



General Assembly

February Session, 2006

***Raised Bill No. 347***

LCO No. 1975

\*01975 \_\_\_\_\_ AGE\*

Referred to Committee on Select Committee on Aging

Introduced by:  
(AGE)

***AN ACT CONCERNING THE AVAILABILITY OF COMMUNITY-BASED SERVICES UNDER THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY.***

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

1 Section 1. Section 17b-342 of the 2006 supplement to the general  
2 statutes is repealed and the following is substituted in lieu thereof  
3 (*Effective July 1, 2006*):

4 (a) The Commissioner of Social Services shall administer the  
5 Connecticut home-care program for the elderly state-wide in order to  
6 prevent the institutionalization of elderly persons (1) who are  
7 recipients of medical assistance, (2) who are eligible for such  
8 assistance, (3) who would be eligible for medical assistance if residing  
9 in a nursing facility, or (4) who meet the criteria for the state-funded  
10 portion of the program under subsection [(i)] (h) of this section. For  
11 purposes of this section, a long-term care facility is a facility which has  
12 been federally certified as a skilled nursing facility or intermediate care  
13 facility. The commissioner shall make any revisions in the state  
14 Medicaid plan required by Title XIX of the Social Security Act prior to  
15 implementing the program. The annualized cost of the community-

16 based services provided to such persons under the program shall not  
17 exceed sixty per cent of the weighted average cost of care in skilled  
18 nursing facilities and intermediate care facilities. The program shall be  
19 structured so that the net cost to the state for long-term facility care in  
20 combination with the community-based services under the program  
21 shall not exceed the net cost the state would have incurred without the  
22 program. The commissioner shall investigate the possibility of  
23 receiving federal funds for the program and shall apply for any  
24 necessary federal waivers. A recipient of services under the program,  
25 and the estate and legally liable relatives of the recipient, shall be  
26 responsible for reimbursement to the state for such services to the  
27 same extent required of a recipient of assistance under the state  
28 supplement program, medical assistance program, temporary family  
29 assistance program or food stamps program. Only a United States  
30 citizen or a noncitizen who meets the citizenship requirements for  
31 eligibility under the Medicaid program shall be eligible for home-care  
32 services under this section, except a qualified alien, as defined in  
33 Section 431 of Public Law 104-193, admitted into the United States on  
34 or after August 22, 1996, or other lawfully residing immigrant alien  
35 determined eligible for services under this section prior to July 1, 1997,  
36 shall remain eligible for such services. Qualified aliens or other  
37 lawfully residing immigrant aliens not determined eligible prior to  
38 July 1, 1997, shall be eligible for services under this section subsequent  
39 to six months from establishing residency. Notwithstanding the  
40 provisions of this subsection, any qualified alien or other lawfully  
41 residing immigrant alien or alien who formerly held the status of  
42 permanently residing under color of law who is a victim of domestic  
43 violence or who has mental retardation shall be eligible for assistance  
44 pursuant to this section. Qualified aliens, as defined in Section 431 of  
45 Public Law 104-193, or other lawfully residing immigrant aliens or  
46 aliens who formerly held the status of permanently residing under  
47 color of law shall be eligible for services under this section provided  
48 other conditions of eligibility are met.

49 (b) The commissioner shall solicit bids through a competitive

50 process and shall contract with an access agency, approved by the  
51 Office of Policy and Management and the Department of Social  
52 Services as meeting the requirements for such agency as defined by  
53 regulations adopted pursuant to subsection [(e)] (j) of this section, that  
54 submits proposals which meet or exceed the minimum bid  
55 requirements. In addition to such contracts, the commissioner may use  
56 department staff to provide screening, coordination, assessment and  
57 monitoring functions for the program.

58 (c) The community-based services covered under the program shall  
59 include, but not be limited to, the following services to the extent that  
60 they are not available under the state Medicaid plan, occupational  
61 therapy, homemaker services, companion services, meals on wheels,  
62 adult day care, transportation, mental health counseling, care  
63 management, elderly foster care, minor home modifications and  
64 assisted living services provided in state-funded congregate housing  
65 and in other assisted living pilot or demonstration projects established  
66 under state law. Recipients of state-funded services and persons who  
67 are determined to be functionally eligible for community-based  
68 services who have an application for medical assistance pending shall  
69 have the cost of home health and community-based services covered  
70 by the program, provided they comply with all medical assistance  
71 application requirements. Access agencies shall not use department  
72 funds to purchase community-based services or home health services  
73 from themselves or any related parties.

