



Senate

General Assembly

File No. 195

February Session, 2012

Substitute Senate Bill No. 30

Senate, April 2, 2012

The Committee on Human Services reported through SEN. MUSTO of the 22nd Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

***AN ACT IMPLEMENTING PROVISIONS OF THE BUDGET
CONCERNING HUMAN SERVICES.***

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

1 Section 1. Section 17b-239 of the 2012 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective from passage*):

4 (a) The rate to be paid by the state to hospitals receiving
5 appropriations granted by the General Assembly and to freestanding
6 chronic disease hospitals, providing services to persons aided or cared
7 for by the state for routine services furnished to state patients, shall be
8 based upon reasonable cost to such hospital, or the charge to the
9 general public for ward services or the lowest charge for semiprivate
10 services if the hospital has no ward facilities, imposed by such
11 hospital, whichever is lowest, except to the extent, if any, that the
12 commissioner determines that a greater amount is appropriate in the
13 case of hospitals serving a disproportionate share of indigent patients.
14 Such rate shall be promulgated annually by the Commissioner of

15 Social Services. Nothing contained in this section shall authorize a
16 payment by the state for such services to any such hospital in excess of
17 the charges made by such hospital for comparable services to the
18 general public. Notwithstanding the provisions of this section, for the
19 rate period beginning July 1, 2000, rates paid to freestanding chronic
20 disease hospitals and freestanding psychiatric hospitals shall be
21 increased by three per cent. For the rate period beginning July 1, 2001,
22 a freestanding chronic disease hospital or freestanding psychiatric
23 hospital shall receive a rate that is two and one-half per cent more than
24 the rate it received in the prior fiscal year and such rate shall remain
25 effective until December 31, 2002. Effective January 1, 2003, a
26 freestanding chronic disease hospital or freestanding psychiatric
27 hospital shall receive a rate that is two per cent more than the rate it
28 received in the prior fiscal year. Notwithstanding the provisions of this
29 subsection, for the period commencing July 1, 2001, and ending June
30 30, 2003, the commissioner may pay an additional total of no more
31 than three hundred thousand dollars annually for services provided to
32 long-term ventilator patients. For purposes of this subsection, "long-
33 term ventilator patient" means any patient at a freestanding chronic
34 disease hospital on a ventilator for a total of sixty days or more in any
35 consecutive twelve-month period. Effective July 1, 2007, each
36 freestanding chronic disease hospital shall receive a rate that is four
37 per cent more than the rate it received in the prior fiscal year.

38 (b) Effective October 1, 1991, the rate to be paid by the state for the
39 cost of special services rendered by such hospitals shall be established
40 annually by the commissioner for each such hospital based on the
41 reasonable cost to each hospital of such services furnished to state
42 patients. Nothing contained [herein] in this subsection shall authorize
43 a payment by the state for such services to any such hospital in excess
44 of the charges made by such hospital for comparable services to the
45 general public.

46 (c) The term "reasonable cost" as used in this section means the cost
47 of care furnished such patients by an efficient and economically
48 operated facility, computed in accordance with accepted principles of

49 hospital cost reimbursement. The commissioner may adjust the rate of
50 payment established under the provisions of this section for the year
51 during which services are furnished to reflect fluctuations in hospital
52 costs. Such adjustment may be made prospectively to cover anticipated
53 fluctuations or may be made retroactive to any date subsequent to the
54 date of the initial rate determination for such year or in such other
55 manner as may be determined by the commissioner. In determining
56 "reasonable cost" the commissioner may give due consideration to
57 allowances for fully or partially unpaid bills, reasonable costs
58 mandated by collective bargaining agreements with certified collective
59 bargaining agents or other agreements between the employer and
60 employees, provided "employees" shall not include persons employed
61 as managers or chief administrators, requirements for working capital
62 and cost of development of new services, including additions to and
63 replacement of facilities and equipment. The commissioner shall not
64 give consideration to amounts paid by the facilities to employees as
65 salary, or to attorneys or consultants as fees, where the responsibility
66 of the employees, attorneys or consultants is to persuade or seek to
67 persuade the other employees of the facility to support or oppose
68 unionization. Nothing in this subsection shall prohibit the
69 commissioner from considering amounts paid for legal counsel related
70 to the negotiation of collective bargaining agreements, the settlement
71 of grievances or normal administration of labor relations.

