



Senate

General Assembly

File No. 462

January Session, 2009

Substitute Senate Bill No. 1122

Senate, April 6, 2009

The Committee on Human Services reported through SEN. DOYLE of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING CHANGES TO THE HUMAN SERVICES STATUTES.

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

1 Section 1. Section 17b-242 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective July 1, 2009*):

3 (a) The Department of Social Services shall determine the rates to be
4 paid to home health care agencies and homemaker-home health aide
5 agencies by the state or any town in the state for persons aided or
6 cared for by the state or any such town. For the period from February
7 1, 1991, to January 31, 1992, inclusive, payment for each service to the
8 state shall be based upon the rate for such service as determined by the
9 Office of Health Care Access, except that for those providers whose
10 Medicaid rates for the year ending January 31, 1991, exceed the median
11 rate, no increase shall be allowed. For those providers whose rates for
12 the year ending January 31, 1991, are below the median rate, increases
13 shall not exceed the lower of the prior rate increased by the most
14 recent annual increase in the consumer price index for urban

15 consumers or the median rate. In no case shall any such rate exceed the
16 eightieth percentile of rates in effect January 31, 1991, nor shall any rate
17 exceed the charge to the general public for similar services. Rates
18 effective February 1, 1992, shall be based upon rates as determined by
19 the Office of Health Care Access, except that increases shall not exceed
20 the prior year's rate increased by the most recent annual increase in the
21 consumer price index for urban consumers and rates effective
22 February 1, 1992, shall remain in effect through June 30, 1993. Rates
23 effective July 1, 1993, shall be based upon rates as determined by the
24 Office of Health Care Access except if the Medicaid rates for any
25 service for the period ending June 30, 1993, exceed the median rate for
26 such service, the increase effective July 1, 1993, shall not exceed one
27 per cent. If the Medicaid rate for any service for the period ending June
28 30, 1993, is below the median rate, the increase effective July 1, 1993,
29 shall not exceed the lower of the prior rate increased by one and one-
30 half times the most recent annual increase in the consumer price index
31 for urban consumers or the median rate plus one per cent. The
32 Commissioner of Social Services shall establish a fee schedule for home
33 health services to be effective on and after July 1, 1994. The
34 commissioner may annually increase any fee in the fee schedule based
35 on an increase in the cost of services. The commissioner shall increase
36 the fee schedule for home health services provided under the
37 Connecticut home-care program for the elderly established under
38 section 17b-342, as amended by this act, effective July 1, 2000, by two
39 per cent over the fee schedule for home health services for the previous
40 year. For the fiscal year ending June 30, 2010, the Commissioner of
41 Social Services shall increase the fees paid to home health care agencies
42 and homemaker-home health aide agencies under the Medicaid
43 program for nursing services, therapy and home health aide services
44 by not less than one-half of the difference between the rates paid by
45 the Department of Social Services for such services on June 30, 2009,
46 and the applicable rates paid by the Medicare program for home
47 health agency services when the Medicare program pays such agencies
48 on a per visit basis. For the fiscal year ending June 30, 2011, and each
49 fiscal year thereafter, the commissioner shall maintain the rates paid to

50 home health care agencies and homemaker-home health aide agencies
51 under the Medicaid program for nursing services, therapy and home
52 health aide services so that such rates are not less than the applicable
53 rates paid by the Medicare program for home health agency services
54 when the Medicare program pays such agencies on a per visit basis.
55 The commissioner may increase any fee payable to a home health care
56 agency or homemaker-home health aide agency upon the application
57 of such an agency evidencing extraordinary costs related to (1) serving
58 persons with AIDS; (2) high-risk maternal and child health care; (3)
59 escort services; [or] (4) extended hour services; or (5) financial distress
60 resulting from serving a disproportionate share of indigent patients. In
61 no case shall any rate or fee exceed the charge to the general public for
62 similar services. A home health care agency or homemaker-home
63 health aide agency which, due to any material change in
64 circumstances, is aggrieved by a rate determined pursuant to this
65 subsection may, within ten days of receipt of written notice of such
66 rate from the Commissioner of Social Services, request in writing a
67 hearing on all items of aggrievement. The commissioner shall, upon
68 the receipt of all documentation necessary to evaluate the request,
69 determine whether there has been such a change in circumstances and
70 shall conduct a hearing if appropriate. The Commissioner of Social
71 Services shall adopt regulations, in accordance with chapter 54, to
72 implement the provisions of this subsection. The commissioner may
73 implement policies and procedures to carry out the provisions of this
74 subsection while in the process of adopting regulations, provided
75 notice of intent to adopt the regulations is published in the Connecticut
76 Law Journal [within] not later than twenty days [of implementing the]
77 after the date of implementation of such policies and procedures. Such
78 policies and procedures shall be valid [for not longer than nine
79 months] until the time final regulations are adopted.

