



General Assembly

**Substitute Bill No. 6790**

January Session, 2005

\*          HB06790APP          050305          \*

**AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE  
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS  
COMMITTEE RELATIVE TO THE MEDICAID ELIGIBILITY  
DETERMINATION PROCESS.**

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

1       Section 1. Section 17b-277 of the general statutes is repealed and the  
2       following is substituted in lieu thereof (*Effective July 1, 2005*):

3       (a) The Commissioner of Social Services shall provide, in accordance  
4       with federal law and regulations, medical assistance under the  
5       Medicaid program to needy pregnant women and children up to one  
6       year of age whose families have an income up to one hundred eighty-  
7       five per cent of the federal poverty level.

8       (b) The commissioner shall [implement presumptive] expedite  
9       eligibility for appropriate pregnant women applicants for the Medicaid  
10      program. [with an emphasis on pregnant women. Such presumptive  
11      eligibility determinations shall be in accordance with applicable  
12      federal law and regulations. The commissioner shall provide such

13 presumptive eligibility determinations on a pilot basis, in one district  
14 office, beginning June 1, 1991, and shall provide them state-wide  
15 effective September 1, 1991.] The process for making expedited  
16 eligibility determinations concerning needy pregnant women shall  
17 ensure that emergency applications for assistance, as determined by  
18 the commissioner, shall be processed no later than twenty-four hours  
19 after receipt of all required information from the applicant, and that  
20 nonemergency applications for assistance, as determined by the  
21 commissioner, shall be processed no later than five calendar days after  
22 the date of receipt of all required information from the applicant.

23 (c) The commissioner shall submit biannual reports to the council,  
24 established pursuant to section 17b-28, on the department's compliance  
25 with the administrative processing requirements set forth in subsection  
26 (b) of this section.

27 Sec. 2. Section 17b-292 of the general statutes is repealed and the  
28 following is substituted in lieu thereof (*Effective July 1, 2005*):

29 (a) A child who resides in a household with a family income which  
30 exceeds one hundred eighty-five per cent of the federal poverty level  
31 and does not exceed three hundred per cent of the federal poverty  
32 level may be eligible for subsidized benefits under the HUSKY Plan,  
33 Part B. The services and cost-sharing requirements under the HUSKY  
34 Plan, Part B shall be substantially similar to the services and cost-  
35 sharing requirements of the largest commercially available health plan  
36 offered by a managed care organization, as defined in section 38a-478,  
37 offered to residents in this state as measured by the number of covered  
38 lives reported to the Insurance Department in the most recent audited  
39 annual report.

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

43 (c) Whenever a court or family support magistrate orders a  
44 noncustodial parent to provide health insurance for a child, such

45 parent may provide for coverage under the HUSKY Plan, Part B.

46 (d) To the extent allowed under federal law, the commissioner shall  
47 not pay for services or durable medical equipment under the HUSKY  
48 Plan, Part B if the enrollee has other insurance coverage for the services  
49 or such equipment.

50 (e) A newborn child who otherwise meets the eligibility criteria for  
51 the HUSKY Plan, Part B shall be eligible for benefits retroactive to his  
52 date of birth, provided an application is filed on behalf of the child  
53 within thirty days of such date.

54 (f) The commissioner shall implement presumptive eligibility for  
55 children applying for Medicaid. Such presumptive eligibility  
56 determinations shall be in accordance with applicable federal law and  
57 regulations. The commissioner shall adopt regulations, in accordance  
58 with chapter 54, to establish standards and procedures for the  
59 designation of organizations as qualified entities to grant presumptive  
60 eligibility. Qualified entities shall ensure that, at the time a  
61 presumptive eligibility determination is made, a completed application  
62 for Medicaid is submitted to the department for a full eligibility  
63 determination. In establishing such standards and procedures, the  
64 commissioner shall ensure the representation of state-wide and local  
65 organizations that provide services to children of all ages in each  
66 region of the state.

