, ABI nursing facilities, hospitals and intermediate care facilities for individuals with intellectual disabilities. This amendment is assigned control number CT-1085.R00.02, which should be used in any future correspondence. The approved amendment is in the Waiver Management System.

The State submitted the amendment on August 26, 2015, to modify the definition of cognitive behavioral services and to establish the service as being provided utilizing two procedure codes, one for face-to-face in person services and one for non-face-to-face activities.

The approved estimates for waiver utilization and expenditures are:

	C Waiver Participants	D Average Annual Waiver Costs	TOTAL
Year 2	180	106,639.73	19,195,151.22
Year 3	255	111,088.18	28,327,485.53
Year 4	330	115,155.55	38,001,333.15
Year 5	405	119,348.06	48,335,964.64

The amendment request conforms fully to the requirements of the Act and regulations. I am approving the amendment with the effective date of December 1, 2015, as you requested. If you have questions concerning this letter, please call Nancy Grano at (617) 565-1695.

Sincerely,

Richard R. McGreal
Associate Regional Administrator

EXHIBIT J

Elaine

Elaine Burns
CTBISN
860-655-4688
Www.CTBISN.org

Date: Tue, 1 Dec 2015 15:32:58 -0500
To: kathy.a.bruni@ct.gov; goldpsych@earthlink.net; barbara@4abisolutions.com; barbara.rhein.phd@sbcglobal.net; ccsmith221@aol.com; drbrockett@sbcglobal.net; econneely@sbcglobal.net; nbirs@comcast.net; jcollon@escrec.org; jameswpier@sbcglobal.net; joseph.struckus@snet.net; jstanwood@hfsc.org; kathleenlord@sbcglobal.net; kim@clinicalneuropsych.com; "lha ddad"@sagerehab.org; holme@att.net; marshallgladstone@hotmail.com; msjphd434@aol.com; mbrisman@stfranciscare.org; bhunter@futures-ct.org; rsampson02@sbcglobal.net; sbrown@hfsc.org; gileadhillfive@att.net; psacsmith@cox.net; tbelliveau@hfsc.org; tmsondik@aol.com
CC: ctbisn@live.com
Subject: Re: follow up information on cognitive behavioral service
From: tariqabdulaziz@neurostrategies.info

Hi Kathy

Please see attached. The change is not posted on the eRegulations system. The change is not effective until after it is posted

When the notification is on the system please send us an email.

Thank you

Tariq Abdulaziz

On 12/1/2015 at 1:38 PM, "Kathy A. Bruni (DSS)" <Kathy.a.Bruni@ct.gov> wrote:

> This email serves as a follow up to the email you received from Valerie Giannelli at Allied regarding the changes to the cognitive behavioral service effective today, 12/1 Thank you to all who assisted in the revision of the service definition and to those who provided input. The final version in the approved waiver is as follows:
>
> Individual interventions designed to increase an individual's cognitive and behavioral capabilities and to further the individual's adjustment to successful community engagement including:
>
> - 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 waiver participant, support system and

providers concerning cognitive and behavioral strategies and interventions specified in the cognitive/ behavioral intervention plan

- Ongoing or periodic assistance with training of the waiver participant, support system and providers concerning cognitive behavior strategies and interventions

- Periodic reassessment and revision as needed, of the cognitive/behavioral intervention plan

This service is performed within the context of the individual's person-centered team, in concert with the case manager. Cognitive/behavioral programs may be provided in the individual's home or in the community in order to reinforce the training in a real-life situation.

The service will be delivered utilizing two procedure codes, one for in person face to face visits that include the participant, providers and/or supporters. A quarterly, in person meeting with the waiver participant is required for this service.

The second procedure code is for non face-to-face service that includes development of the cognitive behavioral plan and phone or other types of interactions with participants, providers or supporters

Just for the purposes of clarification. The service plan will not differentiate face to face versus non face to face hours. As a provider, you can determine that breakdown as long as the billing doesn't exceed the authorized hours in the service plan. Please note the significant increase in the rate for providing the in person service.

Kathy Brunl, MPA, LCSW

Director, HCBS Unit

Department of Social Services

55 Farmington Ave.

Hartford, CT 06105

Phone: 860-424-5177

Fax: 860-424-4963

Tariq Abdulaziz; Ph.D., M.S., M.S., MBA
President and Director

STATE OF CONNECTICUT
OFFICE OF CLAIMS COMMISSIONER

In Re Claim of Tariq Abdulaziz, Ph.D., M.S., MBA, and Neurostrategies, File No. 24260

Affidavit of John F. McCormick

John F. McCormick, being duly sworn, deposes and says:

1. That he is employed by the Department of Social Services as its Director, Office of Quality Assurance.

2. The Office of Quality Assurance conducted an on-site visit to Neurostrategies, Inc./Tariq Abdulaziz to review client records supporting claims for reimbursement paid under the Acquired Brain Injury Medicaid Waiver Program.