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

84 (c) (1) The home health services fee schedule shall include a fee for
85 the administration of medication, which shall apply when the purpose
86 of a nurse's visit is limited to the administration of medication. For the
87 fiscal year ending June 30, 2010, the Commissioner of Social Services
88 shall increase the fees over those for the previous fiscal year paid to
89 home health care agencies and homemaker-home health aide agencies
90 under the Medicaid program for administration of medication by the
91 percentage increase, if any, in the most recent calendar year average in
92 the consumer price index for urban consumers over the average for the
93 previous calendar year and shall increase the fees paid to such
94 agencies for extended hours nursing services by thirty-five per cent
95 over the rates in effect on June 30, 2009.

96 (2) Administration of medication may include, but is not limited to,
97 blood pressure checks, glucometer readings, pulse rate checks and
98 similar indicators of health status. The fee for medication
99 administration shall include administration of medications while the
100 nurse is present, the pre-pouring of additional doses that the client will
101 self-administer at a later time and the teaching of self-administration.
102 The department shall not pay for medication administration in
103 addition to any other nursing service at the same visit. The department
104 may establish prior authorization requirements for this service. Before
105 implementing such change, the Commissioner of Social Services shall
106 consult with the chairpersons of the joint standing committees of the
107 General Assembly having cognizance of matters relating to public
108 health and human services.

109 (d) The home health services fee schedule established pursuant to
110 subsection (c) of this section shall include rates for psychiatric nurse
111 visits.

112 (e) The Department of Social Services, when processing or auditing
113 claims for reimbursement submitted by home health care agencies and
114 homemaker-home health aide agencies shall, in accordance with the
115 provisions of chapter 15, accept electronic records and records bearing
116 the electronic signature of a licensed physician or licensed practitioner

117 of a healthcare profession that has been submitted to the home health
118 care agency or homemaker home-health aide agency.

119 (f) If the electronic record or signature that has been transmitted to a
120 home health care agency or homemaker-home health aide agency is
121 illegible or the department is unable to determine the validity of such
122 electronic record or signature, the department shall review additional
123 evidence of the accuracy or validity of the record or signature,
124 including, but not limited to, (1) the original of the record or signature,
125 or (2) a written statement, made under penalty of false statement, from
126 (A) the licensed physician or licensed practitioner of a health care
127 profession who signed such record, or (B) if such licensed physician or
128 licensed practitioner of a health care profession is unavailable, the
129 medical director of the agency verifying the accuracy or validity of
130 such record or signature, and the department shall make a
131 determination whether the electronic record or signature is valid.

132 (g) The Department of Social Services, when auditing claims
133 submitted by home health care agencies and homemaker-home health
134 aide agencies, shall consider any signature from a licensed physician
135 or licensed practitioner of a health care profession that may be
136 required on a plan of care for home health services, to have been
137 provided in timely fashion if (1) the document bearing such signature
138 was signed prior to the time when such agency seeks reimbursement
139 from the department for services provided, and (2) verbal or telephone
140 orders from the licensed physician or licensed practitioner of a health
141 care profession were received prior to the commencement of services
142 covered by the plan of care and such orders were subsequently
143 documented. Nothing in this subsection shall be construed as limiting
144 the powers of the Commissioner of Public Health to enforce the
145 provisions of sections 19-13-D73 and 19-13-D74 of the regulations of
146 Connecticut state agencies and 42 CFR 484.18(c).

147 (h) Not later than October 1, 2009, the Commissioner of Social
148 Services shall establish a fee schedule and billing codes for the cost of
149 supplies and administration of influenza and pneumococcal

150 polysaccharide vaccines provided by nurses employed by a licensed
151 home health care or homemaker-home health aide agency to persons
152 eligible for benefits under Medicaid, and not otherwise eligible for
153 coverage for such vaccines under Medicare. Such fees and billing
154 requirements shall be identical to those for mass immunizers under
155 Medicare. In the case of the administration of the influenza vaccine in
156 the home to a person eligible for Medicaid, the fee established by the
157 commissioner for the vaccine shall be in addition to the fee otherwise
158 available for administration of medication by a nurse employed by a
159 home health agency, pursuant to subsection (c) of this section. The
160 commissioner shall adopt regulations, in accordance with chapter 54,
161 to carry out the provisions of this subsection. The commissioner may
162 implement policies and procedures to carry out the provisions of this
163 subsection while in the process of adopting regulations, provided
164 notice of the intent to adopt the regulations is published in the
165 Connecticut Law Journal not later than twenty days after the date of
166 implementation of such policies and procedures. Such policies and
167 procedures shall be valid until the time final regulations are adopted.

168 [(h)] (i) For purposes of this section, "licensed practitioner of a
169 healthcare profession" has the same meaning as "licensed practitioner"
170 in section 21a-244a. For purposes of subsections (c), (d) and (h) of this
171 section, "nurse" means an advanced practice registered nurse, licensed
172 under section 20-94a.

