



General Assembly

Substitute Bill No. 662

February Session, 2008

* SB00662HS_APP031808 *

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 subsection (j) as follows (*Effective July 1,*
3 *2008*):

4 (NEW) (j) To the extent permitted by federal law, for purposes of
5 determining Medicaid eligibility for an institutionalized individual, as
6 defined in Section 1917(c) of the Social Security Act, 42 USC 1396p(c),
7 the Department of Social Services shall exclude from consideration an
8 asset owned by that individual if: (1) The individual has an
9 outstanding debt to an institution for care and services that have been
10 provided to the individual that is equal to or more than the value of
11 the asset; (2) the individual demonstrates that he or she is making a
12 bona fide effort to dispose of the asset for fair market value or liquidate
13 such asset and the reason that the asset cannot be disposed of or
14 liquidated is either (A) due to a delay on the part of a financial
15 institution or insurance company; (B) a delay due to the need for the
16 appointment of a conservator for the individual; or (C) a delay due to
17 other circumstances beyond the control of the individual as
18 determined by the commissioner; (3) the amount of the asset does not
19 exceed ten thousand dollars or an amount in excess of ten thousand

20 dollars as approved by the commissioner and does not consist of the
21 corpus of a trust that may be liquidated at the discretion of the trustee;
22 and (4) the individual demonstrates that he or she has agreed to pay
23 the institution that which is necessary to repay such debt upon receipt
24 of the fair market value or liquidation of the asset.

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 Section 17b-276 of the general statutes is repealed and the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

27 (a) The Commissioner of Social Services shall identify geographic
28 areas of the state where competitive bidding for nonemergency
29 transportation services provided to medical assistance recipients to
30 access covered medical services would result in cost savings to the
31 state. For the identified areas, the Commissioner of Social Services, in
32 consultation with the Commissioner of Transportation, the
33 Commissioner of Public Health and the Secretary of the Office of
34 Policy and Management, shall purchase such nonemergency
35 transportation services through a competitive bidding process. Any
36 transportation providers awarded a contract or subcontract for the
37 direct provision of such services shall meet state licensure or
38 certification requirements and the nonemergency transportation
39 requirements established by the Department of Social Services, and
40 shall provide the most cost effective transportation service, provided
41 any contractor awarded a contract solely for coordinating such
42 transportation services shall not be required to meet such licensure or
43 certification requirements and provided the first such contracts for the
44 purchase of such services shall not exceed one year. Prior to awarding
45 a contract pursuant to this section, the Commissioner of Social Services
46 shall consider the effect of the contract on the emergency ambulance
47 primary service areas and volunteer ambulance services affected by
48 the contract. The commissioner may limit the geographic areas to be
49 served by a contractor and may limit the amount of services to be
50 performed by a contractor. The commissioner may operate one or
51 more pilot programs prior to state-wide operation of a competitive
52 bidding program for nonemergency transportation services. By
53 enrolling in the Medicaid program or participating in the

54 competitively bid contract for nonemergency transportation services,
55 providers of nonemergency transportation services agree to offer to
56 recipients of medical assistance all types or levels of transportation
57 services for which they are licensed or certified. Effective October 1,
58 1991, payment for such services shall be made only for services
59 provided to an eligible recipient who is actually transported. A
60 contract entered into pursuant to this section may include services
61 provided by another state agency. Notwithstanding any provision of
62 the general statutes, a contract entered into pursuant to this section
63 shall establish the rates to be paid for the transportation services
64 provided under the contract. A contract entered into pursuant to this
65 section may include services provided by another state agency and
66 shall supersede any conflicting provisions of the regulations of
67 Connecticut state agencies pertaining to medical transportation
68 services. Any contractor awarded a contract solely for coordinating
69 nonemergency transportation services for medical assistance
70 recipients, who also coordinates transportation services for
71 nonmedical assistance recipients, shall disclose to any transportation
72 provider with whom it subcontracts to provide nonemergency
73 transportation services under this section the source of payment at the
74 time the service is requested.

