



General Assembly

February Session, 2008

Raised Bill No. 662

LCO No. 3036

03036_____HS_

Referred to Committee on Human Services

Introduced by:
(HS)

AN ACT CONCERNING MEDICAID ELIGIBILITY AND REIMBURSEMENT.

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

1 Section 1. Section 17b-261 of the 2008 supplement to the general
2 statutes is amended by adding subsections (j) and (k) as follows
3 (*Effective July 1, 2008*):

4 (NEW) (j) The Commissioner of Social Services shall implement
5 presumptive eligibility for persons applying for Medicaid. Such
6 presumptive eligibility determinations shall be in accordance with
7 applicable federal law and regulations. The commissioner shall adopt
8 regulations, in accordance with chapter 54, to establish standards and
9 procedures for the designation of organizations as qualified entities to
10 grant presumptive eligibility. Qualified entities shall ensure that, at the
11 time a presumptive eligibility determination is made, a completed
12 application for Medicaid is submitted to the department for a full
13 eligibility determination.

14 (NEW) (k) To the extent permitted by federal law, for purposes of
15 determining Medicaid eligibility for an institutionalized individual, as

16 defined in Section 1917(c) of the Social Security Act, 42 USC 1396p(c),
17 the Department of Social Services shall exclude from consideration an
18 asset owned by that individual if: (1) The individual has an
19 outstanding debt to an institution for care and services that have been
20 provided to the individual that is equal to or more than the value of
21 the asset; (2) the individual demonstrates that he or she is making a
22 bona fide effort to dispose of the asset for fair market value or liquidate
23 such asset and the reason that the asset cannot be disposed of or
24 liquidated is either (A) due to a delay on the part of a financial
25 institution or insurance company; (B) a delay due to the need for the
26 appointment of a conservator for the individual; or (C) a delay due to
27 other circumstances beyond the control of the individual as
28 determined by the commissioner; (3) the amount of the asset does not
29 exceed ten thousand dollars or an amount in excess of ten thousand
30 dollars as approved by the commissioner and does not consist of the
31 corpus of a trust that may be liquidated at the discretion of the trustee;
32 and (4) the individual demonstrates that he or she has agreed to pay
33 the institution that which is necessary to repay such debt upon receipt
34 of the fair market value or liquidation of the asset.

35 Sec. 2. Section 17b-276 of the general statutes is repealed and the
36 following is substituted in lieu thereof (*Effective July 1, 2008*):

37 (a) The Commissioner of Social Services shall identify geographic
38 areas of the state where competitive bidding for nonemergency
39 transportation services provided to medical assistance recipients to
40 access covered medical services would result in cost savings to the
41 state. For the identified areas, the Commissioner of Social Services, in
42 consultation with the Commissioner of Transportation, the
43 Commissioner of Public Health and the Secretary of the Office of
44 Policy and Management, shall purchase such nonemergency
45 transportation services through a competitive bidding process. Any
46 transportation providers awarded a contract or subcontract for the
47 direct provision of such services shall meet state licensure or
48 certification requirements and the nonemergency transportation

49 requirements established by the Department of Social Services, and
50 shall provide the most cost effective transportation service, provided
51 any contractor awarded a contract solely for coordinating such
52 transportation services shall not be required to meet such licensure or
53 certification requirements and provided the first such contracts for the
54 purchase of such services shall not exceed one year. Prior to awarding
55 a contract pursuant to this section, the Commissioner of Social Services
56 shall consider the effect of the contract on the emergency ambulance
57 primary service areas and volunteer ambulance services affected by
58 the contract. The commissioner may limit the geographic areas to be
59 served by a contractor and may limit the amount of services to be
60 performed by a contractor. The commissioner may operate one or
61 more pilot programs prior to state-wide operation of a competitive
62 bidding program for nonemergency transportation services. By
63 enrolling in the Medicaid program or participating in the
64 competitively bid contract for nonemergency transportation services,
65 providers of nonemergency transportation services agree to offer to
66 recipients of medical assistance all types or levels of transportation
67 services for which they are licensed or certified. Effective October 1,
68 1991, payment for such services shall be made only for services
69 provided to an eligible recipient who is actually transported. A
70 contract entered into pursuant to this section may include services
71 provided by another state agency. Notwithstanding any provision of
72 the general statutes, a contract entered into pursuant to this section
73 shall establish the rates to be paid for the transportation services
74 provided under the contract. A contract entered into pursuant to this
75 section may include services provided by another state agency and
76 shall supersede any conflicting provisions of the regulations of
77 Connecticut state agencies pertaining to medical transportation
78 services. Any contractor awarded a contract solely for coordinating
79 nonemergency transportation services for medical assistance
80 recipients, who also coordinates transportation services for
81 nonmedical assistance recipients, shall disclose to any transportation
82 provider with whom it subcontracts to provide nonemergency

83 transportation services under this section the source of payment at the
84 time the service is requested.