173 Sec. 2. Section 17b-343 of the general statutes is repealed and the
174 following is substituted in lieu thereof (*Effective from passage*):

175 The Commissioner of Social Services shall establish annually the
176 maximum allowable rate to be paid by said agencies for homemaker
177 services, chore person services, companion services, respite care, meals
178 on wheels, adult day care services, case management and assessment
179 services, transportation, mental health counseling and elderly foster
180 care, except that the maximum allowable rates in effect July 1, 1990,
181 shall remain in effect during the fiscal years ending June 30, 1992, and
182 June 30, 1993. The Commissioner of Social Services shall prescribe

183 uniform forms on which agencies providing such services shall report
184 their costs for such services. Such rates shall be determined on the
185 basis of a reasonable payment for necessary services rendered. The
186 maximum allowable rates established by the Commissioner of Social
187 Services for the Connecticut home-care program for the elderly
188 established under section 17b-342, as amended by this act, shall
189 constitute the rates required under this section until revised in
190 accordance with this section. For the fiscal year ending June 30, 2009,
191 the commissioner shall increase the fees over those for the previous
192 fiscal year for homemaker and companion services provided under
193 such program by the percentage increase, if any, in the most recent
194 calendar year average in the consumer price index for urban
195 consumers over the average for the previous calendar year. The
196 Commissioner of Social Services shall establish a fee schedule, to be
197 effective on and after July 1, 1994, for homemaker services, chore
198 person services, companion services, respite care, meals on wheels,
199 adult day care services, case management and assessment services,
200 transportation, mental health counseling and elderly foster care. The
201 commissioner may annually increase any fee in the fee schedule based
202 on an increase in the cost of services. The commissioner shall increase
203 the fee schedule effective July 1, 2000, by not less than five per cent, for
204 adult day care services. Nothing contained in this section shall
205 authorize a payment by the state to any agency for such services in
206 excess of the amount charged by such agency for such services to the
207 general public.

208 Sec. 3. (NEW) (*Effective July 1, 2009*) Not later than January 1, 2010,
209 the Department of Social Services shall establish a fee schedule and
210 billing codes for payments to home health agencies that provide
211 telemonitors to beneficiaries of medical assistance who have chronic
212 conditions, including, but not limited to: (1) Congestive heart failure,
213 (2) diabetes, and (3) chronic obstructive pulmonary disease. The
214 Commissioner of Social Services shall ensure that patients selected to
215 receive telemonitoring services by a home health agency are evaluated
216 to determine (A) the nature of the patient's medical condition and
217 whether such medical condition requires skilled nursing visits that

218 could be reduced through telemonitoring, (B) whether the patient has
219 had a history of frequent hospitalizations or emergency room use over
220 the prior twelve months, (C) the patient's cognitive ability, (D) the
221 patient's support system, and (E) whether the patient resides in a
222 medically underserved area. The commissioner shall adopt
223 regulations, in accordance with chapter 54 of the general statutes, to
224 carry out the provisions of this subsection. The commissioner may
225 implement policies and procedures to carry out the provisions of this
226 subsection while in the process of adopting regulations, provided
227 notice of the intent to adopt the regulations is published in the
228 Connecticut Law Journal not later than twenty days after the date of
229 implementation of such policies and procedures. Such policies and
230 procedures shall be valid until the time final regulations are adopted.

231 Sec. 4. Subsection (c) of section 17b-342 of the general statutes is
232 repealed and the following is substituted in lieu thereof (*Effective July*
233 *1, 2009*):

234 (c) The community-based services covered under the program shall
235 include, but not be limited to, the following services to the extent that
236 they are not available under the state Medicaid plan, occupational
237 therapy, homemaker services, telemonitoring, companion services,
238 meals on wheels, adult day care, transportation, mental health
239 counseling, care management, elderly foster care, minor home
240 modifications and assisted living services provided in state-funded
241 congregate housing and in other assisted living pilot or demonstration
242 projects established under state law. Recipients of state-funded
243 services and persons who are determined to be functionally eligible for
244 community-based services who have an application for medical
245 assistance pending shall have the cost of home health and community-
246 based services covered by the program, provided they comply with all
247 medical assistance application requirements. Access agencies shall not
248 use department funds to purchase community-based services or home
249 health services from themselves or any related parties.

250 Sec. 5. Subsection (a) of section 17b-371 of the general statutes is

251 repealed and the following is substituted in lieu thereof (*Effective from*
252 *passage*):

253 (a) There is established within the General Fund, a separate,
254 nonlapsing account which shall be known as the "Long-Term Care
255 Reinvestment account". The account shall contain any moneys
256 required by law and this section to be deposited in the account. Any
257 funds resulting from the following sources shall be deposited in the
258 account: (1) The enhanced federal medical assistance percentage
259 received by the state under the Money Follows the Person
260 demonstration project pursuant to Section 6071 of the Deficit
261 Reduction Act of 2005, [shall be deposited in the account] (2) federal
262 reimbursement for persons who become eligible for medical assistance
263 as a result of implementation of the demonstration project to provide
264 home and community-based long-term care services, pursuant to
265 section 17b-370, and who would have met the financial eligibility
266 criteria for the state-funded portion of the Connecticut home-care
267 program for the elderly pursuant to section 17b-342, as amended by
268 this act, (3) federal funds received as a result of Medicaid reforms or
269 increases in the federal Medicaid matching funds, and (4) the
270 estimated savings from diverting persons from nursing facility care
271 under such demonstration project. Such savings shall be calculated by
272 subtracting the costs of home and community-based care under the
273 demonstration project from costs of nursing facility care and by
274 reducing that amount by thirty-five per cent, for all persons receiving
275 home and community-based care under the demonstration project.