75 (b) Notwithstanding any other provision of the general statutes, for
76 purposes of administering medical assistance programs, including, but
77 not limited to, the state-administered general assistance program and
78 programs administered pursuant to Title XIX or Title XXI of the Social
79 Security Act, the Department of Social Services shall be the sole state
80 agency that sets emergency and nonemergency medical transportation
81 fees or fee schedules for any transportation services that are
82 reimbursed by the department for said medical assistance programs.

83 Sec. 3. (NEW) (*Effective July 1, 2008*) The Commissioner of Social
84 Services shall provide coverage under the Medicaid program for
85 nonemergency transportation by ambulance without prior
86 authorization for a patient who is: (1) Discharged from an acute care
87 hospital, long-term acute care hospital, psychiatric facility or

88 rehabilitation facility, and admitted as a new admission to another
89 facility, including a residential care facility, skilled nursing facility,
90 psychiatric facility, rehabilitation facility or long-term acute care
91 hospital, where prior authorization has been granted for the new
92 admission; (2) discharged from an acute care hospital, long-term acute
93 care hospital, psychiatric facility or rehabilitation facility, and returned
94 to his or her residence in a residential care facility, skilled nursing
95 facility, psychiatric facility, rehabilitation facility or long-term acute
96 care hospital; or (3) transported to a doctor's office, treatment facility or
97 testing facility either free standing or within a hospital, provided one
98 of the following conditions is met: (A) The patient is on oxygen not
99 available to the patient except by ambulance, (B) the patient is unable
100 to sit in a wheelchair or tolerate any other means of transport other
101 than a stretcher due to risk of injury, or (C) the patient's medical
102 condition requires monitoring by trained personnel.

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

105 (a) The Department of Social Services shall determine the rates to be
106 paid to home health care agencies and homemaker-home health aide
107 agencies by the state or any town in the state for persons aided or
108 cared for by the state or any such town. For the period from February
109 1, 1991, to January 31, 1992, inclusive, payment for each service to the
110 state shall be based upon the rate for such service as determined by the
111 Office of Health Care Access, except that for those providers whose
112 Medicaid rates for the year ending January 31, 1991, exceed the median
113 rate, no increase shall be allowed. For those providers whose rates for
114 the year ending January 31, 1991, are below the median rate, increases
115 shall not exceed the lower of the prior rate increased by the most
116 recent annual increase in the consumer price index for urban
117 consumers or the median rate. In no case shall any such rate exceed the
118 eightieth percentile of rates in effect January 31, 1991, nor shall any rate
119 exceed the charge to the general public for similar services. Rates
120 effective February 1, 1992, shall be based upon rates as determined by
121 the Office of Health Care Access, except that increases shall not exceed

122 the prior year's rate increased by the most recent annual increase in the
123 consumer price index for urban consumers and rates effective
124 February 1, 1992, shall remain in effect through June 30, 1993. Rates
125 effective July 1, 1993, shall be based upon rates as determined by the
126 Office of Health Care Access except if the Medicaid rates for any
127 service for the period ending June 30, 1993, exceed the median rate for
128 such service, the increase effective July 1, 1993, shall not exceed one
129 per cent. If the Medicaid rate for any service for the period ending June
130 30, 1993, is below the median rate, the increase effective July 1, 1993,
131 shall not exceed the lower of the prior rate increased by one and one-
132 half times the most recent annual increase in the consumer price index
133 for urban consumers or the median rate plus one per cent. The
134 Commissioner of Social Services shall establish a fee schedule for home
135 health services to be effective on and after July 1, 1994. The
136 commissioner may annually increase any fee in the fee schedule based
137 on an increase in the cost of services. The commissioner shall increase
138 the fee schedule for home health services provided under the
139 Connecticut home-care program for the elderly established under
140 section 17b-342, effective July 1, 2000, by two per cent over the fee
141 schedule for home health services for the previous year. The
142 commissioner may increase any fee payable to a home health care
143 agency or homemaker-home health aide agency upon the application
144 of such an agency evidencing extraordinary costs related to (1) serving
145 persons with AIDS; (2) high-risk maternal and child health care; (3)
146 escort services; or (4) extended hour services. In no case shall any rate
147 or fee exceed the charge to the general public for similar services. A
148 home health care agency or homemaker-home health aide agency
149 which, due to any material change in circumstances, is aggrieved by a
150 rate determined pursuant to this subsection may, [within] not later
151 than ten days [of] after receipt of written notice of such rate from the
152 Commissioner of Social Services, request in writing a hearing on all
153 items of aggrievement. The commissioner shall, upon the receipt of all
154 documentation necessary to evaluate the request, determine whether
155 there has been such a change in circumstances and shall conduct a
156 hearing if appropriate. The Commissioner of Social Services shall

