



General Assembly

February Session, 2002

Bill No. 5023

LCO No. 476

Referred to Committee on Appropriations

Introduced by:

REP. WARD, 86th Dist.

SEN. DELUCA, 32nd Dist.

AN ACT CONCERNING IMPLEMENTING THE GOVERNOR'S BUDGET REGARDING THE DEPARTMENT OF SOCIAL SERVICES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 20 of public act 01-2 of the June special session is
2 repealed and the following is substituted in lieu thereof (*Effective July*
3 *1, 2002*):

4 Notwithstanding any provision of this chapter, the Commissioner of
5 Social Services may [implement a mandatory program of primary care
6 case management] enter into a contract with a consortium of federally-
7 qualified community health centers to provide medical assistance to
8 beneficiaries eligible under sections 17b-257 and 17b-259, as amended
9 by this act. [The Department of Social Services may enter into contracts
10 for medical services and program management to implement the
11 provisions of this section.]

12 Sec. 2. Section 17b-257 of the general statutes, as amended by section
13 59 of public act 01-2 of the June special session and section 129 of

14 public act 01-9 of the June special session, is repealed and the following
15 is substituted in lieu thereof (*Effective July 1, 2002*):

16 On and after July 1, 1998, the Commissioner of Social Services shall
17 implement a state medical assistance program for persons ineligible for
18 Medicaid and on or before April 1, 1997, the commissioner shall
19 implement said program in the towns in which the fourteen regional
20 or district offices of the Department of Social Services are located. The
21 commissioner shall establish a schedule for the transfer of recipients of
22 medical assistance administered by towns under the general assistance
23 program to the state program. To the extent possible, the
24 administration of the state medical assistance program shall parallel
25 that of the Medicaid program as it is administered to recipients of
26 temporary family assistance, including eligibility criteria concerning
27 income and assets. Payment for medical services shall be made only
28 for individuals determined eligible. The rates of payment for medical
29 services shall be those of the Medicaid program. Medical services
30 covered under the program shall be those covered under the Medicaid
31 program, except that eye care, optical hardware and optometry care,
32 home health care, durable medical equipment, podiatry, chiropractic,
33 natureopathy, nonemergency medical transportation and long-term
34 care and services available pursuant to a home and community-based
35 services waiver under Section 1915 of the Social Security Act shall not
36 be covered. On or after April 1, 1997, the commissioner shall
37 implement a managed care program for medical services provided
38 under this program, except services provided pursuant to section 17a-
39 453a. Notwithstanding the provisions of sections 4a-51 and 4a-57, the
40 commissioner may enter into contracts, including, but not limited to,
41 purchase of service agreements to implement the provisions of this
42 section.

43 Sec. 3. Subsection (b) of section 17b-259 of the general statutes, as
44 amended by section 60 of public act 01-2 of the June special session
45 and sections 107 and 129 of public act 01-9 of the June special session,
46 is repealed and the following is substituted in lieu thereof (*Effective July*

47 1, 2002):

48 (b) The medical services for which a town shall be liable under this
49 section and for which a town shall be reimbursed by the state shall be
50 limited to the following medically necessary services provided such
51 services are covered under the Medicaid program: (1) Physician
52 services, (2) hospital services, on an inpatient basis subject to the
53 provisions of section 17b-220 and outpatient care, (3) community clinic
54 services, (4) prescription drugs, excluding over-the-counter drugs, (5)
55 hearing aids, (6) laboratory and x-ray services, (7) emergency dental
56 services, (8) emergency medical transportation, [(9) glasses, and (10)]
57 and (9) examinations (A) needed to determine unemployability, or (B)
58 requested by an attorney to establish the eligibility of a person
59 receiving general assistance benefits for federal supplementary
60 security income benefits pursuant to section 17b-119. Services not
61 covered under this program include, but are not limited to,
62 nonemergency medical transportation, eye care, optical hardware and
63 optometry care, home health care, durable medical equipment,
64 podiatry, chiropractic and natureopathy. In lieu of providing medical
65 services, in accordance with this section, a town or group of towns
66 may submit a plan to the Department of Social Services for approval to
67 provide medical services in some other manner. The department shall
68 approve the plan only if the persons served under it receive at least the
69 services listed in this subsection and the plan offers the possibility of
70 improved medical care or cost savings. The department shall
71 encourage a town or group of towns to contract for the management of
72 such medically necessary services.