85 (b) Notwithstanding any other provision of the general statutes, for
86 purposes of administering medical assistance programs, including, but
87 not limited to, the state-administered general assistance program and
88 programs administered pursuant to Title XIX or Title XXI of the Social
89 Security Act, the Department of Social Services shall be the sole state
90 agency that sets emergency and nonemergency medical transportation
91 fees or fee schedules for any transportation services that are
92 reimbursed by the department for said medical assistance programs.

93 Sec. 3. (NEW) (*Effective July 1, 2008*) (a) The Commissioner of Social
94 Services shall provide coverage under the Medicaid program for
95 nonemergency transportation by ambulance without prior
96 authorization for a patient who is: (1) Discharged from an acute care
97 hospital, long-term acute care hospital, psychiatric facility or
98 rehabilitation facility, and admitted as a new admission to another
99 facility, including a residential care facility, skilled nursing facility,
100 psychiatric facility, rehabilitation facility or long-term acute care
101 hospital, where prior authorization has been granted for the new
102 admission; (2) discharged from an acute care hospital, long-term acute
103 care hospital, psychiatric facility or rehabilitation facility, and returned
104 to his or her residence in a residential care facility, skilled nursing
105 facility, psychiatric facility, rehabilitation facility or long-term acute
106 care hospital; or (3) transported to a doctor's office, treatment facility or
107 testing facility either free standing or within a hospital, provided one
108 of the following conditions is met: (A) The patient is on oxygen not
109 available to the patient except by ambulance, (B) the patient is unable
110 to sit in a wheelchair or tolerate any other means of transport other
111 than a stretcher due to risk of injury, or (C) the patient's medical
112 condition requires monitoring by trained personnel.

113 (b) The commissioner shall ensure that personnel are available
114 twenty-four hours a day, seven days a week for purposes of the prior

115 authorization required for the nonemergency transportation by
116 ambulance of patients not described in subsection (a) of this section.

117 Sec. 4. Section 17b-242 of the general statutes is repealed and the
118 following is substituted in lieu thereof (*Effective July 1, 2008*):

119 (a) The Department of Social Services shall determine the rates to be
120 paid to home health care agencies and homemaker-home health aide
121 agencies by the state or any town in the state for persons aided or
122 cared for by the state or any such town. [For the period from February
123 1, 1991, to January 31, 1992, inclusive, payment for each service to the
124 state shall be based upon the rate for such service as determined by the
125 Office of Health Care Access, except that for those providers whose
126 Medicaid rates for the year ending January 31, 1991, exceed the median
127 rate, no increase shall be allowed. For those providers whose rates for
128 the year ending January 31, 1991, are below the median rate, increases
129 shall not exceed the lower of the prior rate increased by the most
130 recent annual increase in the consumer price index for urban
131 consumers or the median rate. In no case shall any such rate exceed the
132 eightieth percentile of rates in effect January 31, 1991, nor shall any rate
133 exceed the charge to the general public for similar services. Rates
134 effective February 1, 1992, shall be based upon rates as determined by
135 the Office of Health Care Access, except that increases shall not exceed
136 the prior year's rate increased by the most recent annual increase in the
137 consumer price index for urban consumers and rates effective
138 February 1, 1992, shall remain in effect through June 30, 1993. Rates
139 effective July 1, 1993, shall be based upon rates as determined by the
140 Office of Health Care Access except if the Medicaid rates for any
141 service for the period ending June 30, 1993, exceed the median rate for
142 such service, the increase effective July 1, 1993, shall not exceed one
143 per cent. If the Medicaid rate for any service for the period ending June
144 30, 1993, is below the median rate, the increase effective July 1, 1993,
145 shall not exceed the lower of the prior rate increased by one and one-
146 half times the most recent annual increase in the consumer price index
147 for urban consumers or the median rate plus one per cent.] The

148 Commissioner of Social Services shall establish a fee schedule for home
149 health services. [to be effective on and after July 1, 1994.] The
150 commissioner [may] shall annually increase any fee in the fee schedule
151 based on [an increase in the cost of services. The commissioner shall
152 increase the fee schedule for home health services provided under the
153 Connecticut home-care program for the elderly established under
154 section 17b-342, effective July 1, 2000, by two per cent over the fee
155 schedule for home health services for the previous year] the increase, if
156 any, in the consumer price index for urban consumers. The
157 commissioner may increase any fee payable to a home health care
158 agency or homemaker-home health aide agency upon the application
159 of such an agency evidencing extraordinary costs related to (1) serving
160 persons with AIDS; (2) high-risk maternal and child health care; (3)
161 escort services; or (4) extended hour services. In no case shall any rate
162 or fee exceed the charge to the general public for similar services. A
163 home health care agency or homemaker-home health aide agency
164 which, due to any material change in circumstances, is aggrieved by a
165 rate determined pursuant to this subsection may, [within] not later
166 than ten days [of] after receipt of written notice of such rate from the
167 Commissioner of Social Services, request in writing a hearing on all
168 items of aggrievement. The commissioner shall, upon the receipt of all
169 documentation necessary to evaluate the request, determine whether
170 there has been such a change in circumstances and shall conduct a
171 hearing if appropriate. The Commissioner of Social Services shall
172 adopt regulations, in accordance with chapter 54, to implement the
173 provisions of this subsection. The commissioner, pursuant to section
174 17b-10, may implement policies and procedures to carry out the
175 provisions of this subsection while in the process of adopting
176 regulations, provided notice of intent to adopt the regulations is
177 published in the Connecticut Law Journal [within] not later than
178 twenty days [of implementing the] after implementation of such
179 policies and procedures. Such policies and procedures shall be valid
180 [for not longer than nine months] until the time final regulations are
181 adopted.