276 Sec. 6. Section 2-33a of the general statutes is repealed and the
277 following is substituted in lieu thereof (*Effective July 1, 2009*):

278 The General Assembly shall not authorize an increase in general
279 budget expenditures for any fiscal year above the amount of general
280 budget expenditures authorized for the previous fiscal year by a
281 percentage which exceeds the greater of the percentage increase in
282 personal income or the percentage increase in inflation, unless the
283 Governor declares an emergency or the existence of extraordinary

284 circumstances and at least three-fifths of the members of each house of
285 the General Assembly vote to exceed such limit for the purposes of
286 such emergency or extraordinary circumstances. Any such declaration
287 shall specify the nature of such emergency or circumstances and may
288 provide that such proposed additional expenditures shall not be
289 considered general budget expenditures for the current fiscal year for
290 the purposes of determining general budget expenditures for the
291 ensuing fiscal year and any act of the General Assembly authorizing
292 such expenditures may contain such provision. As used in this section,
293 "increase in personal income" means the average of the annual increase
294 in personal income in the state for each of the preceding five years,
295 according to United States Bureau of Economic Analysis data;
296 "increase in inflation" means the increase in the consumer price index
297 for urban consumers during the preceding twelve-month period,
298 according to United States Bureau of Labor Statistics data; and "general
299 budget expenditures" means expenditures from appropriated funds
300 authorized by public or special act of the General Assembly, provided
301 (1) general budget expenditures shall not include expenditures for
302 payment of the principal of and interest on bonds, notes or other
303 evidences of indebtedness, expenditures pursuant to section 4-30a, [or]
304 current or increased expenditures for statutory grants to distressed
305 municipalities, provided such grants are in effect on July 1, 1991, or
306 expenditures made with funds received from the federal government
307 under the Medicaid program, and (2) expenditures for the
308 implementation of federal mandates or court orders shall not be
309 considered general budget expenditures for the first fiscal year in
310 which such expenditures are authorized, but shall be considered
311 general budget expenditures for such year for the purposes of
312 determining general budget expenditures for the ensuing fiscal year.
313 As used in this section, "federal mandates" means those programs or
314 services in which the state must participate, or in which the state
315 participated on July 1, 1991, and in which the state must meet federal
316 entitlement and eligibility criteria in order to receive federal
317 reimbursement, provided expenditures for program or service
318 components which are optional under federal law or regulation shall

319 be considered general budget expenditures.

320 Sec. 7. Section 17b-94 of the general statutes is repealed and the
321 following is substituted in lieu thereof (*Effective July 1, 2009*):

322 [(a) In the case of causes of action of beneficiaries of aid under the
323 state supplement program, medical assistance program, aid to families
324 with dependent children program, temporary family assistance
325 program or state-administered general assistance program, subject to
326 subsections (b) and (c) of section 17b-93, or of a parent of a beneficiary
327 of the aid to families with dependent children program, the temporary
328 family assistance program or the state-administered general assistance
329 program, the claim of the state shall be a lien against the proceeds
330 therefrom in the amount of the assistance paid or fifty per cent of the
331 proceeds received by such beneficiary or such parent after payment of
332 all expenses connected with the cause of action, whichever is less, for
333 repayment under said section 17b-93, and shall have priority over all
334 other claims except attorney's fees for said causes, expenses of suit,
335 costs of hospitalization connected with the cause of action by
336 whomever paid over and above hospital insurance or other such
337 benefits, and, for such period of hospitalization as was not paid for by
338 the state, physicians' fees for services during any such period as are
339 connected with the cause of action over and above medical insurance
340 or other such benefits; and such claim shall consist of the total
341 assistance repayment for which claim may be made under said
342 programs. The proceeds of such causes of action shall be assignable to
343 the state for payment of the amount due under said section 17b-93,
344 irrespective of any other provision of law. Upon presentation to the
345 attorney for the beneficiary of an assignment of such proceeds
346 executed by the beneficiary or his conservator or guardian, such
347 assignment shall constitute an irrevocable direction to the attorney to
348 pay the Commissioner of Administrative Services in accordance with
349 its terms, except if, after settlement of the cause of action or judgment
350 thereon, the Commissioner of Administrative Services does not inform
351 the attorney for the beneficiary of the amount of lien which is to be
352 paid to the Commissioner of Administrative Services within forty-five

353 days of receipt of the written request of such attorney for such
354 information, such attorney may distribute such proceeds to such
355 beneficiary and shall not be liable for any loss the state may sustain
356 thereby.]