157 adopt regulations, in accordance with chapter 54, to implement the
158 provisions of this subsection. The commissioner, pursuant to section
159 17b-10, may implement policies and procedures to carry out the
160 provisions of this subsection while in the process of adopting
161 regulations, provided notice of intent to adopt the regulations is
162 published in the Connecticut Law Journal [within] not later than
163 twenty days [of implementing the] after implementation of such
164 policies and procedures. Such policies and procedures shall be valid
165 for not longer than nine months.

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

170 (c) The home health services fee schedule shall include fees for a
171 skilled nursing visit, which shall apply when a patient (1) has one or
172 more active medical conditions requiring the attention of a nurse, or
173 (2) has been diagnosed with a serious and persistent mental illness that
174 requires the interventions of a psychiatric nurse. A skilled nursing visit
175 shall include, but not be limited to, assessment and monitoring of
176 blood pressure readings, blood glucose checks, pulse rate checks,
177 execution of any medical regimen under the direction of a physician
178 licensed in this state or a state that borders this state and, in the case of
179 any patient with a serious and persistent mental illness, mental status
180 assessment and the teaching of symptom management techniques.

181 [(c)] (d) The home health services fee schedule shall include a fee for
182 the administration of medication, which shall apply when the purpose
183 of a nurse's visit is limited to the administration of medication.
184 [Administration of medication may include, but is not limited to, blood
185 pressure checks, glucometer readings, pulse rate checks and similar
186 indicators of health status.] The fee for medication administration shall
187 include administration of medications while the nurse is present, the
188 pre-pouring of additional doses that the client will self-administer at a
189 later time and the teaching of self-administration. [The department

190 shall not pay for medication administration in addition to any other
191 nursing service at the same visit. The department may establish prior
192 authorization requirements for this service. Before implementing such
193 change, the Commissioner of Social Services shall consult with the
194 chairpersons of the joint standing committees of the General Assembly
195 having cognizance of matters relating to public health and human
196 services.] When the purpose of a nurse's visit is other than the
197 administration of medication, the visit shall be reimbursed at the
198 skilled nursing visit fee established under subsection (c) of this section.

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

202 (e) The Department of Social Services, when processing or auditing
203 claims for reimbursement submitted by home health care agencies and
204 homemaker-home health aide agencies shall, in accordance with the
205 provisions of chapter 15, accept electronic records and records bearing
206 the electronic signature of a licensed physician or licensed practitioner
207 of a healthcare profession that has been submitted to the home health
208 care agency or homemaker home-health aide agency.

209 (f) If the electronic record or signature that has been transmitted to a
210 home health care agency or homemaker-home health aide agency is
211 illegible or the department is unable to determine the validity of such
212 electronic record or signature, the department shall review additional
213 evidence of the accuracy or validity of the record or signature,
214 including, but not limited to, (1) the original of the record or signature,
215 or (2) a written statement, made under penalty of false statement, from
216 (A) the licensed physician or licensed practitioner of a health care
217 profession who signed such record, or (B) if such licensed physician or
218 licensed practitioner of a health care profession is unavailable, the
219 medical director of the agency verifying the accuracy or validity of
220 such record or signature, and the department shall make a
221 determination whether the electronic record or signature is valid.