182 (b) The Department of Social Services shall monitor the rates
183 charged by home health care agencies and homemaker-home health
184 aide agencies. Such agencies shall file annual cost reports and service
185 charge information with the department.

186 (c) The home health services fee schedule shall include fees for a
187 skilled nursing visit, which shall apply (1) when a patient has one or
188 more active medical conditions requiring the attention of a nurse, or
189 (2) when a patient has been diagnosed with a serious and persistent
190 mental illness that requires the interventions of a psychiatric nurse. A
191 skilled nursing visit shall include, but not be limited to, assessment
192 and monitoring of blood pressure readings, blood glucose checks,
193 pulse rate checks, execution of any medical regimen under the
194 direction of a physician licensed in this state or a state that borders this
195 state and, in the case of any patient with a serious and persistent
196 mental illness, mental status assessment and the teaching of symptom
197 management techniques.

198 [(c)] (d) The home health services fee schedule shall include a fee for
199 the administration of medication, which shall apply when the purpose
200 of a nurse's visit is limited to the administration of medication.
201 [Administration of medication may include, but is not limited to, blood
202 pressure checks, glucometer readings, pulse rate checks and similar
203 indicators of health status.] The fee for medication administration shall
204 include administration of medications while the nurse is present, the
205 pre-pouring of additional doses that the client will self-administer at a
206 later time and the teaching of self-administration. [The department
207 shall not pay for medication administration in addition to any other
208 nursing service at the same visit. The department may establish prior
209 authorization requirements for this service. Before implementing such
210 change, the Commissioner of Social Services shall consult with the
211 chairpersons of the joint standing committees of the General Assembly
212 having cognizance of matters relating to public health and human
213 services.] When the purpose of a nurse's visit is other than the
214 administration of medication, the visit shall be reimbursed at the

215 skilled nursing visit fee established under subsection (c) of this section.

216 [(d) The home health services fee schedule established pursuant to
217 subsection (c) of this section shall include rates for psychiatric nurse
218 visits.]

219 (e) The Department of Social Services, when processing or auditing
220 claims for reimbursement submitted by home health care agencies and
221 homemaker-home health aide agencies shall, in accordance with the
222 provisions of chapter 15, accept electronic records and records bearing
223 the electronic signature of a licensed physician or licensed practitioner
224 of a healthcare profession that has been submitted to the home health
225 care agency or homemaker home-health aide agency.

226 (f) If the electronic record or signature that has been transmitted to a
227 home health care agency or homemaker-home health aide agency is
228 illegible or the department is unable to determine the validity of such
229 electronic record or signature, the department shall review additional
230 evidence of the accuracy or validity of the record or signature,
231 including, but not limited to, (1) the original of the record or signature,
232 or (2) a written statement, made under penalty of false statement, from
233 (A) the licensed physician or licensed practitioner of a health care
234 profession who signed such record, or (B) if such licensed physician or
235 licensed practitioner of a health care profession is unavailable, the
236 medical director of the agency verifying the accuracy or validity of
237 such record or signature, and the department shall make a
238 determination whether the electronic record or signature is valid.

239 (g) The Department of Social Services, when auditing claims
240 submitted by home health care agencies and homemaker-home health
241 aide agencies, shall consider any signature from a licensed physician
242 or licensed practitioner of a health care profession that may be
243 required on a plan of care for home health services, to have been
244 provided in timely fashion if (1) the document bearing such signature
245 was signed prior to the time when such agency seeks reimbursement
246 from the department for services provided, and (2) verbal or telephone

247 orders from the licensed physician or licensed practitioner of a health
248 care profession were received prior to the commencement of services
249 covered by the plan of care and such orders were subsequently
250 documented. Nothing in this subsection shall be construed as limiting
251 the powers of the Commissioner of Public Health to enforce the
252 provisions of sections 19-13-D73 and 19-13-D74 of the regulations of
253 Connecticut state agencies and 42 CFR 484.18(c).