357 [(b)] In the case of an inheritance of an estate by a beneficiary of aid
358 under the state supplement program, medical assistance program, aid
359 to families with dependent children program, temporary family
360 assistance program or state-administered general assistance program,
361 subject to subsections (b) and (c) of section 17b-93, as amended by this
362 act, fifty per cent of the assets of the estate payable to the beneficiary or
363 the amount of such assets equal to the amount of assistance paid,
364 whichever is less, shall be assignable to the state for payment of the
365 amount due under said section 17b-93, as amended by this act. The
366 state shall have a lien against such assets in the applicable amount
367 specified in this subsection. The Court of Probate shall accept any such
368 assignment executed by the beneficiary or any such lien notice if such
369 assignment or lien notice is filed by the Commissioner of
370 Administrative Services with the court prior to the distribution of such
371 inheritance, and to the extent of such inheritance not already
372 distributed, the court shall order distribution in accordance therewith.
373 If the Commissioner of Administrative Services receives any assets of
374 an estate pursuant to any such assignment, the commissioner shall be
375 subject to the same duties and liabilities concerning such assigned
376 assets as the beneficiary.

377 Sec. 8. Subsection (a) of section 17b-93 of the general statutes is
378 repealed and the following is substituted in lieu thereof (*Effective July*
379 *1, 2009*):

380 (a) If a beneficiary of aid under the state supplement program,
381 medical assistance program, aid to families with dependent children
382 program, temporary family assistance program or state-administered
383 general assistance program has or acquires property of any kind or
384 interest in any property [,] or estate [or claim] of any kind, except
385 moneys received for the replacement of real or personal property, the

386 state of Connecticut shall have a claim subject to subsections (b) and (c)
387 of this section, which shall have priority over all other unsecured
388 claims and unrecorded encumbrances, against such beneficiary for the
389 full amount paid, subject to the provisions of section 17b-94, as
390 amended by this act, to him or [in] on his behalf under said programs;
391 and, in addition thereto, the parents of an aid to dependent children
392 beneficiary, a state-administered general assistance beneficiary or a
393 temporary family assistance beneficiary shall be liable to repay, subject
394 to the provisions of said section 17b-94, as amended by this act, to the
395 state the full amount of any such aid paid to or in behalf of either
396 parent, his spouse, and his child or children. The state of Connecticut
397 shall have a lien against property of any kind or interest in any
398 property [,] or estate [or claim] of any kind of the parents of an aid to
399 dependent children beneficiary, in addition and not in substitution of
400 its claim, for amounts owing under any order for support of any court
401 or any family support magistrate, including any arrearage under such
402 order, provided household goods and other personal property
403 identified in section 52-352b, real property pursuant to section 17b-79,
404 as long as such property is used as a home for the beneficiary and
405 money received for the replacement of real or personal property, shall
406 be exempt from such lien.

407 Sec. 9. Section 17b-129 of the general statutes is repealed and the
408 following is substituted in lieu thereof (*Effective July 1, 2009*):

409 [(a) If any beneficiary of aid under sections 17b-122, 17b-124 to 17b-
410 132, inclusive, 17b-136 to 17b-138, inclusive, 17b-194 to 17b-197,
411 inclusive, 17b-222 to 17b-250, inclusive, 17b-256, 17b-263, 17b-340 to
412 17b-350, inclusive, 17b-689b and 17b-743 to 17b-747, inclusive, has a
413 cause of action, a town that provided aid to such beneficiary shall have
414 a claim against the proceeds of such cause of action for the amount of
415 such aid or fifty per cent of the proceeds received by such beneficiary
416 after payment of all expenses connected with the cause of action,
417 whichever is less, which shall have priority over all other unsecured
418 claims and unrecorded encumbrances. Such claim shall be a lien,
419 subordinate to any interest the state may possess under section 17b-94,

420 against the proceeds from such cause of action, for the amount
421 established in accordance with this section, and such lien shall have
422 priority over all other claims except attorney's fees for such causes of
423 action, expenses of suit, costs of hospitalization connected with the
424 cause of action by whomever paid, over and above hospital insurance
425 or other such benefits, and, for such period of hospitalization as was
426 not paid for by the town, physician's fees for services during any such
427 period as are connected with the cause of action over and above
428 medical insurance or other such benefits. Where the state also has a
429 claim against the proceeds of such cause of action under section 17b-
430 94, the total amount of the claims by the state under said section and
431 the town under this subsection shall not exceed fifty per cent of the
432 proceeds received by the recipient after the allowable expenses and the
433 town's claim shall be reduced accordingly. The proceeds of such causes
434 of action shall be assignable to the town for payment of such lien
435 irrespective of any other provision of law except section 17b-94. Upon
436 presentation to the attorney for the beneficiary of an assignment of
437 such proceeds executed by the beneficiary or his conservator or
438 guardian, such assignment shall constitute an irrevocable direction to
439 the attorney to pay the town in accordance with its terms.]