67 ~~[(f)]~~ (g) The commissioner shall enter into a contract with an entity  
68 to be a single point of entry servicer for applicants and enrollees under  
69 the HUSKY Plan, Part A and Part B. The servicer shall jointly market  
70 both Part A and Part B together as the HUSKY Plan. Such servicer shall  
71 develop and implement public information and outreach activities  
72 with community programs. Such servicer shall electronically transmit  
73 data with respect to enrollment and disenrollment in the HUSKY Plan,  
74 Part B to the commissioner.

75 (h) Upon the expiration of any contractual provisions entered into  
76 pursuant to subsection (g) of this section, the commissioner shall

77 develop a new contract for single point of entry services and Medicaid  
78 managed care enrollment brokerage services. The commissioner may  
79 enter into one or more contractual arrangements for such services for a  
80 contract period not to exceed seven years. Such contracts shall include  
81 performance measures, including, but not limited to, specified time  
82 limits for the processing of applications, parameters setting forth the  
83 requirements for a completed and reviewable application and the  
84 percentage of applications forwarded to the department in a complete  
85 and timely fashion. Such contracts shall also include a process for  
86 identifying and correcting noncompliance with established  
87 performance measures, including sanctions applicable for instances of  
88 continued noncompliance with performance measures.

89 [(g)] (i) The single point of entry servicer shall send an application  
90 and supporting documents to the commissioner for determination of  
91 eligibility of a child who resides in a household with a family income  
92 of one hundred eighty-five per cent or less of the federal poverty level.  
93 The servicer shall enroll eligible beneficiaries in the applicant's choice  
94 of managed care plan. Upon enrollment in a managed care plan, the  
95 eligible beneficiary shall remain enrolled in such managed care plan  
96 for six months from the date of such enrollment unless the eligible  
97 beneficiary demonstrates good cause to the satisfaction of the  
98 commissioner of the need to enroll in a different managed care plan.

99 [(h)] (j) Not more than twelve months after the determination of  
100 eligibility for benefits under the HUSKY Plan, Part A and Part B and  
101 annually thereafter, the commissioner or the servicer, as the case may  
102 be, shall determine if the child continues to be eligible for the plan. The  
103 commissioner or the servicer shall mail an application form to each  
104 participant in the plan for the purposes of obtaining information to  
105 make a determination on eligibility. To the extent permitted by federal  
106 law, in determining eligibility for benefits under the HUSKY Plan, Part  
107 A and Part B with respect to family income, the commissioner or the  
108 servicer shall rely upon information provided in such form by the  
109 participant unless the commissioner or the servicer has reason to  
110 believe that such information is inaccurate or incomplete. The

111 determination of eligibility shall be coordinated with health plan open  
112 enrollment periods.

113 (k) The commissioner shall develop a system to allow applicants for  
114 health insurance coverage under HUSKY Plan, Part A and Part B to  
115 complete such applications on-line through use of the Internet. Such  
116 system shall provide for: (1) The automated transmittal of application  
117 data to the department's computerized eligibility management system,  
118 (2) the acceptance of electronic signatures, (3) a mechanism that  
119 ensures that only completed applications may be electronically  
120 forwarded to the department, and (4) security measures that ensure  
121 that information provided in such on-line applications remain subject  
122 to the protections of section 17b-90 and the federal Health Insurance  
123 Portability and Accountability Act of 1996, Public Law 104-191. Such  
124 system shall be available on a pilot basis not later than March 1, 2006,  
125 and shall be available state-wide not later than July 1, 2006. The  
126 commissioner shall collaborate with qualified entities, managed care  
127 plans and providers to promote the use of such an on-line system.

128 [(i)] (l) The commissioner shall implement the HUSKY Plan, Part B  
129 while in the process of adopting necessary policies and procedures in  
130 regulation form in accordance with the provisions of section 17b-10.

131 [(j)] (m) The commissioner shall adopt regulations, in accordance  
132 with chapter 54, to establish residency requirements and income  
133 eligibility for participation in the HUSKY Plan, Part B and procedures  
134 for a simplified mail-in application process. Notwithstanding the  
135 provisions of section 17b-257b, such regulations shall provide that any  
136 child adopted from another country by an individual who is a citizen  
137 of the United States and a resident of this state shall be eligible for  
138 benefits under the HUSKY Plan, Part B upon arrival in this state.