73 Sec. 4. (NEW) (*Effective July 1, 2002*) (a) The Commissioner of Social
74 Services may seek a federal waiver to (1) implement a pilot program to
75 provide subsidies toward employee premium costs that are required
76 for participation in an employer-sponsored health care plan for (A)
77 parents or needy caretaker relatives of children under nineteen years
78 of age, and (B) adults who have no children, and (2) upon
79 implementation of the waiver, provide coverage under HUSKY Plan,

80 Part B to parents or needy caretaker relatives of children under
81 nineteen years of age whose income is under one hundred fifty per
82 cent of the federal poverty level.

83 (b) Participation in the subsidized employee premium pursuant to
84 the waiver shall be limited to applicants who have household incomes
85 below one hundred eighty-five per cent of the federal poverty level.
86 The waiver may include, but shall not be limited to, the following
87 components: (1) A subsidy that pays (A) no more than sixty dollars a
88 month for a premium that an employee with no children is required to
89 pay to participate in an employer-sponsored health care plan, and (B)
90 no more than one hundred dollars a month for each family member for
91 families that consist of parents or needy caretaker relatives with
92 children under nineteen years of age for a premium that such family is
93 required to pay to participate in an employer-sponsored health care
94 plan; (2) an identification of the minimum benefits standard that an
95 employer-sponsored health plan is required to meet to qualify for
96 participation in the pilot program; (3) a limitation on the number of
97 pilot program participants to assure the program is operated within
98 available appropriations; (4) an option for the commissioner to contract
99 with a private entity to administer the pilot program; and (5) a plan for
100 the evaluation of the cost effectiveness and client satisfaction for
101 persons enrolled in the subsidized employee premium pilot program.

102 Sec. 5. Subsection (a) of section 17b-261 of the general statutes, as
103 amended by section 3 of public act 01-2 of the June special session and
104 section 129 of public act 01-9 of the June special session, is repealed
105 and the following is substituted in lieu thereof (*Effective July 1, 2002*):

106 (a) Medical assistance shall be provided for any otherwise eligible
107 person whose income, including any available support from legally
108 liable relatives and the income of the person's spouse or dependent
109 child, is not more than one hundred forty-three per cent, pending
110 approval of a federal waiver applied for pursuant to subsection (d) of
111 this section, of the benefit amount paid to a person with no income

112 under the temporary family assistance program in the appropriate
113 region of residence and if such person is an institutionalized
114 individual as defined in Section 1917(c) of the Social Security Act, 42
115 USC 1396p(c), and has not made an assignment or transfer or other
116 disposition of property for less than fair market value for the purpose
117 of establishing eligibility for benefits or assistance under this section.
118 Any such disposition shall be treated in accordance with Section
119 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
120 property made on behalf of an applicant or recipient or the spouse of
121 an applicant or recipient by a guardian, conservator, person
122 authorized to make such disposition pursuant to a power of attorney
123 or other person so authorized by law shall be attributed to such
124 applicant, recipient or spouse. A disposition of property ordered by a
125 court shall be evaluated in accordance with the standards applied to
126 any other such disposition for the purpose of determining eligibility.
127 The commissioner shall establish the standards for eligibility for
128 medical assistance at one hundred forty-three per cent of the benefit
129 amount paid to a family unit of equal size with no income under the
130 temporary family assistance program in the appropriate region of
131 residence, pending federal approval, except that the medical assistance
132 program shall provide coverage to persons under the age of nineteen
133 up to one hundred eighty-five per cent of the federal poverty level
134 without an asset limit. On and after January 1, 2001, said medical
135 assistance program shall also provide coverage to persons under the
136 age of nineteen and their parents and needy caretaker relatives who
137 qualify for coverage under Section 1931 of the Social Security Act with
138 family income up to one hundred fifty per cent of the federal poverty
139 level without an asset limit, upon the request of such a person or upon
140 a redetermination of eligibility, provided no such Section 1931 medical
141 assistance shall be provided to said children, parents or needy
142 caretaker relatives with income above one hundred per cent of the
143 federal poverty level on or after the implementation date of a waiver
144 obtained pursuant to section 4 of this act. Such levels shall be based on
145 the regional differences in such benefit amount, if applicable, unless

146 such levels based on regional differences are not in conformance with
147 federal law. Any income in excess of the applicable amounts shall be
148 applied as may be required by said federal law, and assistance shall be
149 granted for the balance of the cost of authorized medical assistance. All
150 contracts entered into on and after July 1, 1997, pursuant to this section
151 shall include provisions for collaboration of managed care
152 organizations with the Healthy Families Connecticut Program
153 established pursuant to section 17a-56. The Commissioner of Social
154 Services shall provide applicants for assistance under this section, at
155 the time of application, with a written statement advising them of the
156 effect of an assignment or transfer or other disposition of property on
157 eligibility for benefits or assistance.