254 (h) Not later than October 1, 2009, the Commissioner of Social
255 Services shall establish a fee schedule and billing codes for the cost of
256 supplies and administration of influenza and pneumoccal
257 polysaccharide vaccines provided by nurses employed by a licensed
258 home health care or homemaker-home health aide agency to persons
259 eligible for benefits under Title XIX of the Social Security Act, and not
260 otherwise eligible for coverage for such vaccines under Title XVIII of
261 the Social Security Act. Such fees and billing requirements shall be
262 identical to those for mass immunizers under Title XVIII of the Social
263 Security Act.

264 [(h)] (i) For purposes of this section, "licensed practitioner of a
265 healthcare profession" has the same meaning as "licensed practitioner"
266 in section 21a-244a. For purposes of subsections (c), (d) and (h) of this
267 section, "nurse" means an advanced practice nurse, registered nurse or
268 practical nurse licensed under chapter 378.

269 Sec. 5. (Effective July 1, 2008) For the fiscal year ending on June 30,
270 2009, the Commissioner of Social Services shall increase the rates paid
271 to home health care agencies and homemaker-home health aide
272 agencies under the Medicaid program for nursing services, extended
273 hourly nursing services, therapy and home health aide services by not
274 less than twenty-nine per cent of the rate paid by the Department of
275 Social Services for such services on June 30, 2008.

276 Sec. 6. (NEW) (Effective July 1, 2008) (a) On or before January 1, 2009,
277 the Department of Social Services shall establish a two-year pilot
278 program to investigate the feasibility and appropriateness of using

279 telemonitors to manage and treat up to one hundred fifty Medicaid
280 fee-for-service patients in the community with (1) congestive heart
281 failure, (2) diabetes, its indicative conditions, or both, and (3) chronic
282 obstructive pulmonary disease. The Commissioner of Social Services
283 shall contract through a request for proposals process with no fewer
284 than six home health agencies to operate the pilot program in
285 accordance with this section. Each proposal shall include a detailed
286 description of the entity's plan for administering the pilot program and
287 methods and procedures for data collection and reporting.

288 (b) In selecting patients to participate in the pilot program under
289 this section, each contracted home health agency shall consider the
290 following factors: (1) The nature of the patient's medical condition and
291 whether such medical condition requires health care services of
292 unusually high frequency, urgency or duration, (2) the patient's
293 cognitive ability, (3) whether the patient resides in a medically
294 underserved area, and (4) whether the patient has support from a
295 relative or other caregiver.

296 (c) Not later than December 31, 2011, the Commissioner of Social
297 Services shall evaluate the pilot program established under this section
298 and shall submit a report, in accordance with section 11-4a of the
299 general statutes, of the commissioner's findings and recommendations
300 to the joint standing committees of the General Assembly having
301 cognizance of matters relating to human services and public health.
302 Such report shall include an evaluation of the data collected with
303 respect to improved chronic disease management and cost savings
304 based on patient outcomes.

305 Sec. 7. Section 17b-340 of the 2008 supplement to the general statutes
306 is amended by adding subsection (j) as follows (*Effective July 1, 2008*):

307 (NEW) (j) For the fiscal year ending June 30, 2009, and each fiscal
308 year thereafter, the Commissioner of Social Services shall increase the
309 rate of reimbursement for rest homes with nursing supervision to a
310 rate that is eighty-five per cent of the rate paid by the department to

311 chronic and convalescent nursing homes, provided such rate shall not
312 exceed the private pay rate for such rest homes with nursing
313 supervision.

314 Sec. 8. Subdivision (5) of subsection (f) of section 17b-340 of the 2008
315 supplement to the general statutes is repealed and the following is
316 substituted in lieu thereof (*Effective July 1, 2008*):

317 (5) For the purpose of determining allowable fair rent, a facility with
318 allowable fair rent less than the twenty-fifth percentile of the state-
319 wide allowable fair rent shall be reimbursed as having allowable fair
320 rent equal to the twenty-fifth percentile of the state-wide allowable fair
321 rent, provided for the fiscal years ending June 30, 1996, and June 30,
322 1997, the reimbursement may not exceed the twenty-fifth percentile of
323 the state-wide allowable fair rent for the fiscal year ending June 30,
324 1995. On and after July 1, [1998] 2008, the Commissioner of Social
325 Services [may] shall allow minimum fair rent as the basis upon which
326 reimbursement associated with improvements to real property is
327 added. Beginning with the fiscal year ending June 30, 1996, any facility
328 with a rate of return on real property other than land in excess of
329 eleven per cent shall have such allowance revised to eleven per cent.
330 Effective July 1, 2008, any chronic and convalescent nursing home and
331 rest home with nursing supervision that has fully amortized (A) the
332 base value of its original real property, other than land, or (B) the base
333 value of its real property, other than land, for property additions
334 associated with an increase in bed capacity in such facility shall have
335 the fair rental allowance for the use of such real property replaced with
336 the lesser of: (i) A value equal to twelve dollars multiplied by the
337 facility's total annual resident days, or (ii) the previous fair rental
338 allowance received for such real property other than land. In no event
339 shall a facility receive allowable fair rent less than the twenty-fifth
340 percentile of the state-wide allowable fair rent. Any facility or its
341 related realty affiliate which finances or refinances debt through bonds
342 issued by the State of Connecticut Health and Education Facilities
343 Authority shall report the terms and conditions of such financing or