222 (g) The Department of Social Services, when auditing claims
223 submitted by home health care agencies and homemaker-home health
224 aide agencies, shall consider any signature from a licensed physician
225 or licensed practitioner of a health care profession that may be
226 required on a plan of care for home health services, to have been
227 provided in timely fashion if (1) the document bearing such signature
228 was signed prior to the time when such agency seeks reimbursement
229 from the department for services provided, and (2) verbal or telephone
230 orders from the licensed physician or licensed practitioner of a health
231 care profession were received prior to the commencement of services
232 covered by the plan of care and such orders were subsequently
233 documented. Nothing in this subsection shall be construed as limiting
234 the powers of the Commissioner of Public Health to enforce the
235 provisions of sections 19-13-D73 and 19-13-D74 of the regulations of
236 Connecticut state agencies and 42 CFR 484.18(c).

237 (h) For purposes of this section, "licensed practitioner of a healthcare
238 profession" has the same meaning as "licensed practitioner" in section
239 21a-244a. For purposes of subsections (c) and (d) of this section,
240 "nurse" means an advanced practice nurse, registered nurse or
241 practical nurse licensed under chapter 378.

242 Sec. 5. (NEW) (*Effective July 1, 2008*) (a) On or before January 1, 2009,
243 the Department of Social Services shall establish a two-year pilot
244 program to investigate the feasibility and appropriateness of using
245 telemonitors to manage and treat up to one hundred fifty Medicaid
246 fee-for-service patients in the community with (1) congestive heart
247 failure, (2) diabetes, its indicative conditions, or both, and (3) chronic
248 obstructive pulmonary disease. The Commissioner of Social Services
249 shall contract through a request for proposals process with no fewer
250 than six home health agencies to operate the pilot program in
251 accordance with this section. Each proposal shall include a detailed
252 description of the entity's plan for administering the pilot program and
253 methods and procedures for data collection and reporting.

254 (b) In selecting patients to participate in the pilot program under

255 this section, each contracted home health agency shall consider the
256 following factors: (1) The nature of the patient's medical condition and
257 whether such medical condition requires health care services of
258 unusually high frequency, urgency or duration, (2) the patient's
259 cognitive ability, (3) whether the patient resides in a medically
260 underserved area, and (4) whether the patient has support from a
261 relative or other caregiver.

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

271 Sec. 6. Subsection (a) of section 17b-354 of the 2008 supplement to
272 the general statutes is repealed and the following is substituted in lieu
273 thereof (*Effective July 1, 2008*):

274 (a) Except for applications deemed complete as of August 9, 1991,
275 the Department of Social Services shall not accept or approve any
276 requests for additional nursing home beds or modify the capital cost of
277 any prior approval for the period from September 4, 1991, through
278 June 30, 2012, except (1) beds restricted to use by patients with
279 acquired immune deficiency syndrome or traumatic brain injury; (2)
280 beds associated with a continuing care facility which guarantees life
281 care for its residents; (3) Medicaid certified beds to be relocated from
282 one licensed nursing facility to another licensed nursing facility,
283 provided (A) the availability of beds in an area of need will not be
284 adversely affected; (B) no such relocation shall result in an increase in
285 state expenditures; and (C) the relocation results in a reduction in the
286 number of nursing facility beds in the state; (4) a request for no more
287 than twenty beds submitted by a licensed nursing facility that