158 Sec. 6. Section 17b-292 of the general statutes, as amended by
159 sections 1, 3 and 4 of public act 01-137, is repealed and the following is
160 substituted in lieu thereof (*Effective July 1, 2002*):

161 (a) A child who resides in a household with a family income which
162 exceeds one hundred eighty-five per cent of the federal poverty level
163 and does not exceed three hundred per cent of the federal poverty
164 level may be eligible for subsidized benefits under the HUSKY Plan,
165 Part B.

166 (b) A child who resides in a household with a family income over
167 three hundred per cent of the federal poverty level may be eligible for
168 unsubsidized benefits under the HUSKY Plan, Part B.

169 (c) Whenever a court or family support magistrate orders a
170 noncustodial parent to provide health insurance for a child, such
171 parent may provide for coverage under the HUSKY Plan, Part B.

172 (d) Parents or needy caretaker relatives who have (1) children under
173 nineteen years of age who receive medical assistance pursuant to
174 section 17b-261, as amended by this act, and (2) incomes under one
175 hundred fifty per cent of the federal poverty level may be eligible for
176 subsidized benefits under the HUSKY Plan, Part B. A parent or needy

177 caretaker relative whose incomes exceeds one hundred per cent of the
178 federal poverty level but does not exceed one hundred fifty per cent of
179 the federal poverty level shall be required to pay any premium or
180 copayment in the amount equivalent to that required under the
181 HUSKY Plan, Part B for a family with an income that exceeds two
182 hundred thirty-five per cent of the federal poverty level but does not
183 exceed three hundred per cent of the federal poverty level pursuant to
184 schedules established under section 17b-295.

185 [(d)] (e) A child who has been determined to be eligible for benefits
186 under either the HUSKY Plan, Part A or Part B shall remain eligible for
187 said plan for a period of twelve months from such child's
188 determination of eligibility unless the child attains the age of nineteen
189 years or is no longer a resident of the state.

190 [(e)] (f) To the extent allowed under federal law, the commissioner
191 shall not pay for services or durable medical equipment under the
192 HUSKY Plan, Part B if the enrollee has other insurance coverage for
193 the services or such equipment.

194 [(f)] (g) A newborn child who otherwise meets the eligibility criteria
195 for the HUSKY Plan, Part B shall be eligible for benefits retroactive to
196 his date of birth, provided an application is filed on behalf of the child
197 within thirty days of such date.

198 [(g)] (h) The commissioner shall implement presumptive eligibility
199 for children applying for Medicaid. Such presumptive eligibility
200 determinations shall be in accordance with applicable federal law and
201 regulations. The commissioner shall adopt regulations, in accordance
202 with chapter 54, to establish standards and procedures for the
203 designation of organizations as qualified entities to grant presumptive
204 eligibility. In establishing such regulations, the commissioner shall
205 ensure the representation of state-wide and local organizations that
206 provide services to children of all ages in each region of the state.

207 [(h)] (i) The commissioner shall enter into a contract with an entity

208 to be a single point of entry servicer for applicants and enrollees under
209 the HUSKY Plan, Part A and Part B. The servicer shall jointly market
210 both Part A and Part B together as the HUSKY Plan. Such servicer shall
211 develop and implement public information and outreach activities
212 with community programs. Such servicer shall electronically transmit
213 data with respect to enrollment and disenrollment in the HUSKY Plan,
214 Part B to the commissioner who may transmit such data to the
215 Children's Health Council.

216 [(i)] (j) To the extent permitted by federal law, the single point of
217 entry servicer may be one of the entities authorized to grant
218 presumptive eligibility under the HUSKY Plan, Part A.

219 [(j)] (k) The single point of entry servicer shall send an application
220 and supporting documents to the commissioner for determination of
221 eligibility of a child who resides in a household with a family income
222 of one hundred eighty-five per cent or less of the federal poverty level.
223 The servicer shall enroll eligible beneficiaries in the applicant's choice
224 of managed care plan.