344 refinancing to the Commissioner of Social Services within thirty days
345 of completing such financing or refinancing. The Commissioner of
346 Social Services may revise the facility's fair rent component of its rate
347 to reflect any financial benefit the facility or its related realty affiliate
348 received as a result of such financing or refinancing, including, but not
349 limited to, reductions in the amount of debt service payments or
350 period of debt repayment. The commissioner shall allow actual debt
351 service costs for bonds issued by the State of Connecticut Health and
352 Educational Facilities Authority if such costs do not exceed property
353 costs allowed pursuant to subsection (f) of section 17-311-52 of the
354 regulations of Connecticut state agencies, provided the commissioner
355 may allow higher debt service costs for such bonds for good cause. For
356 facilities which first open on or after October 1, 1992, the commissioner
357 shall determine allowable fair rent for real property other than land
358 based on the rate of return for the cost year in which such bonds were
359 issued. The financial benefit resulting from a facility financing or
360 refinancing debt through such bonds shall be shared between the state
361 and the facility to an extent determined by the commissioner on a case-
362 by-case basis and shall be reflected in an adjustment to the facility's
363 allowable fair rent.

364 Sec. 9. Subdivision (1) of subsection (d) of section 19a-537 of the
365 general statutes is repealed and the following is substituted in lieu
366 thereof (*Effective July 1, 2008*):

367 (1) A facility shall be reimbursed for reserving the bed of a resident
368 who is hospitalized for a maximum of seven days including the
369 admission date of hospitalization, if on such date the nursing home
370 documents that (A) it has a vacancy rate of not more than [three] six
371 beds or [three] six per cent of licensed capacity, whichever is greater,
372 and (B) it contacted the hospital and the hospital failed to provide
373 objective information confirming that the person would be unable to
374 return to the nursing home within fifteen days of the date of
375 hospitalization.

376 Sec. 10. Subsection (a) of section 17b-354 of the 2008 supplement to
377 the general statutes is repealed and the following is substituted in lieu
378 thereof (*Effective July 1, 2008*):

379 (a) Except for applications deemed complete as of August 9, 1991,
380 the Department of Social Services shall not accept or approve any
381 requests for additional nursing home beds or modify the capital cost of
382 any prior approval for the period from September 4, 1991, through
383 June 30, 2012, except (1) beds restricted to use by patients with
384 acquired immune deficiency syndrome or traumatic brain injury; (2)
385 beds associated with a continuing care facility which guarantees life
386 care for its residents; (3) Medicaid certified beds to be relocated from
387 one licensed nursing facility to another licensed nursing facility,
388 provided (A) the availability of beds in an area of need will not be
389 adversely affected; (B) no such relocation shall result in an increase in
390 state expenditures; and (C) the relocation results in a reduction in the
391 number of nursing facility beds in the state; (4) a request for no more
392 than twenty beds submitted by a licensed nursing facility that
393 participates in neither the Medicaid program nor the Medicare
394 program, admits residents and provides health care to such residents
395 without regard to their income or assets and demonstrates its financial
396 ability to provide lifetime nursing home services to such residents
397 without participating in the Medicaid program to the satisfaction of
398 the department, provided the department does not accept or approve
399 more than one request pursuant to this subdivision; [and] (5) a request
400 for no more than twenty beds associated with a free standing facility
401 dedicated to providing hospice care services for terminally ill persons
402 operated by an organization previously authorized by the Department
403 of Public Health to provide hospice services in accordance with section
404 19a-122b of the 2008 supplement to the general statutes; and (6) new or
405 existing Medicaid certified beds to be relocated from a licensed
406 nursing facility in a municipality, with a 2004 estimated population of
407 one hundred twenty-five thousand, to a location within the same
408 municipality provided such Medicaid certified beds do not exceed
409 sixty beds. Notwithstanding the provisions of this subsection, any

410 provision of the general statutes or any decision of the Office of Health
411 Care Access, (i) the date by which construction shall begin for each
412 nursing home certificate of need in effect August 1, 1991, shall be
413 December 31, 1992, (ii) the date by which a nursing home shall be
414 licensed under each such certificate of need shall be October 1, 1995,
415 and (iii) the imposition of such dates shall not require action by the
416 Commissioner of Social Services. Except as provided in subsection (c)
417 of this section, a nursing home certificate of need in effect August 1,
418 1991, shall expire if construction has not begun or licensure has not
419 been obtained in compliance with the dates set forth in subparagraphs
420 (i) and (ii) of this subsection.