139 Sec. 3. Section 17b-261 of the general statutes is repealed and the  
140 following is substituted in lieu thereof (*Effective July 1, 2005*):

141 (a) Medical assistance shall be provided for any otherwise eligible  
142 person whose income, including any available support from legally

143 liable relatives and the income of the person's spouse or dependent  
144 child, is not more than one hundred forty-three per cent, pending  
145 approval of a federal waiver applied for pursuant to subsection (d) of  
146 this section, of the benefit amount paid to a person with no income  
147 under the temporary family assistance program in the appropriate  
148 region of residence and if such person is an institutionalized  
149 individual as defined in Section 1917(c) of the Social Security Act, 42  
150 USC 1396p(c), and has not made an assignment or transfer or other  
151 disposition of property for less than fair market value for the purpose  
152 of establishing eligibility for benefits or assistance under this section.  
153 Any such disposition shall be treated in accordance with Section  
154 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of  
155 property made on behalf of an applicant or recipient or the spouse of  
156 an applicant or recipient by a guardian, conservator, person  
157 authorized to make such disposition pursuant to a power of attorney  
158 or other person so authorized by law shall be attributed to such  
159 applicant, recipient or spouse. A disposition of property ordered by a  
160 court shall be evaluated in accordance with the standards applied to  
161 any other such disposition for the purpose of determining eligibility.  
162 The commissioner shall establish the standards for eligibility for  
163 medical assistance at one hundred forty-three per cent of the benefit  
164 amount paid to a family unit of equal size with no income under the  
165 temporary family assistance program in the appropriate region of  
166 residence, pending federal approval, except that the medical assistance  
167 program shall provide coverage to persons under the age of nineteen  
168 up to one hundred eighty-five per cent of the federal poverty level  
169 without an asset limit. Said medical assistance program shall also  
170 provide coverage to persons under the age of nineteen and their  
171 parents and needy caretaker relatives who qualify for coverage under  
172 Section 1931 of the Social Security Act with family income up to one  
173 hundred per cent of the federal poverty level without an asset limit,  
174 upon the request of such a person or upon a redetermination of  
175 eligibility. Such levels shall be based on the regional differences in  
176 such benefit amount, if applicable, unless such levels based on regional  
177 differences are not in conformance with federal law. Any income in

178 excess of the applicable amounts shall be applied as may be required  
179 by said federal law, and assistance shall be granted for the balance of  
180 the cost of authorized medical assistance. All contracts entered into on  
181 and after July 1, 1997, pursuant to this section shall include provisions  
182 for collaboration of managed care organizations with the Healthy  
183 Families Connecticut Program established pursuant to section 17a-56.  
184 The Commissioner of Social Services shall provide applicants for  
185 assistance under this section, at the time of application, with a written  
186 statement advising them of the effect of an assignment or transfer or  
187 other disposition of property on eligibility for benefits or assistance.

188 (b) For the purposes of the Medicaid program, the Commissioner of  
189 Social Services shall consider parental income and resources as  
190 available to a child under eighteen years of age who is living with his  
191 or her parents and is blind or disabled for purposes of the Medicaid  
192 program, or to any other child under twenty-one years of age who is  
193 living with his or her parents.

194 (c) For the purposes of determining eligibility for the Medicaid  
195 program, an available asset is one that is actually available to the  
196 applicant or one that the applicant has the legal right, authority or  
197 power to obtain or to have applied for the applicant's general or  
198 medical support. If the terms of a trust provide for the support of an  
199 applicant, the refusal of a trustee to make a distribution from the trust  
200 does not render the trust an unavailable asset. Notwithstanding the  
201 provisions of this subsection, the availability of funds in a trust or  
202 similar instrument funded in whole or in part by the applicant or the  
203 applicant's spouse shall be determined pursuant to the Omnibus  
204 Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of  
205 this subsection shall not apply to special needs trust, as defined in 42  
206 USC 1396p(d)(4)(A).

207 (d) The transfer of an asset in exchange for other valuable  
208 consideration shall be allowable to the extent the value of the other  
209 valuable consideration is equal to or greater than the value of the asset  
210 transferred.