225 [(k)] (l) Not more than twelve months after the determination of
226 eligibility for benefits under the HUSKY Plan, Part A and Part B and
227 annually thereafter, the commissioner or the servicer, as the case may
228 be, shall determine if the child continues to be eligible for the plan. The
229 commissioner or the servicer shall mail an application form to each
230 participant in the plan for the purposes of obtaining information to
231 make a determination on eligibility. To the extent permitted by federal
232 law, in determining eligibility for benefits under the HUSKY Plan, Part
233 A and Part B with respect to family income, the commissioner or the
234 servicer shall rely upon information provided in such form by the
235 participant unless the commissioner or the servicer has reason to
236 believe that such information is inaccurate or incomplete. The
237 determination of eligibility shall be coordinated with health plan open
238 enrollment periods.

239 [(l)] (m) The commissioner shall implement the HUSKY Plan, Part B

240 while in the process of adopting necessary policies and procedures in
241 regulation form in accordance with the provisions of section 17b-10.

242 [(m)] (n) The commissioner shall adopt regulations, in accordance
243 with chapter 54, to establish residency requirements and income
244 eligibility for participation in the HUSKY Plan, Part B and procedures
245 for a simplified mail-in application process. Notwithstanding the
246 provisions of section 17b-257b, such regulations shall provide that any
247 child adopted from another country by an individual who is a citizen
248 of the United States and a resident of this state shall be eligible for
249 benefits under the HUSKY Plan, Part B upon arrival in this state.

250 Sec. 7. Section 17b-280 of the general statutes is repealed and the
251 following is substituted in lieu thereof (*Effective July 1, 2002*):

252 [Notwithstanding any provision of the regulations of Connecticut
253 state agencies concerning payment for drugs provided to Medicaid
254 recipients (1) effective July 1, 1989] Effective September 1, 2002, the
255 state shall reimburse for all legend drugs provided [to such recipients
256 at] under the Medicaid, state-administered general assistance, general
257 assistance, ConnPACE and Connecticut AIDS drug assistance
258 programs at the lower of (1) the rate established by the Health Care
259 Finance Administration as the federal acquisition cost, [or, if no such
260 rate is established, the commissioner shall establish and periodically
261 revise the estimated acquisition cost in accordance with federal
262 regulations. The] or (2) the average wholesale price minus thirteen and
263 one-half per cent. Effective September 1, 2002, the commissioner shall
264 [also] establish a professional fee to be paid to licensed pharmacies for
265 dispensing drugs to Medicaid, state-administered general assistance,
266 general assistance, ConnPACE and Connecticut AIDS drug assistance
267 recipients in accordance with federal regulations; [and (2) on] such fee
268 shall be three dollars and fifty cents for each prescription. On and after
269 September 4, 1991, payment for legend and nonlegend drugs provided
270 to Medicaid recipients shall be based upon the actual package size
271 dispensed. Effective October 1, 1991, reimbursement for over-the-

272 counter drugs for such recipients shall be limited to those over-the-
273 counter drugs and products published in the Connecticut Formulary,
274 or the cross reference list, issued by the commissioner. The cost of all
275 over-the-counter drugs and products provided to residents of nursing
276 facilities, chronic disease hospitals, and intermediate care facilities for
277 the mentally retarded shall be included in the facilities' per diem rate.

278 Sec. 8. (NEW) (*Effective July 1, 2002*) The Commissioner of Social
279 Services may establish maximum allowable costs to be paid under the
280 Medicaid, state-administered general assistance, general assistance,
281 ConnPACE and Connecticut AIDS drug assistance programs for
282 generic prescription drugs based on, but not limited to, actual
283 acquisition costs.

284 Sec. 9. Section 17b-363a of the general statutes is amended by
285 adding subsection (f) as follows (*Effective July 1, 2002*):

286 (NEW) (f) Any long-term care facility that violates or fails to comply
287 with the provisions of this section shall be fined thirty thousand
288 dollars for each incidence of noncompliance. The commissioner may
289 offset payments due a facility to collect the penalty. Prior to imposing
290 any penalty pursuant to this subsection, the commissioner shall notify
291 the long-term care facility of the alleged violation and the
292 accompanying penalty and shall permit such facility to request that the
293 department review its findings. A facility shall request such review
294 within fifteen days of receipt of the notice of violation from the
295 department. The department shall stay the imposition of any penalty
296 pending the outcome of the review. The commissioner may impose a
297 penalty upon a facility pursuant to this subsection regardless of
298 whether a change in ownership of the facility has taken place since the
299 time of the violation, provided the department issued notice of the
300 alleged violation and the accompanying penalty prior to the effective
301 date of the change in ownership and record of such notice is readily
302 available in a central registry maintained by the department. Payments
303 of fines received pursuant to this subsection shall be deposited in the