440 [(b)] (a) In the case of an inheritance of an estate by a beneficiary of
441 aid under sections 17b-122, 17b-124 to 17b-132, inclusive, 17b-136 to
442 17b-138, inclusive, 17b-194 to 17b-197, inclusive, 17b-222 to 17b-250,
443 inclusive, 17b-256, 17b-263, 17b-340 to 17b-350, inclusive, 17b-689b and
444 17b-743 to 17b-747, inclusive, fifty per cent of the assets of the estate
445 payable to the beneficiary or the amount of such assets equal to the
446 amount of assistance paid, whichever is less, shall be assignable to the
447 town. Where the state also has an assignment of such assets under
448 section 17b-94, the total amount of the claims of the state under said
449 section and the town under this subsection shall not exceed fifty per
450 cent of the assets of the estate payable to the beneficiary and the town's
451 assigned share shall be reduced accordingly. The Court of Probate
452 shall accept any such assignment executed by the beneficiary and filed
453 by the town with the court prior to the distribution of such inheritance,
454 and to the extent of such inheritance not already distributed, the court

455 shall order distribution in accordance therewith. If the town receives
 456 any assets of an estate pursuant to any such assignment, the town shall
 457 be subject to the same duties and liabilities concerning such assigned
 458 assets as the beneficiary.

459 [(c)] (b) No claim shall be made, or lien applied, against any
 460 payment made pursuant to chapter 135, any payment made pursuant
 461 to section 47-88d or 47-287, any moneys received as a settlement or
 462 award in a housing or employment or public accommodation
 463 discrimination case, any court-ordered retroactive rent abatement,
 464 including any made pursuant to subsection (e) of section 47a-14h, or
 465 section 47a-4a, 47a-5 or 47a-57, or any security deposit refund pursuant
 466 to subsection (d) of section 47a-21 paid to a beneficiary of assistance
 467 under sections 17b-122, 17b-124 to 17b-132, inclusive, 17b-136 to 17b-
 468 138, inclusive, 17b-194 to 17b-197, inclusive, 17b-222 to 17b-250,
 469 inclusive, 17b-256, 17b-263, 17b-340 to 17b-350, inclusive, 17b-689b and
 470 17b-743 to 17b-747, inclusive.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2009</i>	17b-242
Sec. 2	<i>from passage</i>	17b-343
Sec. 3	<i>July 1, 2009</i>	New section
Sec. 4	<i>July 1, 2009</i>	17b-342(c)
Sec. 5	<i>from passage</i>	17b-371(a)
Sec. 6	<i>July 1, 2009</i>	2-33a
Sec. 7	<i>July 1, 2009</i>	17b-94
Sec. 8	<i>July 1, 2009</i>	17b-93(a)
Sec. 9	<i>July 1, 2009</i>	17b-129

Statement of Legislative Commissioners:

Changed the effective date of section 2 to effective from passage for accuracy because the new language affects the current fiscal year.

HS *Joint Favorable Subst.-LCO*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect
Department of Social Services	GF - See Below

Municipal Impact: None

Explanation

Section 1 of this bill increases certain Medicaid home health fees. These rates would be increased to the comparable Medicare rate over the course of the FY 10-11 biennium. It is not currently known by what percentage Medicaid rates are below those paid by Medicare. The state currently spends approximately \$190 million annually on Medicaid home care services. Therefore, for every 5% increase in rates paid, the state would incur increased annual costs of \$9.5 million.

The bill also requires the Department of Social Services (DSS) to cover flu and pneumonia vaccines under Medicaid-funded home health care for beneficiaries ineligible to receive the vaccines under Medicare. This would result in an additional billable cost to the state that would be dependent upon the fee established for the services. To the extent that these additional vaccinations prevent Medicaid funded hospitalizations or nursing home stays, significant offsetting savings may result.

Section 2 of the bill requires DSS to increase the FY 09 rates paid under the state funded Connecticut Home Care program by the rate for the consumer price index - urban. Based on a 1.8% increase, this requirement would cost \$400,000 for the remainder of FY 09, with an annualized cost of \$1.2 million.

Sections 3 and 4 of the bill require DSS to provide coverage of

telemonitoring under Medicaid and the Connecticut Home Care program for certain clients with chronic conditions. This service is anticipated to have a net savings overall. The FY 10-11 biennial budget (as approved by the Appropriations Committee) included funding for a pilot program under Medicaid. This pilot was anticipated to save \$100,000 in FY 10 and \$250,000 in FY 11.

Section 5 expands the funding sources for the Long-Term Care Reinvestment Account. This will result in a significant revenue loss for the General Fund, as the money diverted to the Reinvestment Account would otherwise be dedicated to the General Fund.

Section 6 exempts expenditures made with federal Medicaid funds from general budget expenditures for the purpose of calculating the state spending cap. This provision has no direct fiscal impact.

Sections 7 through 9 repeals the state's ability to claim or apply a lien against any type of claim in which the beneficiary has an interest, or lawsuit proceeds received by the beneficiary. By law, a beneficiary of aid under the State Supplement, Medicaid, Temporary Family Assistance, or State Administered General Assistance programs must repay the state for any assistance they receive, with some exceptions.

Under current law, the state can claim or place a lien against a beneficiary's property, estate, or certain types of claim in which the beneficiary has an interest. The state can also place a lien against any beneficiary's lawsuit proceeds for the full amount of assistance paid or 50% of the proceeds after expenses, whichever is less.

This bill will result in a significant revenue loss to the state. Under the bill, the Department of Administrative Services (DAS) would not be able to lien causes of actions. In FY 08, the DAS collected \$18.3 million from liens on causes of actions.