421 Sec. 11. Subsection (d) of section 17b-99 of the 2008 supplement to
422 the general statutes is repealed and the following is substituted in lieu
423 thereof (*Effective July 1, 2008*):

424 (d) The Commissioner of Social Services, or any entity with whom
425 the commissioner contracts, for the purpose of conducting an audit of
426 a service provider that participates as provider of services in a
427 program operated or administered by the department pursuant to this
428 chapter or chapter 319t, 319v, 319y or 319ff, shall conduct any such
429 audit in accordance with the provisions of this subsection. For
430 purposes of this subsection "provider" means a person, public agency,
431 private agency or proprietary agency that is licensed, certified or
432 otherwise approved by the commissioner to supply services
433 authorized by the programs set forth in said chapters.

434 (1) Not less than thirty days prior to the commencement of any such
435 audit, the commissioner, or any entity with whom the commissioner
436 contracts to conduct an audit of a participating provider, shall provide
437 written notification of the audit to such provider, unless the
438 commissioner, or any entity with whom the commissioner contracts to
439 conduct an audit of a participating provider makes a good faith
440 determination that (A) the health or safety of a recipient of services is
441 at risk; or (B) the provider is engaging in vendor fraud.

442 (2) Any such audit shall be limited in scope to claims during the
443 period commencing two calendar years prior to the date of the written
444 notice provided pursuant to subdivision (1) of this subsection and
445 ending on the date of such notice and shall not exceed more than two
446 hundred claims for such period of time.

447 [(2)] (3) Any clerical error, including, but not limited to,
448 recordkeeping, typographical, scrivener's or computer error,
449 discovered in a record or document produced for any such audit, shall
450 not of itself constitute a wilful violation of program rules and shall not
451 be used as the basis for extrapolated projections unless proof of intent
452 to commit fraud or otherwise violate program rules is established.

453 [(3)] (4) A finding of overpayment or underpayment to a provider in
454 a program operated or administered by the department pursuant to
455 this chapter or chapter 319t, 319v, 319y or 319ff, shall not be based on
456 extrapolated projections unless the rate of payment error exceeds ten
457 per cent and the commissioner makes a written finding that (A) there
458 is a sustained or high level of payment error involving the provider, or
459 (B) documented educational intervention has failed to correct the level
460 of payment error. [, or (C) the value of the claims in aggregate exceeds
461 one hundred fifty thousand dollars on an annual basis.]

462 [(4)] (5) A provider, in complying with the requirements of any such
463 audit, shall be allowed not less than thirty days to provide
464 documentation in connection with any discrepancy discovered and
465 brought to the attention of such provider in the course of any such
466 audit.

467 [(5)] (6) The commissioner, or any entity with whom the
468 commissioner contracts, for the purpose of conducting an audit of a
469 provider of any of the programs operated or administered by the
470 department pursuant to this chapter or chapter 319t, 319v, 319y or
471 319ff, shall produce a preliminary written report concerning any audit
472 conducted pursuant to this subsection, and such preliminary report
473 shall be provided to the provider that was the subject of the audit, not

474 more than sixty days after the conclusion of such audit.

475 ~~[(6)]~~ (7) The commissioner, or any entity with whom the
476 commissioner contracts, for the purpose of conducting an audit of a
477 provider of any of the programs operated or administered by the
478 department pursuant to this chapter or chapter 319t, 319v, 319y or
479 319ff, shall, following the issuance of the preliminary report pursuant
480 to subdivision ~~[(5)]~~ (6) of this subsection, hold an exit conference with
481 any provider that was the subject of any audit pursuant to this
482 subsection for the purpose of discussing the preliminary report.

483 ~~[(7)]~~ (8) The commissioner, or any entity with which the
484 commissioner contracts, for the purpose of conducting an audit of a
485 service provider, shall produce a final written report concerning any
486 audit conducted pursuant to this subsection. Such final written report
487 shall be provided to the provider that was the subject of the audit not
488 more than sixty days after the date of the exit conference conducted
489 pursuant to subdivision ~~[(6)]~~ (7) of this subsection, unless the
490 commissioner, or any entity with which the commissioner contracts,
491 for the purpose of conducting an audit of a service provider, agrees to
492 a later date or there are other referrals or investigations pending
493 concerning the provider.

494 ~~[(8)]~~ (9) Any provider aggrieved by a decision contained in a final
495 written report issued pursuant to subdivision ~~[(7)]~~ (8) of this
496 subsection, may, not later than thirty days after the receipt of the final
497 report, request, in writing, a review on all items of aggrievement. Such
498 request shall contain a detailed written description of each specific
499 item of aggrievement. The ~~[designee of]~~ person designated by the
500 commissioner [who presides] to preside over the review shall, prior to
501 such review, conduct a hearing on the merits of the provider's request
502 for review. The designee of the commissioner shall be impartial and
503 shall not be an employee of the Department of Social Services Office of
504 Quality Assurance or an employee of an entity with whom the
505 commissioner contracts for the purpose of conducting an audit of a

506 service provider. The designee of the commissioner shall issue a
507 decision not later than thirty days after the conclusion of the hearing.
508 Any provider aggrieved by a decision of the commissioner's designee
509 may appeal such decision to the Superior Court in accordance with the
510 provisions of chapter 54.