211 (e) The Commissioner of Social Services shall seek a waiver from  
212 federal law to permit federal financial participation for Medicaid  
213 expenditures for families with incomes of one hundred forty-three per  
214 cent of the temporary family assistance program payment standard.

215 (f) Notwithstanding the provisions of subsection (a) of this section,  
216 on or after April 1, 2003, all parent and needy caretaker relatives with  
217 incomes exceeding one hundred per cent of the federal poverty level,  
218 who are receiving medical assistance pursuant to this section, shall be  
219 ineligible for such medical assistance. On and after February 28, 2003,  
220 the Department of Social Services shall not accept applications for  
221 medical assistance program coverage under Section 1931 of the Social  
222 Security Act from parent and needy caretaker relatives with incomes  
223 exceeding one hundred per cent of the federal poverty level until on or  
224 after July 1, 2005.

225 (g) To the extent permitted by federal law, Medicaid eligibility shall  
226 be extended for two years to a family that becomes ineligible for  
227 medical assistance under Section 1931 of the Social Security Act while  
228 one of its members who is a caretaker relative is employed or due to  
229 receipt of child support income or a family with an adult who, within  
230 six months of becoming ineligible under Section 1931 of the Social  
231 Security Act becomes employed.

232 (h) An institutionalized spouse applying for Medicaid and having a  
233 spouse living in the community shall be required, to the maximum  
234 extent permitted by law, to divert income to such community spouse  
235 in order to raise the community spouse's income to the level of the  
236 minimum monthly needs allowance, as described in Section 1924 of  
237 the Social Security Act. Such diversion of income shall occur before the  
238 community spouse is allowed to retain assets in excess of the  
239 community spouse protected amount described in Section 1924 of the  
240 Social Security Act. The Commissioner of Social Services, pursuant to  
241 section 17b-10, may implement the provisions of this subsection while  
242 in the process of adopting regulations, provided the commissioner  
243 prints notice of intent to adopt the regulations in the Connecticut Law

244 Journal within twenty days of adopting such policy. Such policy shall  
 245 be valid until the time final regulations are effective.

246 (i) The Commissioner of Social Services shall pursue a waiver from  
 247 federal law to the Centers for Medicare and Medicaid Services to  
 248 permit the standard of promptness for processing Medicaid long-term  
 249 care applications to be extended from forty-five days to ninety days  
 250 and to provide that the redetermination period for Medicaid long-term  
 251 care applications be extended from one year to two years.

252 Sec. 4. (*Effective July 1, 2005*) The Commissioner of Social Services, in  
 253 consultation with the department's regional administrators, shall  
 254 monitor the processing of Medicaid applications by the district offices  
 255 of the department to determine whether there are variations between  
 256 such offices concerning overdue applications, denial of applications  
 257 and redeterminations for program eligibility, and if such variations are  
 258 found to exist, the reasons therefor. Not later than January 1, 2006, the  
 259 commissioner shall report, in accordance with section 11-4a of the  
 260 general statutes, findings on the causes of variation in the processing  
 261 of Medicaid applications by the district offices of the department,  
 262 including any quantitative or qualitative factors that contribute to such  
 263 variation, to the joint standing committee of the General Assembly  
 264 having cognizance of matters relating to human services.

265 Sec. 5. (*Effective July 1, 2005*) The sum of one million dollars is  
 266 appropriated to the Department of Social Services, from the General  
 267 Fund, for the fiscal year ending June 30, 2006, for personal services to  
 268 permit the department to hire an additional fourteen eligibility  
 269 determination employees to facilitate the expeditious processing of  
 270 applications for programs administered or operated by the  
 271 department.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2005</i>	17b-277
Sec. 2	<i>July 1, 2005</i>	17b-292

Sec. 3	<i>July 1, 2005</i>	17b-261
Sec. 4	<i>July 1, 2005</i>	New section
Sec. 5	<i>July 1, 2005</i>	New section

**PRI**      *Joint Favorable Subst.*

**HS**        *Joint Favorable*

**APP**      *Joint Favorable*