In addition to the significant loss of revenue, removing the state's ability to recover Medicaid costs from causes of actions may put the state in jeopardy of violating federal Medicaid rules -- which would

affect the state's participation in the Medicaid program.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

Sources: Public hearing testimony, DSS cost and caseload data, FY 10-11 Biennial budget request

OLR Bill Analysis

SB 1122

AN ACT CONCERNING CHANGES TO THE HUMAN SERVICES STATUTES.

SUMMARY:

This bill makes several changes in the statutes governing Department of Social Services (DSS) programs. It:

1. excludes expenditures made with federal Medicaid funds from general budget expenditures for the purpose of calculating the state spending cap;
2. increases certain Medicaid rates for home health and homemaker-home health aide agencies;
3. increases the FY 09 fees paid for homemaker and companion services provided under the Connecticut Home Care Program for Elders (CHCPE);
4. requires the DSS commissioner to provide Medicaid coverage for flu and pneumonia vaccines for beneficiaries ineligible to receive the vaccines under Medicare;
5. requires the DSS commissioner to provide coverage of telemonitoring services under Medicaid and CHCPE;
6. limits state claims against certain public assistance beneficiaries; and
7. expands the funding sources for the Long-Term Care Reinvestment Account.

EFFECTIVE DATE: July 1, 2009, except for the provisions regarding the Long-Term Care Reinvestment Account and increased fees for

homemaker and companion services under CHCPE, which take effect upon passage

§ 6 — STATE SPENDING CAP

The bill excludes expenditures made with federal Medicaid funds from being considered general budget expenditures in calculating the state spending cap. Current law also exempts from this calculation (1) principal and interest payments on bonds and other state indebtedness, (2) expenditures for statutory grants to distressed municipalities, or (3) first year expenditures on federal mandates or court orders and (CGS § 2-33a).

By law, the legislature must limit the increase in general budget expenditures each year to the average growth in personal income over the past five years or the inflation rate over the last year, whichever is greater. The cap may be exceeded if the governor declares an emergency or there are extraordinary circumstances and at least 3/5 of both the House and Senate agree.

§ 1 — INCREASED MEDICAID RATES FOR HOME HEALTH AGENCIES AND HOMEMAKER-HOME HEALTH AIDE AGENCIES

Nursing, Therapy, and Home Health Aide Services Fees

The bill requires the DSS commissioner to increase the Medicaid fees paid to home health care agencies and homemaker-home health aide agencies for nursing services, therapy, and home health aide services. For FY 10, he must increase these fees by at least half the difference between the DSS Medicaid rates in effect on June 30, 2009 and the applicable per-visit Medicare rates for home health agency services. And starting FY 11, he must pay rates for these services at least as high as the applicable per-visit Medicare rates for home health agency services.

The bill adds a condition under which the commissioner may increase an agency's fees: financial distress resulting from serving a disproportionate share of indigent patients. Currently, he may increase an agency's fees if it demonstrates extraordinary costs related to (1)

serving individuals with AIDS, (2) high risk maternal and child health care, (3) escort services, or (4) extended hour services.

By law, the DSS commissioner may implement policies and procedures to administer these agency rates while in the process of adopting them in regulation, provided notice is published in the *Connecticut Law Journal* no later than 20 days after they are implemented. The bill specifies that these policies and procedures are valid until the final regulations are adopted. Under current law, they are only valid for up to nine months.

Home Health Medication Administration and Extended Hours Nursing Services Fees

In FY 10, the bill requires the DSS commissioner to increase the Medicaid fees paid to these agencies for certain home health services. Specifically, it requires him to increase (1) the medication administration fee by the percentage increase, if any, in the most recent calendar year average in the Consumer Price Index for Urban Consumers over the average for the previous year and (2) extended hours nursing services fees by 35% over the rates in effect on June 30, 2009. Under the bill, home health services fees for medication administration, extended hours nursing services, and psychiatric nurse visits apply only to services provided by a licensed advanced practice registered nurse (APRN).

§ 2 — INCREASED RATES FOR HOMEMAKER-HOME HEALTH AIDE AGENCIES UNDER THE CONNECTICUT HOMECARE PROGRAM FOR ELDERLY (CHCPE)

The bill requires the DSS commissioner to increase the FY 09 fees for homemaker and companion services provided under CHCPE by the percentage increase, if any, in the most recent calendar year average in the Consumer Price Index for Urban Consumers over the average for the previous year.

CHCPE, which has both a Medicaid waiver and state-funded component, provides home and community based services for qualifying individuals aged 65 and older who are institutionalized or

at risk of institutionalization. Services include care management, adult day care, adult foster care, homemaker services, transportation, meals-on-wheels, minor home modifications, and certain assisted living services.

§ 1 — MEDICAID COVERAGE OF FLU AND PNEUMONIA VACCINES

Starting October 1, 2009, the bill requires the DSS commissioner to establish a fee schedule and billing codes for the cost of supplies and the administration of flu and pneumonia vaccines to Medicaid recipients who are ineligible for the vaccines under Medicare. The vaccines must be provided by a licensed APRN employed by a licensed home health care or homemaker-home health aide agency. (These agencies already provide this service for Medicare patients.)