511 [(9)] (10) The provisions of this subsection shall not apply to any
512 audit conducted by the Medicaid Fraud Control Unit established
513 within the Office of the Chief State's Attorney.

514 (11) The commissioner shall adopt regulations, in accordance with
515 chapter 54, to carry out the provisions of this subsection. The
516 commissioner shall attach a copy of such regulations with the written
517 notification of the audit to the provider under subdivision (1) of this
518 subsection.

519 Sec. 12. Section 17b-278a of the general statutes is repealed and the
520 following is substituted in lieu thereof (*Effective July 1, 2008*):

521 The Commissioner of Social Services shall amend the Medicaid state
522 plan to provide coverage for treatment for smoking cessation ordered
523 by a licensed healthcare professional who possesses valid and current
524 state licensure to prescribe such drugs. [in accordance with a plan
525 developed by the commissioner to provide smoking cessation services.
526 The commissioner shall present such plan to the joint standing
527 committees of the General Assembly having cognizance of matters
528 relating to human services and appropriations by January 1, 2003, and,
529 if such plan is approved by said committees and funding is provided
530 in the budget for the fiscal year ending June 30, 2004, such plan shall
531 be implemented on July 1, 2003.]

532 Sec. 13. Section 17b-261a of the general statutes is repealed and the
533 following is substituted in lieu thereof (*Effective October 1, 2008*):

534 (a) [Any] Except as provided in subsection (d) of this section, any
535 transfer or assignment of assets resulting in the imposition of a penalty

536 period shall be presumed to be made with the intent, on the part of the
537 transferor or the transferee, to enable the transferor to obtain or
538 maintain eligibility for medical assistance. This presumption may be
539 rebutted only by clear and convincing evidence that the transferor's
540 eligibility or potential eligibility for medical assistance was not a basis
541 for the transfer or assignment.

542 (b) Any transfer or assignment of assets resulting in the
543 establishment or imposition of a penalty period shall create a debt, as
544 defined in section 36a-645, that shall be due and owing by the
545 transferor or transferee to the Department of Social Services in an
546 amount equal to the amount of the medical assistance provided to or
547 on behalf of the transferor on or after the date of the transfer of assets,
548 but said amount shall not exceed the fair market value of the assets at
549 the time of transfer. The Commissioner of Social Services, the
550 Commissioner of Administrative Services and the Attorney General
551 shall have the power or authority to seek administrative, legal or
552 equitable relief as provided by other statutes or by common law.

553 (c) The Commissioner of Social Services may waive the imposition
554 of a penalty period when the transferor (1) in accordance with the
555 provisions of section 3025.25 of the department's Uniform Policy
556 Manual, suffers from dementia at the time of application for medical
557 assistance and cannot explain transfers that would otherwise result in
558 the imposition of a penalty period; or (2) suffered from dementia at the
559 time of the transfer; or (3) was exploited into making such a transfer
560 due to dementia. Waiver of the imposition of a penalty period does not
561 prohibit the establishment of a debt in accordance with subsection (b)
562 of this section.

563 (d) An uncompensated transfer of assets made by the donation of a
564 conservation easement or conservation restriction that qualifies as a
565 qualified conservation contribution under Section 170(h) of the Internal
566 Revenue Code of 1986, or any subsequent corresponding internal
567 revenue code of the United States, as amended from time to time, shall

568 be presumed not to have been made for the purpose of qualifying for
569 medical assistance. The Commissioner of Social Services may rebut
570 this presumption by clear and convincing evidence that the donation
571 of the qualified conservation contribution was in fact made for such
572 purpose.

573 [(d)] (e) The Commissioner of Social Services, pursuant to section
574 17b-10, shall implement the policies and procedures necessary to carry
575 out the provisions of this section while in the process of adopting such
576 policies and procedures in regulation form, provided notice of intent to
577 adopt regulations is published in the Connecticut Law Journal not later
578 than twenty days after implementation. Such policies and procedures
579 shall be valid until the time final regulations are effective.

580 Sec. 14. (NEW) (*Effective July 1, 2008*) (a) There is established within
581 the General Fund, a separate, nonlapsing account to be known as the
582 state Medicaid pending pool account. The account shall contain all
583 moneys required by law to be deposited in the account.

584 (b) Moneys held in the account shall be used by the Department of
585 Social Services to advance payments to nursing home facilities, as
586 defined in section 19a-521 of the general statutes, certified to
587 participate in the Medicaid program, to cover the cost of care provided
588 by such nursing home facilities to residents who have applied for the
589 Medicaid program and are awaiting approval by the Department of
590 Social Services. Upon approval of such application, the Department of
591 Social Services shall make the proper adjustments to the
592 reimbursement methodology for such nursing home facility. The
593 Commissioner of Social Services shall adopt regulations, in accordance
594 with the provisions of chapter 54 of the general statutes, to establish
595 criteria for the disbursement of funds pursuant to this section.