3. On or about July 10, 2015, I received the attached request, marked as Exhibit C-2, from Michael Kogut, Esq., on behalf of Neurostrategies, Inc./Tariq Abdulaziz, requesting "a complete copy of the provider's file in your office."

4. I responded to Attorney Kogut's request on August 2, 2015 by declining to produce the requested filed, indicating that, "The Department's file concerning this record review is not public information in accordance with sections 1-210(b)(13) and 4-276 of the Connecticut General Statutes." A true copy of my August 2, 2015 is attached hereto as Exhibit C-3.

5. Neither Attorney Kogut, Neurostrategies, Inc. nor Tariq Abdulaziz subsequently challenged my refusal to produce the requested provider file by requesting an administrative hearing before the Freedom of Information Commission.

John F. McCormick

Exhibit C-1

382

ss: Hartford, Connecticut

John F. McCormick, being duly sworn, personally appeared before me on this 6th day of Sept 2016 and swore to the truth of the foregoing statements.

Brenda M Lanella

Commissioner of the Superior Court

383

THE
LAW OFFICES OF
MICHAEL T. KOGUT

75 MARKET PLACE
SPRINGFIELD, MA 01103

TELEPHONE 413.348.2167
FACSIMILE 413.739-7168
MKOGUT@KOGUTLAW.COM

July 10, 2015

VIA ELECTRONIC MAIL ONLY
Mr. John F. McCormick
Office of Quality Assurance
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Re: **Neurostrategies, Inc/Tariq Abdulaziz, Ph.D., MS., MBA**
23 Kate Way, Windsor Locks, CT 06096

Dear Mr. McCormick:

Please be advised that the undersigned represents the above-named Neurostrategies, Inc. and Tariq Abdulaziz, Ph.D., M.S., MBA.

I understand that the Office of Quality Assurance of the Department of Social Services ("Department") conducted an audit of this provider one year ago. To date, the provider has not received any information relative to your audit.

By this correspondence, I am formally requesting a complete copy of the provider's file in your office, including but not limited to, a draft audit, notes, memoranda, electronioc correspondence and work papers relative to your audit.

Kindly forward all such information within seven (7) days. If not received, I have been authorized to take necessary action to obtain this information.

I have also been authorized to review the manner in which the Department terminated the previous provider agreement to determine whether such action was within legal and regulatory authority of the Department.

Thanking you for your attention to this matter, I remain,

Very truly yours,
/s/Michael T. Kogut
Michael T. Kogut

Cc: Tariq Abdulaziz, Ph.D., M.S., MBA

Exhibit C-2

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF QUALITY ASSURANCE

John F. McCormick, CPA
Director

Telephone
(860) 424-5920
Facsimile
(860) 424-5900

August 2, 2015

Michael T. Kogut
The Law Offices of Michael T. Kogut
75 Market Place
Springfield, MA 01103

Re: Neurostrategies, Inc. / Tariq Abdulaziz

Dear Mr. Kogut:

The purpose of this letter is to respond to your communication to me, dated July 10, 2015, concerning the above-referenced provider (the "provider").

With regard to your request for the provider's file, the Department of Social Services (the "Department") did not conduct an audit, as you state in your letter. Rather, the Department conducted an on-site visit to review the client's records supporting claims paid under the Acquired Brain Injury Medicaid Waiver Program. This was done pursuant to the provider agreements that the provider signed on January 15, 2004 and October 23, 2014.

The Department's file concerning this record review is not public information, in accordance with sections 1-210(b) (13) and 4-276 of the Connecticut General Statutes. Accordingly, the Department will not be sending you the information in the provider's file.

Finally, contrary to the statement in your letter, the Department has not terminated any provider agreement with the provider.

Sincerely,

John F. McCormick, Director
Office of Quality Assurance

JFM

Cc: Kathleen Brennan, Deputy Commissioner
David Dearborn, Director of Communications
Brenda Parrella, Director of Legal Counsel, Regulations & Administrative Hearings
Kathy Bruni, Director of Alternate Care Unit

Exhibit C-3

385