72 (d) The state shall also pay to such hospitals for each outpatient
73 clinic and emergency room visit a reasonable rate to be established
74 annually by the commissioner for each hospital, such rate to be
75 determined by the reasonable cost of such services. The emergency
76 room visit rates in effect June 30, 1991, shall remain in effect through
77 June 30, 1993, except those which would have been decreased effective
78 July 1, 1991, or July 1, 1992, shall be decreased. Nothing contained
79 [herein] in this subsection shall authorize a payment by the state for
80 such services to any hospital in excess of the charges made by such
81 hospital for comparable services to the general public. For those
82 outpatient hospital services paid on the basis of a ratio of cost to
83 charges, the ratios in effect June 30, 1991, shall be reduced effective

84 July 1, 1991, by the most recent annual increase in the consumer price
85 index for medical care. For those outpatient hospital services paid on
86 the basis of a ratio of cost to charges, the ratios computed to be
87 effective July 1, 1994, shall be reduced by the most recent annual
88 increase in the consumer price index for medical care. The emergency
89 room visit rates in effect June 30, 1994, shall remain in effect through
90 December 31, 1994. The Commissioner of Social Services shall establish
91 a fee schedule for outpatient hospital services to be effective on and
92 after January 1, 1995, and may annually modify such fee schedule if
93 such modification is needed to ensure that the conversion to an
94 administrative services organization is cost neutral to hospitals in the
95 aggregate and ensures patient access. Utilization shall not be a factor in
96 determining cost neutrality. Except with respect to the rate periods
97 beginning July 1, 1999, and July 1, 2000, such fee schedule shall be
98 adjusted annually beginning July 1, 1996, to reflect necessary increases
99 in the cost of services. Notwithstanding the provisions of this
100 subsection, the fee schedule for the rate period beginning July 1, 2000,
101 shall be increased by ten and one-half per cent, effective June 1, 2001.
102 Notwithstanding the provisions of this subsection, outpatient rates in
103 effect as of June 30, 2003, shall remain in effect through June 30, 2005.
104 Effective July 1, 2006, subject to available appropriations, the
105 commissioner shall increase outpatient service fees for services that
106 may include clinic, emergency room, magnetic resonance imaging, and
107 computerized axial tomography.

108 (e) The commissioner shall adopt regulations, in accordance with
109 the provisions of chapter 54, establishing criteria for defining
110 emergency and nonemergency visits to hospital emergency rooms. All
111 nonemergency visits to hospital emergency rooms shall be paid at the
112 hospital's outpatient clinic services rate. Nothing contained in this
113 subsection or the regulations adopted hereunder shall authorize a
114 payment by the state for such services to any hospital in excess of the
115 charges made by such hospital for comparable services to the general
116 public.

117 (f) On and after October 1, 1984, the state shall pay to an acute care

118 general hospital for the inpatient care of a patient who no longer
119 requires acute care a rate determined by the following schedule: For
120 the first seven days following certification that the patient no longer
121 requires acute care the state shall pay the hospital at a rate of fifty per
122 cent of the hospital's actual cost; for the second seven-day period
123 following certification that the patient no longer requires acute care the
124 state shall pay seventy-five per cent of the hospital's actual cost; for the
125 third seven-day period following certification that the patient no
126 longer requires acute care and for any period of time thereafter, the
127 state shall pay the hospital at a rate of one hundred per cent of the
128 hospital's actual cost. On and after July 1, 1995, no payment shall be
129 made by the state to an acute care general hospital for the inpatient
130 care of a patient who no longer requires acute care and is eligible for
131 Medicare unless the hospital does not obtain reimbursement from
132 Medicare for that stay.