304 General Fund and credited to the Medicaid account.

305 Sec. 10. (NEW) (*Effective July 1, 2002*) The Commissioner of Social
306 Services may establish a voluntary mail order option for any
307 maintenance prescription drug covered under the Medicaid, state-
308 administered general assistance, general assistance, ConnPACE or
309 Connecticut AIDS drug assistance programs.

310 Sec. 11. (NEW) (*Effective July 1, 2002*) The Commissioner of Social
311 Services may implement a pharmaceutical purchasing initiative by
312 contracting with an established entity for the purchase of maintenance
313 drugs through the lowest pricing available notwithstanding the
314 provisions of section 17b-280 of the general statutes, as amended by
315 this act, for Medicaid, state-administered general assistance, general
316 assistance, ConnPACE and Connecticut AIDS drug assistance
317 recipients. Any entity with whom the commissioner contracts for the
318 purposes of this section shall have an established pharmaceutical
319 network and a demonstrated capability of processing the prescription
320 volume anticipated for Medicaid, state-administered general
321 assistance, general assistance, ConnPACE and Connecticut AIDS drug
322 assistance recipients.

323 Sec. 12. Subdivision (4) of subsection (f) of section 17b-340 of the
324 general statutes, as amended by section 52 of public act 01-2 of the June
325 special session and sections 95 and 129 of public act 01-9 of the June
326 special session, is repealed and the following is substituted in lieu
327 thereof (*Effective July 1, 2002*):

328 (4) For the fiscal year ending June 30, 1992, (A) no facility shall
329 receive a rate that is less than the rate it received for the rate year
330 ending June 30, 1991; (B) no facility whose rate, if determined pursuant
331 to this subsection, would exceed one hundred twenty per cent of the
332 state-wide median rate, as determined pursuant to this subsection,
333 shall receive a rate which is five and one-half per cent more than the
334 rate it received for the rate year ending June 30, 1991; and (C) no
335 facility whose rate, if determined pursuant to this subsection, would be

336 less than one hundred twenty per cent of the state-wide median rate,
337 as determined pursuant to this subsection, shall receive a rate which is
338 six and one-half per cent more than the rate it received for the rate year
339 ending June 30, 1991. For the fiscal year ending June 30, 1993, no
340 facility shall receive a rate that is less than the rate it received for the
341 rate year ending June 30, 1992, or six per cent more than the rate it
342 received for the rate year ending June 30, 1992. For the fiscal year
343 ending June 30, 1994, no facility shall receive a rate that is less than the
344 rate it received for the rate year ending June 30, 1993, or six per cent
345 more than the rate it received for the rate year ending June 30, 1993.
346 For the fiscal year ending June 30, 1995, no facility shall receive a rate
347 that is more than five per cent less than the rate it received for the rate
348 year ending June 30, 1994, or six per cent more than the rate it received
349 for the rate year ending June 30, 1994. For the fiscal years ending June
350 30, 1996, and June 30, 1997, no facility shall receive a rate that is more
351 than three per cent more than the rate it received for the prior rate
352 year. For the fiscal year ending June 30, 1998, a facility shall receive a
353 rate increase that is not more than two per cent more than the rate that
354 the facility received in the prior year. For the fiscal year ending June
355 30, 1999, a facility shall receive a rate increase that is not more than
356 three per cent more than the rate that the facility received in the prior
357 year and that is not less than one per cent more than the rate that the
358 facility received in the prior year, exclusive of rate increases associated
359 with a wage, benefit and staffing enhancement rate adjustment added
360 for the period from April 1, 1999, to June 30, 1999, inclusive. For the
361 fiscal year ending June 30, 2000, each facility, except a facility with an
362 interim rate or replaced interim rate for the fiscal year ending June 30,
363 1999, and a facility having a certificate of need or other agreement
364 specifying rate adjustments for the fiscal year ending June 30, 2000,
365 shall receive a rate increase equal to one per cent applied to the rate the
366 facility received for the fiscal year ending June 30, 1999, exclusive of
367 the facility's wage, benefit and staffing enhancement rate adjustment.
368 For the fiscal year ending June 30, 2000, no facility with an interim rate,
369 replaced interim rate or scheduled rate adjustment specified in a