74 (d) Physicians, hospitals, long-term care facilities and other licensed  
75 health care facilities may disclose, and, as a condition of eligibility for  
76 the program, elderly persons, their guardians, and relatives shall  
77 disclose, upon request from the Department of Social Services, such  
78 financial, social and medical information as may be necessary to enable  
79 the department or any agency administering the program on behalf of  
80 the department to provide services under the program. Long-term care  
81 facilities shall supply the Department of Social Services with the names  
82 and addresses of all applicants for admission. Any information

83 provided pursuant to this subsection shall be confidential and shall not  
84 be disclosed by the department or administering agency.

85 [(e) The commissioner shall adopt regulations, in accordance with  
86 the provisions of chapter 54, to define "access agency", to implement  
87 and administer the program, to establish uniform state-wide standards  
88 for the program and a uniform assessment tool for use in the screening  
89 process and to specify conditions of eligibility.]

90 [(f)] (e) The commissioner may require long-term care facilities to  
91 inform applicants for admission of the program established under this  
92 section and to distribute such forms as the commissioner prescribes for  
93 the program. Such forms shall be supplied by and be returnable to the  
94 department.

95 [(g)] (f) The commissioner shall report annually, by June first, to the  
96 joint standing committee of the General Assembly having cognizance  
97 of matters relating to human services on the program in such detail,  
98 depth and scope as said committee requires to evaluate the effect of the  
99 program on the state and program participants. Such report shall  
100 include information on (1) the number of persons diverted from  
101 placement in a long-term care facility as a result of the program, (2) the  
102 number of persons screened, (3) the average cost per person in the  
103 program, (4) the administration costs, (5) the estimated savings, and (6)  
104 a comparison between costs under the different contracts.

105 [(h)] (g) An individual who is otherwise eligible for services  
106 pursuant to this section shall, as a condition of participation in the  
107 program, apply for medical assistance benefits pursuant to section 17b-  
108 260 when requested to do so by the department and shall accept such  
109 benefits if determined eligible.

110 [(i)] (h) (1) On and after July 1, 1992, the Commissioner of Social  
111 Services shall, within available appropriations, administer a state-  
112 funded portion of the program for persons (A) who are sixty-five years  
113 of age and older; (B) who are inappropriately institutionalized or at

114 risk of inappropriate institutionalization; (C) whose income is less than  
115 or equal to the amount allowed under subdivision (3) of subsection (a)  
116 of this section; and (D) whose assets, if single, do not exceed the  
117 minimum community spouse protected amount pursuant to Section  
118 4022.05 of the department's uniform policy manual or, if married, the  
119 couple's assets do not exceed one hundred fifty per cent of said  
120 community spouse protected amount and on and after April 1, 2007,  
121 whose assets, if single, do not exceed one hundred fifty per cent of the  
122 minimum community spouse protected amount pursuant to Section  
123 4022.05 of the department's uniform policy manual or, if married, the  
124 couple's assets do not exceed two hundred per cent of said community  
125 spouse protected amount.

126 (2) Any person whose income exceeds two hundred per cent of the  
127 federal poverty level shall contribute to the cost of care in accordance  
128 with the methodology established for recipients of medical assistance  
129 pursuant to Sections 5035.20 and 5035.25 of the department's uniform  
130 policy manual.

131 (3) On and after June 30, 1992, the program shall serve persons  
132 receiving state-funded home and community-based services from the  
133 department, persons receiving services under the promotion of  
134 independent living for the elderly program operated by the  
135 Department of Social Services, regardless of age, and persons receiving  
136 services on June 19, 1992, under the home care demonstration project  
137 operated by the Department of Social Services. Such persons receiving  
138 state-funded services whose income and assets exceed the limits  
139 established pursuant to subdivision (1) of this subsection may continue  
140 to participate in the program, but shall be required to pay the total cost  
141 of care, including case management costs.

142 (4) Services shall not be increased for persons who received services  
143 under the promotion of independent living for the elderly program  
144 over the limits in effect under said program in the fiscal year ending  
145 June 30, 1992, unless a person's needs increase and the person is

146 eligible for Medicaid.