The fees and billing requirements must be identical to those in effect for mass immunizers under Medicare. (A “mass immunizer” is a provider or supplier enrolled in Medicare to offer the flu vaccine to a large number of individuals.) If the flu vaccine is provided by an APRN in a Medicaid recipient’s home, the fee must be added to the home health agency medication administration fee.

§ 3 & 4 — COVERAGE OF TELEMONITORING SERVICES UNDER MEDICAID AND CHCPE

Medicaid

The bill requires the DSS commissioner by January 1, 2010, to establish a fee schedule and billing codes to reimburse home health agencies that provide telemonitors to Medicaid recipients who have chronic conditions, including congestive heart failure, diabetes, and chronic obstructive pulmonary disease.

It requires the commissioner to ensure that all patients a home health agency selects to receive telemonitoring services are evaluated to determine (1) the nature of the patient’s medical condition and whether it requires skilled nursing visits that could be reduced through telemonitoring, (2) whether the patient has a history of frequent hospitalizations or emergency room use over the past year,

(3) the patient's cognitive ability and support system, and (4) whether the patient lives in a medically underserved area.

CHCPE

The bill adds telemonitoring to the list of services covered under CHCPE.

§§ 7-9 — STATE CLAIMS AGAINST STATE ASSISTANCE BENEFICIARIES

By law, a beneficiary of aid under the State Supplement, Medicaid, Aid to Families with Dependent Children (replaced by TFA in 1997), Temporary Family Assistance, or State Administered General Assistance programs must repay the state for any assistance they receive, with some exceptions.

Under current law, the state can claim or place a lien against a beneficiary's property, estate, or any type of claim in which the beneficiary has an interest, except for money received for the replacement of real or personal property. It can also place a lien against any beneficiary's lawsuit proceeds for the full amount of assistance paid or 50% of the proceeds after expenses, whichever is less. This lien has priority over all other claims except attorney's fees, hospital costs associated with the lawsuit, and doctor's fees.

The state can also recover assistance it has provided to beneficiaries if they later inherit money or win a lottery. The state can place liens on their property and recover from their estates when they die.

The bill repeals the state's ability to claim or apply a lien against (1) any type of claim in which the beneficiary has an interest or (2) lawsuit proceeds received by the beneficiary. It also repeals a similar law governing towns' ability to recover assistance provided to residents (former town-administered General Assistance recipients). The state took over that program in 1997, but towns can still recover benefits paid in certain circumstances.

If a beneficiary receives an inheritance, the law, unchanged by the

bill, continues to give the state and towns a lien on 50% of the payable assets up to the amount of the assistance paid by the state.

§ 5 — LONG-TERM CARE REINVESTMENT ACCOUNT

The Long-Term Care Reinvestment Account is a nonlapsing General Fund account established to hold the enhanced federal matching funds the state receives from implementing the federal Money Follows the Person (MFP) demonstration program. MFP is a five-year program that permits states to move individuals out of nursing homes or other institutional settings and into less-restrictive, community-based settings without jeopardizing federal funding.

The bill requires the following funds also to be deposited into the account:

1. federal reimbursement funds received under the “MFP II” demonstration project for individuals who would have met the financial eligibility criteria for the state-funded portion of CHCPE (but, individuals who are financially eligible for the state-funded portion of CHCPE would be ineligible for Medicaid and would not receive federal matching funds);
2. federal funds received resulting from Medicaid reforms or increases in federal Medicaid matching funds; and
3. estimated savings from diverting individuals from institutional care under the demonstration project. (It is unclear whether this applies to individuals under MFP, MFP II or both programs.)

Under the bill, these savings must be calculated by subtracting the cost of home- and community-based care provided under the demonstration from the cost of institutional care and reducing that amount by 35% for all individuals receiving home and community based services under the demonstration.

The law requires DSS to develop a plan to establish and implement a demonstration program similar to MFP. This program, referred to as

“MFP II,” must provide home- and community-based long-term care services to adults (age 18 and older) who (1) are institutionalized or at risk of institutionalization and (2) meet CHCPE’s financial and level of care eligibility criteria established in regulations. MFP II was created to allow adults who do not meet MFP’s federally mandated six-month institutionalization requirement to receive similar services.

§ 1 & 3 — IMPLEMENTING POLICIES AND PROCEDURES

The bill requires the commissioner to implement policies and procedures to administer provisions pertaining to Medicaid coverage of (1) telemonitoring services and (2) flu and pneumonia vaccines while in the process of adopting them in regulation, provided notice is published in the *Connecticut Law Journal* no later than 20 days after they are implemented. These policies and procedures are valid until the final regulations are adopted.

BACKGROUND

Related Bills

SB 843, reported favorably by the Human Services committee, delays the establishment of the Long-Term Care Reinvestment Account by two years, from July 1, 2009 until July 1, 2011.

COMMITTEE ACTION

Human Services Committee

Joint Favorable

Yea 13 Nay 6 (03/19/2009)