288 participates in neither the Medicaid program nor the Medicare
289 program, admits residents and provides health care to such residents
290 without regard to their income or assets and demonstrates its financial
291 ability to provide lifetime nursing home services to such residents
292 without participating in the Medicaid program to the satisfaction of
293 the department, provided the department does not accept or approve
294 more than one request pursuant to this subdivision; [and] (5) a request
295 for no more than twenty beds associated with a free standing facility
296 dedicated to providing hospice care services for terminally ill persons
297 operated by an organization previously authorized by the Department
298 of Public Health to provide hospice services in accordance with section
299 19a-122b of the 2008 supplement to the general statutes; and (6) new or
300 existing Medicaid certified beds to be relocated from a licensed
301 nursing facility in a municipality, with a 2004 estimated population of
302 one hundred twenty-five thousand, to a location within the same
303 municipality provided such Medicaid certified beds do not exceed
304 sixty beds. Notwithstanding the provisions of this subsection, any
305 provision of the general statutes or any decision of the Office of Health
306 Care Access, (i) the date by which construction shall begin for each
307 nursing home certificate of need in effect August 1, 1991, shall be
308 December 31, 1992, (ii) the date by which a nursing home shall be
309 licensed under each such certificate of need shall be October 1, 1995,
310 and (iii) the imposition of such dates shall not require action by the
311 Commissioner of Social Services. Except as provided in subsection (c)
312 of this section, a nursing home certificate of need in effect August 1,
313 1991, shall expire if construction has not begun or licensure has not
314 been obtained in compliance with the dates set forth in subparagraphs
315 (i) and (ii) of this subsection.

316 Sec. 7. Subsection (d) of section 17b-99 of the 2008 supplement to the
317 general statutes is repealed and the following is substituted in lieu
318 thereof (*Effective July 1, 2008*):

319 (d) The Commissioner of Social Services, or any entity with whom
320 the commissioner contracts, for the purpose of conducting an audit of
321 a service provider that participates as provider of services in a

322 program operated or administered by the department pursuant to this
323 chapter or chapter 319t, 319v, 319y or 319ff, shall conduct any such
324 audit in accordance with the provisions of this subsection. For
325 purposes of this subsection "provider" means a person, public agency,
326 private agency or proprietary agency that is licensed, certified or
327 otherwise approved by the commissioner to supply services
328 authorized by the programs set forth in said chapters.

329 (1) Not less than thirty days prior to the commencement of any such
330 audit, the commissioner, or any entity with whom the commissioner
331 contracts to conduct an audit of a participating provider, shall provide
332 written notification of the audit to such provider, unless the
333 commissioner, or any entity with whom the commissioner contracts to
334 conduct an audit of a participating provider makes a good faith
335 determination that (A) the health or safety of a recipient of services is
336 at risk; or (B) the provider is engaging in vendor fraud.

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

342 ~~[(2)]~~ (3) Any clerical error, including, but not limited to,
343 recordkeeping, typographical, scrivener's or computer error,
344 discovered in a record or document produced for any such audit, shall
345 not of itself constitute a wilful violation of program rules and shall not
346 be used as the basis for extrapolated projections unless proof of intent
347 to commit fraud or otherwise violate program rules is established.

348 ~~[(3)]~~ (4) A finding of overpayment or underpayment to a provider in
349 a program operated or administered by the department pursuant to
350 this chapter or chapter 319t, 319v, 319y or 319ff, shall not be based on
351 extrapolated projections unless the rate of payment error exceeds ten
352 per cent and the commissioner makes a written finding that (A) there
353 is a sustained or high level of payment error involving the provider, or

354 (B) documented educational intervention has failed to correct the level
355 of payment error, [or (C) the value of the claims in aggregate exceeds
356 one hundred fifty thousand dollars on an annual basis.]

357 [(4)] (5) A provider, in complying with the requirements of any such
358 audit, shall be allowed not less than thirty days to provide
359 documentation in connection with any discrepancy discovered and
360 brought to the attention of such provider in the course of any such
361 audit.