596 Sec. 15. Section 17b-343 of the general statutes is repealed and the
597 following is substituted in lieu thereof (*Effective July 1, 2008*):

598 The Commissioner of Social Services shall establish annually the

599 maximum allowable rate to be paid by said agencies for homemaker
600 services, chore person services, companion services, respite care, meals
601 on wheels, adult day care services, case management and assessment
602 services, transportation, mental health counseling and elderly foster
603 care, except that the maximum allowable rates in effect July 1, 1990,
604 shall remain in effect during the fiscal years ending June 30, 1992, and
605 June 30, 1993. The Commissioner of Social Services shall prescribe
606 uniform forms on which agencies providing such services shall report
607 their costs for such services. Such rates shall be determined on the
608 basis of a reasonable payment for necessary services rendered. The
609 maximum allowable rates established by the Commissioner of Social
610 Services for the Connecticut home-care program for the elderly
611 established under section 17b-342 shall constitute the rates required
612 under this section until revised in accordance with this section. The
613 Commissioner of Social Services shall establish a fee schedule, to be
614 effective on and after July 1, 1994, for homemaker services, chore
615 person services, companion services, respite care, meals on wheels,
616 adult day care services, case management and assessment services,
617 transportation, mental health counseling and elderly foster care. The
618 commissioner may annually increase any fee in the fee schedule based
619 on an increase in the cost of services. The commissioner shall increase
620 the fee schedule effective July 1, 2000, by not less than five per cent, for
621 adult day care services. The commissioner shall increase the fee
622 schedule effective July 1, 2008, by not less than ____ per cent, for
623 transportation services. Nothing contained in this section shall
624 authorize a payment by the state to any agency for such services in
625 excess of the amount charged by such agency for such services to the
626 general public.

627 Sec. 16. (NEW) (*Effective July 1, 2008*) The Commissioner of Social
628 Services shall establish and administer a pilot program that shall
629 operate in an identical manner to the Money Follows the Person
630 demonstration project pursuant to section 17b-369 of the 2008
631 supplement to the general statutes, except that persons need not be
632 institutionalized for at least six months to be eligible for the program.

633 The pilot program shall serve no more than fifty persons. Services
 634 available under the pilot program shall include, but not be limited to,
 635 personal care assistance services. The commissioner may apply for a
 636 Medicaid research and demonstration waiver under Section 1115 of the
 637 Social Security Act, if such waiver is necessary to implement the pilot
 638 program. The commissioner may, if necessary, modify any existing
 639 Medicaid home or community-based waiver if such modification is
 640 required to implement the pilot program.

641 Sec. 17. (*Effective July 1, 2008*) The sum of ____ dollars is
 642 appropriated to the Department of Mental Health and Addiction
 643 Services, from the General Fund, for the fiscal year ending June 30,
 644 2009, for the purpose of increasing the rate of reimbursement to
 645 hospitals for inpatient and outpatient behavioral health visits under
 646 the state-administered general assistance program to equal the rate of
 647 reimbursement provided to hospitals for inpatient and outpatient
 648 visits under the Medicaid program.

649 Sec. 18. (*Effective July 1, 2008*) The sum of ____ dollars is
 650 appropriated to the Department of Social Services, from the General
 651 Fund, for the fiscal year ending June 30, 2009, for deposit in the state
 652 Medicaid pending pool account established pursuant to section 14 of
 653 this act.

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| This act shall take effect as follows and shall amend the following sections: | | |
| Section 1 | <i>July 1, 2008</i> | 17b-261 |
| Sec. 2 | <i>July 1, 2008</i> | 17b-276 |
| Sec. 3 | <i>July 1, 2008</i> | New section |
| Sec. 4 | <i>July 1, 2008</i> | 17b-242 |
| Sec. 5 | <i>July 1, 2008</i> | New section |
| Sec. 6 | <i>July 1, 2008</i> | New section |
| Sec. 7 | <i>July 1, 2008</i> | 17b-340 |
| Sec. 8 | <i>July 1, 2008</i> | 17b-340(f)(5) |
| Sec. 9 | <i>July 1, 2008</i> | 19a-537(d)(1) |
| Sec. 10 | <i>July 1, 2008</i> | 17b-354(a) |

| | | |
|---------|------------------------|-------------|
| Sec. 11 | <i>July 1, 2008</i> | 17b-99(d) |
| Sec. 12 | <i>July 1, 2008</i> | 17b-278a |
| Sec. 13 | <i>October 1, 2008</i> | 17b-261a |
| Sec. 14 | <i>July 1, 2008</i> | New section |
| Sec. 15 | <i>July 1, 2008</i> | 17b-343 |
| Sec. 16 | <i>July 1, 2008</i> | New section |
| Sec. 17 | <i>July 1, 2008</i> | New section |
| Sec. 18 | <i>July 1, 2008</i> | New section |

Statement of Purpose:

To implement changes concerning eligibility and reimbursement for the Medicaid program.

[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.]