370 certificate of need or other agreement for the fiscal year ending June
371 30, 2000, shall receive a rate increase that is more than one per cent
372 more than the rate the facility received in the fiscal year ending June
373 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a
374 facility with an interim rate or replaced interim rate for the fiscal year
375 ending June 30, 2000, and a facility having a certificate of need or other
376 agreement specifying rate adjustments for the fiscal year ending June
377 30, 2001, shall receive a rate increase equal to two per cent applied to
378 the rate the facility received for the fiscal year ending June 30, 2000,
379 subject to verification of wage enhancement adjustments pursuant to
380 subdivision (15) of this subsection. For the fiscal year ending June 30,
381 2001, no facility with an interim rate, replaced interim rate or
382 scheduled rate adjustment specified in a certificate of need or other
383 agreement for the fiscal year ending June 30, 2001, shall receive a rate
384 increase that is more than two per cent more than the rate the facility
385 received for the fiscal year ending June 30, 2000. For the fiscal year
386 ending June 30, 2002, each facility shall receive a rate that is two and
387 one-half per cent more than the rate the facility received in the prior
388 fiscal year. For the fiscal year ending June 30, 2003, each facility shall
389 receive a rate that is two per cent more than the rate the facility
390 received in the prior fiscal year except that such increase shall be
391 effective August 1, 2002, and such facility rate in effect for the fiscal
392 year ending June 30, 2002, shall be paid for services provided in July,
393 2002. The Commissioner of Social Services shall add fair rent increases
394 to any other rate increases established pursuant to this subdivision for
395 a facility which has undergone a material change in circumstances
396 related to fair rent.

397 Sec. 13. Section 17b-346 of the general statutes is repealed and the
398 following is substituted in lieu thereof (*Effective July 1, 2002*):

399 (a) Effective October 1, 1991, every chronic and convalescent
400 nursing home, chronic disease hospital associated with a chronic and
401 convalescent nursing home, and rest home with nursing supervision,
402 that participates in the medical assistance program provided in Title

403 XIX of the Social Security Act shall, as a condition of participation in
404 said program, if eligible, maintain or execute a provider agreement
405 with the Secretary of Health and Human Services to participate in the
406 Medicare program under Title XVIII of the Social Security Act to the
407 same extent that the facility participates in the Title XIX medical
408 assistance program. [However, such facility may seek the approval of
409 the Department of Social Services to have a larger portion of its facility
410 certified for the Title XIX medical assistance program than for the Title
411 XVIII Medicare program if the facility is certified for a distinct part
412 pursuant to the Title XVIII Medicare program and the facility
413 demonstrates to the satisfaction of the department that the number of
414 beds in the distinct part will be adequate to ensure access to Title XVIII
415 Medicare certified beds to all eligible Title XVIII recipients who might
416 reasonably be expected to seek admission to, or return to, such
417 facility.]

418 (b) The commissioner may issue a rate for any facility which fails to
419 comply with the provisions of this section provided such rate may not
420 be lower than the lowest rate paid to a facility for the same level of
421 care.

422 Sec. 14. Subsection (a) of section 17b-492 of the general statutes, as
423 amended by section 22 of public act 01-2 of the June special session
424 and section 129 of public act 01-9 of the June special session, is
425 repealed and the following is substituted in lieu thereof (*Effective July*
426 *1, 2002*):

427 (a) Eligibility for participation in the program shall be limited to any
428 resident (1) who is sixty-five years of age or older or who is disabled,
429 (2) (A) whose annual income, if unmarried, is less than thirteen
430 thousand eight hundred dollars, except after April 1, 2002, such annual
431 income is less than twenty thousand dollars, or whose annual income,
432 if married, when combined with that of the resident's spouse is less
433 than sixteen thousand six hundred dollars, except after April 1, 2002,
434 such combined annual income is less than twenty-seven thousand one