362 [(5)] (6) The commissioner, or any entity with whom the
363 commissioner contracts, for the purpose of conducting an audit of a
364 provider of any of the programs operated or administered by the
365 department pursuant to this chapter or chapter 319t, 319v, 319y or
366 319ff, shall produce a preliminary written report concerning any audit
367 conducted pursuant to this subsection, and such preliminary report
368 shall be provided to the provider that was the subject of the audit, not
369 more than sixty days after the conclusion of such audit.

370 [(6)] (7) The commissioner, or any entity with whom the
371 commissioner contracts, for the purpose of conducting an audit of a
372 provider of any of the programs operated or administered by the
373 department pursuant to this chapter or chapter 319t, 319v, 319y or
374 319ff, shall, following the issuance of the preliminary report pursuant
375 to subdivision [(5)] (6) of this subsection, hold an exit conference with
376 any provider that was the subject of any audit pursuant to this
377 subsection for the purpose of discussing the preliminary report.

378 [(7)] (8) The commissioner, or any entity with which the
379 commissioner contracts, for the purpose of conducting an audit of a
380 service provider, shall produce a final written report concerning any
381 audit conducted pursuant to this subsection. Such final written report
382 shall be provided to the provider that was the subject of the audit not
383 more than sixty days after the date of the exit conference conducted
384 pursuant to subdivision [(6)] (7) of this subsection, unless the
385 commissioner, or any entity with which the commissioner contracts,

386 for the purpose of conducting an audit of a service provider, agrees to
387 a later date or there are other referrals or investigations pending
388 concerning the provider.

389 ~~[(8)]~~ (9) Any provider aggrieved by a decision contained in a final
390 written report issued pursuant to subdivision ~~[(7)]~~ (8) of this
391 subsection, may, not later than thirty days after the receipt of the final
392 report, request, in writing, a review on all items of aggrievement. Such
393 request shall contain a detailed written description of each specific
394 item of aggrievement. The ~~[designee of]~~ person designated by the
395 commissioner [who presides] to preside over the review shall, prior to
396 such review, conduct a hearing on the merits of the provider's request
397 for review. The designee of the commissioner shall be impartial and
398 shall not be an employee of the Department of Social Services Office of
399 Quality Assurance or an employee of an entity with whom the
400 commissioner contracts for the purpose of conducting an audit of a
401 service provider. The designee of the commissioner shall issue a
402 decision not later than thirty days after the conclusion of the hearing.
403 Any provider aggrieved by a decision of the commissioner's designee
404 may appeal such decision to the Superior Court in accordance with the
405 provisions of chapter 54.

406 ~~[(9)]~~ (10) The provisions of this subsection shall not apply to any
407 audit conducted by the Medicaid Fraud Control Unit established
408 within the Office of the Chief State's Attorney.

409 (11) The commissioner shall adopt regulations, in accordance with
410 chapter 54, to carry out the provisions of this subsection. The
411 commissioner shall attach a copy of such regulations with the written
412 notification of the audit to the provider under subdivision (1) of this
413 subsection.

414 Sec. 8. Section 17b-278a of the general statutes is repealed and the
415 following is substituted in lieu thereof (*Effective July 1, 2008*):

416 The Commissioner of Social Services shall amend the Medicaid state
417 plan to provide coverage for treatment for smoking cessation ordered

418 by a licensed healthcare professional who possesses valid and current
419 state licensure to prescribe such drugs. [in accordance with a plan
420 developed by the commissioner to provide smoking cessation services.
421 The commissioner shall present such plan to the joint standing
422 committees of the General Assembly having cognizance of matters
423 relating to human services and appropriations by January 1, 2003, and,
424 if such plan is approved by said committees and funding is provided
425 in the budget for the fiscal year ending June 30, 2004, such plan shall
426 be implemented on July 1, 2003.]