147 (5) The annualized cost of services provided to an individual under  
148 the state-funded portion of the program shall not exceed fifty per cent  
149 of the weighted average cost of care in nursing homes in the state,  
150 except an individual who received services costing in excess of such  
151 amount under the Department of Social Services in the fiscal year  
152 ending June 30, 1992, may continue to receive such services, provided  
153 the annualized cost of such services does not exceed eighty per cent of  
154 the weighted average cost of such nursing home care. The  
155 commissioner may allow the cost of services provided to an individual  
156 to exceed the maximum cost established pursuant to this subdivision  
157 in a case of extreme hardship, as determined by the commissioner,  
158 provided in no case shall such cost exceed that of the weighted cost of  
159 such nursing home care.

160 [(j) The Commissioner of Social Services may implement revised  
161 criteria for the operation of the program while in the process of  
162 adopting such criteria in regulation form, provided the commissioner  
163 prints notice of intention to adopt the regulations in the Connecticut  
164 Law Journal within twenty days of implementing the policy. Such  
165 criteria shall be valid until the time final regulations are effective.]

166 (i) The commissioner shall implement presumptive eligibility for  
167 persons, sixty-five years of age or older, who apply for either the  
168 Medicaid-funded or state-funded portion of the Connecticut home-  
169 care program for the elderly. Such presumptive eligibility  
170 determinations shall be in accordance with applicable federal law and  
171 regulations. Qualified entities shall ensure that, at the time a  
172 presumptive eligibility determination is made, a completed application  
173 for Medicaid is submitted to the department for a full eligibility  
174 determination.

175 (j) The Commissioner of Social Services, pursuant to section 17b-10,  
176 shall implement the policies and procedures necessary to carry out the  
177 provisions of this section, while in the process of adopting such

178 policies and procedures in regulation form, provided notice of intent to  
179 adopt regulations is published in the Connecticut Law Journal not later  
180 than twenty days after implementation. Such policies and procedures  
181 shall include a definition of "access agency", the establishment of  
182 uniform state-wide standards for the program, the development of a  
183 uniform assessment tool for use in the screening process, specified  
184 conditions of eligibility, and the establishment of standards and  
185 procedures for the designation of organizations as qualified entities to  
186 grant presumptive eligibility and shall be valid until the time final  
187 regulations are effective.

188       Sec. 2. Subsection (a) of section 17b-253 of the general statutes is  
189 repealed and the following is substituted in lieu thereof (*Effective July*  
190 *1, 2006*):

191       (a) The Department of Social Services shall seek appropriate  
192 amendments to its Medicaid regulations and state plan to allow  
193 protection of resources and income pursuant to section 17b-252. Such  
194 protection shall be provided, to the extent approved by the federal  
195 Centers for Medicare and Medicaid Services, for any purchaser of a  
196 precertified long-term care policy and shall last for the life of the  
197 purchaser. Such protection shall be provided under the Medicaid  
198 program or its successor program. Any purchaser of a precertified  
199 long-term care policy shall be guaranteed coverage under the  
200 Medicaid program or its successor program, to the extent the  
201 individual meets all applicable eligibility requirements for the  
202 Medicaid program or its successor program. Until such time as  
203 eligibility requirements are prescribed for Medicaid's successor  
204 program, for the purposes of this subsection, the applicable eligibility  
205 requirements shall be the Medicaid program's requirements as of the  
206 date its successor program was enacted. The Department of Social  
207 Services shall count insurance benefit payments toward resource  
208 exclusion to the extent such payments (1) are for services paid for by a  
209 precertified long-term care policy; (2) are for the lower of the actual  
210 charge and the amount paid by the insurance company; (3) are for

211 nursing home care, or formal services delivered to insureds in the  
212 community as part of a care plan approved by an access agency  
213 approved by the Office of Policy and Management and the  
214 Department of Social Services as meeting the requirements for such  
215 agency, as defined in regulations adopted pursuant to subsection [(e)]  
216 (j) of section 17b-342, as amended by this act; and (4) are for services  
217 provided after the individual meets the coverage requirements for  
218 long-term care benefits established by the Department of Social  
219 Services for this program. The Commissioner of Social Services shall  
220 adopt regulations, in accordance with chapter 54, to implement the  
221 provisions of this subsection and sections 17b-251, 17b-252, 17b-254  
222 and 38a-475, as amended by this act, relating to determining eligibility  
223 of applicants for Medicaid, or its successor program, and the coverage  
224 requirements for long-term care benefits.