435 hundred dollars, or (B) in the event the program is granted a waiver to
436 be eligible for federal financial participation, then, after July 1, 2002,
437 whose annual income, if unmarried, is less than twenty-five thousand
438 eight hundred dollars, or whose annual income, if married, when
439 combined with that of the resident's spouse is less than thirty-four
440 thousand eight hundred dollars, (3) who is not insured under a policy
441 which provides full or partial coverage for prescription drugs once a
442 deductible amount is met, [and] (4) whose available assets are below
443 fifty thousand dollars if unmarried and seventy-five thousand dollars
444 if married, (A) the asset limit for a married resident shall be
445 determined by combining the value of assets available to both spouses,
446 and (B) for the purposes of this section available assets are those that
447 are considered available in determining eligibility in the Connecticut
448 Home Care For Elders Program, and (5) on and after September 15,
449 1991, who pays an annual twenty-five-dollar registration fee to the
450 Department of Social Services. Effective January 1, 2002, the
451 commissioner shall commence accepting applications from individuals
452 who will become eligible to participate in the program as of April 1,
453 2002. On January 1, 1998, and annually thereafter, the commissioner
454 shall, by the adoption of regulations in accordance with chapter 54,
455 increase the income limits established under this subsection over those
456 of the previous fiscal year to reflect the annual inflation adjustment in
457 Social Security income, if any. Each such adjustment shall be
458 determined to the nearest one hundred dollars.

459 Sec. 15. Section 4 of public act 01-2 of the June special session is
460 repealed and the following is substituted in lieu thereof (*Effective July*
461 *1, 2002*):

462 (a) The Commissioner of Social Services shall seek a waiver of
463 federal law for the purpose of establishing that the penalty period
464 during which an applicant for or recipient of assistance for long-term
465 care under the Medicaid program is ineligible for Medicaid-funded
466 services due to a transfer of assets for less than fair market value shall
467 begin in the month the applicant is found otherwise eligible for

468 Medicaid coverage of services rather than in the month of the transfer
469 of assets. This section shall only apply to transfers that occur on or
470 after the effective date of the waiver. The provisions of section 17b-8
471 shall apply to this section.

472 (b) Any transfer or assignment of assets resulting in the imposition
473 of a penalty period under this section shall be presumed to be made
474 with the intent, on the part of the transferee, to enable the transferor to
475 obtain or maintain eligibility for medical assistance. This presumption
476 may be rebutted only by clear and convincing evidence that the
477 transferor's eligibility or potential eligibility for medical assistance was
478 not a basis for the transferee's acceptance of the transfer or assignment.

479 (c) On or after the implementation date of an approved waiver
480 under this section, the Commissioner of Social Services may adopt
481 regulations, in accordance with the provisions of chapter 54, to allow
482 the transferor to establish undue hardship in the case where the
483 transferee continues to possess the transferred asset or has other assets
484 of comparable value with which to pay the cost of the transferor's care.
485 The commissioner shall implement the policies and procedures
486 necessary to carry out the provisions of this subsection while in the
487 process of adopting such regulations and procedures in regulation
488 form, provided notice of intent to adopt the regulations is published in
489 the Connecticut Law Journal within twenty days after implementation.
490 Such policies and procedures shall be valid until the time final
491 regulations are effective.

492 (d) A transfer or assignment of assets resulting in a penalty period
493 shall create a debt, as defined in section 36a-645, that shall be due and
494 owing by the transferee to the Department of Social Services in an
495 amount equal to the amount of medical assistance provided to or on
496 behalf of the transferor on and after the date of the transfer of assets,
497 but said amount shall not exceed the fair market value of the assets at
498 the time of the transfer.

499 Sec. 16. (Effective July 1, 2002) Sections 1 and 2 of public act 01-2 of

500 the June special session and section 17b-605 of the general statutes are
501 repealed.

This act shall take effect as follows:	
Section 1	<i>July 1, 2002</i>
Sec. 2	<i>July 1, 2002</i>
Sec. 3	<i>July 1, 2002</i>
Sec. 4	<i>July 1, 2002</i>
Sec. 5	<i>July 1, 2002</i>
Sec. 6	<i>July 1, 2002</i>
Sec. 7	<i>July 1, 2002</i>
Sec. 8	<i>July 1, 2002</i>
Sec. 9	<i>July 1, 2002</i>
Sec. 10	<i>July 1, 2002</i>
Sec. 11	<i>July 1, 2002</i>
Sec. 12	<i>July 1, 2002</i>
Sec. 13	<i>July 1, 2002</i>
Sec. 14	<i>July 1, 2002</i>
Sec. 15	<i>July 1, 2002</i>
Sec. 16	<i>July 1, 2002</i>

Statement of Purpose:

To implement the Governor's budget recommendations.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]