427 Sec. 9. Section 17b-261a of the general statutes is repealed and the
428 following is substituted in lieu thereof (*Effective October 1, 2008*):

429 (a) [Any] Except as provided in subsection (d) of this section, any
430 transfer or assignment of assets resulting in the imposition of a penalty
431 period shall be presumed to be made with the intent, on the part of the
432 transferor or the transferee, to enable the transferor to obtain or
433 maintain eligibility for medical assistance. This presumption may be
434 rebutted only by clear and convincing evidence that the transferor's
435 eligibility or potential eligibility for medical assistance was not a basis
436 for the transfer or assignment.

437 (b) Any transfer or assignment of assets resulting in the
438 establishment or imposition of a penalty period shall create a debt, as
439 defined in section 36a-645, that shall be due and owing by the
440 transferor or transferee to the Department of Social Services in an
441 amount equal to the amount of the medical assistance provided to or
442 on behalf of the transferor on or after the date of the transfer of assets,
443 but said amount shall not exceed the fair market value of the assets at
444 the time of transfer. The Commissioner of Social Services, the
445 Commissioner of Administrative Services and the Attorney General
446 shall have the power or authority to seek administrative, legal or
447 equitable relief as provided by other statutes or by common law.

448 (c) The Commissioner of Social Services may waive the imposition
449 of a penalty period when the transferor (1) in accordance with the

450 provisions of section 3025.25 of the department's Uniform Policy
451 Manual, suffers from dementia at the time of application for medical
452 assistance and cannot explain transfers that would otherwise result in
453 the imposition of a penalty period; or (2) suffered from dementia at the
454 time of the transfer; or (3) was exploited into making such a transfer
455 due to dementia. Waiver of the imposition of a penalty period does not
456 prohibit the establishment of a debt in accordance with subsection (b)
457 of this section.

458 (d) An uncompensated transfer of assets made by the donation of a
459 conservation easement or conservation restriction that qualifies as a
460 qualified conservation contribution under Section 170(h) of the Internal
461 Revenue Code of 1986, or any subsequent corresponding internal
462 revenue code of the United States, as amended from time to time, shall
463 be presumed not to have been made for the purpose of qualifying for
464 medical assistance. The Commissioner of Social Services may rebut
465 this presumption by clear and convincing evidence that the donation
466 of the qualified conservation contribution was in fact made for such
467 purpose.

468 [(d)] (e) The Commissioner of Social Services, pursuant to section
469 17b-10, shall implement the policies and procedures necessary to carry
470 out the provisions of this section while in the process of adopting such
471 policies and procedures in regulation form, provided notice of intent to
472 adopt regulations is published in the Connecticut Law Journal not later
473 than twenty days after implementation. Such policies and procedures
474 shall be valid until the time final regulations are effective.

475 Sec. 10. (NEW) (Effective July 1, 2008) (a) There is established within
476 the General Fund a separate, nonlapsing account to be known as the
477 state Medicaid pending pool account. The account shall contain all
478 moneys required by law to be deposited in the account.

479 (b) Moneys held in the account shall be used by the Department of
480 Social Services to advance payments to nursing home facilities, as
481 defined in section 19a-521 of the general statutes, certified to

482 participate in the Medicaid program, to cover the cost of care provided
483 by such nursing home facilities to residents who have applied for the
484 Medicaid program and are awaiting approval by the Department of
485 Social Services. Upon approval of such application, the Department of
486 Social Services shall make the proper adjustments to the
487 reimbursement methodology for such nursing home facility. The
488 Commissioner of Social Services shall adopt regulations, in accordance
489 with the provisions of chapter 54 of the general statutes, to establish
490 criteria for the disbursement of funds pursuant to this section.

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>	17b-354(a)
Sec. 7	<i>July 1, 2008</i>	17b-99(d)
Sec. 8	<i>July 1, 2008</i>	17b-278a
Sec. 9	<i>October 1, 2008</i>	17b-261a
Sec. 10	<i>July 1, 2008</i>	New section

HS

Joint Favorable Subst. C/R

APP