225       Sec. 3. Subsection (g) of section 17b-354 of the 2006 supplement to  
226 the general statutes is repealed and the following is substituted in lieu  
227 thereof (*Effective July 1, 2006*):

228       (g) (1) A continuing care facility which guarantees life care for its  
229 residents, as defined in subsection (b) of this section, (A) shall arrange  
230 for a medical assessment to be conducted by an independent physician  
231 or an access agency approved by the Office of Policy and Management  
232 and the Department of Social Services as meeting the requirements for  
233 such agency as defined by regulations adopted pursuant to subsection  
234 [(e)] (j) of section 17b-342, as amended by this act, prior to the  
235 admission of any resident to the nursing facility and shall document  
236 such assessment in the resident's medical file, and (B) may transfer or  
237 discharge a resident who has intentionally transferred assets in a sum  
238 which will render the resident unable to pay the cost of nursing facility  
239 care in accordance with the contract between the resident and the  
240 facility.

241       (2) A continuing care facility which guarantees life care for its  
242 residents, as defined in subsection (b) of this section, may, for the

243 seven-year period immediately subsequent to becoming operational,  
244 accept nonresidents directly as nursing facility patients on a  
245 contractual basis provided any such contract shall include, but not be  
246 limited to, requiring the facility (A) to document that placement of the  
247 patient in such facility is medically appropriate; (B) to apply to a  
248 potential nonresident patient the financial eligibility criteria applied to  
249 a potential resident of the facility pursuant to said subsection (b); and  
250 (C) to at least annually screen each nonresident patient to ensure the  
251 maintenance of assets, income and insurance sufficient to cover the  
252 cost of at least forty-two months of nursing facility care. A facility may  
253 transfer or discharge a nonresident patient upon the patient exhausting  
254 assets sufficient to pay the costs of his care or upon the facility  
255 determining the patient has intentionally transferred assets in a sum  
256 which will render the patient unable to pay the costs of a total of forty-  
257 two months of nursing facility care from the date of initial admission  
258 to the nursing facility. Any such transfer or discharge shall be  
259 conducted in accordance with section 19a-535. The commissioner may  
260 grant up to a three-year extension of the period during which a facility  
261 may accept nonresident patients, provided the facility is in compliance  
262 with the provisions of this section.

263 Sec. 4. Section 38a-475 of the general statutes is repealed and the  
264 following is substituted in lieu thereof (*Effective July 1, 2006*):

265 The Insurance Department shall only precertify long-term care  
266 insurance policies which (1) alert the purchaser to the availability of  
267 consumer information and public education provided by the  
268 Department of Social Services pursuant to section 17b-251; (2) offer the  
269 option of home and community-based services in addition to nursing  
270 home care; (3) in all home care plans, include case management  
271 services delivered by an access agency approved by the Office of  
272 Policy and Management and the Department of Social Services as  
273 meeting the requirements for such agency as defined in regulations  
274 adopted pursuant to subsection [(e)] (j) of section 17b-342, as amended  
275 by this act, which services shall include, but need not be limited to, the

276 development of a comprehensive individualized assessment and care  
 277 plan and, as needed, the coordination of appropriate services and the  
 278 monitoring of the delivery of such services; (4) provide inflation  
 279 protection; (5) provide for the keeping of records and an explanation of  
 280 benefit reports on insurance payments which count toward Medicaid  
 281 resource exclusion; and (6) provide the management information and  
 282 reports necessary to document the extent of Medicaid resource  
 283 protection offered and to evaluate the Connecticut Partnership for  
 284 Long-Term Care. No policy shall be precertified if it requires prior  
 285 hospitalization or a prior stay in a nursing home as a condition of  
 286 providing benefits. The commissioner may adopt regulations, in  
 287 accordance with chapter 54, to carry out the precertification provisions  
 288 of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2006</i>	17b-342
Sec. 2	<i>July 1, 2006</i>	17b-253(a)
Sec. 3	<i>July 1, 2006</i>	17b-354(g)
Sec. 4	<i>July 1, 2006</i>	38a-475

**Statement of Purpose:**

To improve the availability of access to community-based services under the Connecticut home-care program for the elderly through the implementation of presumptive eligibility.

*[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.]*