133 [(g) Effective June 1, 2001, the commissioner shall establish inpatient
134 hospital rates in accordance with the method specified in regulations
135 adopted pursuant to this section and applied for the rate period
136 beginning October 1, 2000, except that the commissioner shall update
137 each hospital's target amount per discharge to the actual allowable cost
138 per discharge based upon the 1999 cost report filing multiplied by
139 sixty-two and one-half per cent if such amount is higher than the target
140 amount per discharge for the rate period beginning October 1, 2000, as
141 adjusted for the ten per cent incentive identified in Section 4005 of
142 Public Law 101-508. If a hospital's rate is increased pursuant to this
143 subsection, the hospital shall not receive the ten per cent incentive
144 identified in Section 4005 of Public Law 101-508. For rate periods
145 beginning October 1, 2001, through September 30, 2006, the
146 commissioner shall not apply an annual adjustment factor to the target
147 amount per discharge. Effective April 1, 2005, the revised target
148 amount per discharge for each hospital with a target amount per
149 discharge less than three thousand seven hundred fifty dollars shall be
150 three thousand seven hundred fifty dollars. Effective October 1, 2007,
151 the commissioner, in consultation with the Secretary of the Office of
152 Policy and Management, shall establish, within available

153 appropriations, an increased target amount per discharge of not less
154 than four thousand two hundred fifty dollars for each hospital with a
155 target amount per discharge less than four thousand two hundred fifty
156 dollars for the rate period ending September 30, 2007, and the
157 commissioner may apply an annual adjustment factor to the target
158 amount per discharge for hospitals that are not increased as a result of
159 this adjustment. Not later than October 1, 2008, the commissioner shall
160 submit a report to the joint standing committees of the General
161 Assembly having cognizance of matters relating to public health,
162 human services and appropriations and the budgets of state agencies
163 identifying any increased target amount per discharge established or
164 annual adjustment factor applied on or after October 1, 2006, and the
165 associated cost increase estimates related to such actions.]

166 Sec. 2. Subsection (a) of section 17b-282c of the general statutes is
167 repealed and the following is substituted in lieu thereof (*Effective July*
168 *1, 2012*):

169 (a) All nonemergency dental services provided under the
170 Department of Social Services' dental programs, as described in section
171 17b-282b, shall be subject to prior authorization. Nonemergency
172 services that are exempt from the prior authorization process shall
173 include diagnostic, prevention, basic restoration procedures and
174 nonsurgical extractions that are consistent with standard and
175 reasonable dental practices. Dental benefit limitations shall apply to
176 each client regardless of the number of providers serving the client.
177 The commissioner may recoup payments for services that are
178 determined not to be for an emergency condition or otherwise in
179 excess of what is medically necessary. The commissioner shall
180 periodically, but not less than quarterly, review payments for
181 emergency dental services and basic restoration procedures for
182 appropriateness of payment. For the purposes of this section,
183 "emergency condition" means a dental condition manifesting itself by
184 acute symptoms of sufficient severity, including severe pain, such that
185 a prudent layperson, who possesses an average knowledge of health
186 and medicine, could reasonably expect the absence of immediate

187 dental attention to result in placing the health of the individual, or
188 with respect to a pregnant woman, the health of the woman or her
189 unborn child, in serious jeopardy, cause serious impairment to body
190 functions or cause serious dysfunction of any body organ or part.

191 Sec. 3. Subsection (b) of section 17b-239c of the 2012 supplement to
192 the general statutes is repealed and the following is substituted in lieu
193 thereof (*Effective from passage*):

194 (b) Effective July 1, 2011, interim payments made to hospitals
195 pursuant to this section for the succeeding [fifteen] twenty-seven
196 months shall be based on 2009 federal fiscal year data and may be
197 adjusted at the commissioner's discretion for accuracy. Effective
198 October 1, [2012] 2013, interim payments shall be based on the most
199 recent federal fiscal year data available. For federal fiscal year 2011 and
200 succeeding federal fiscal years, final disproportionate share payment
201 amounts shall be recalculated and reallocated in accordance with
202 Section 1001(d) of Public Law 108-173, the Medicare Prescription Drug,
203 Improvement, and Modernization Act of 2003. The commissioner shall
204 prescribe uniform annual hospital data reporting forms. Payments
205 made pursuant to this section shall be in addition to inpatient hospital
206 rates determined pursuant to section 17b-239, as amended by this act.
207 The commissioner may withhold payment to a hospital to offset
208 money owed by the hospital to the state.

209 Sec. 4. Subsection (a) of section 17b-244 of the 2012 supplement to
210 the general statutes is repealed and the following is substituted in lieu
211 thereof (*Effective July 1, 2012*):

212 (a) The room and board component of the rates to be paid by the
213 state to private facilities and facilities operated by regional education
214 service centers which are licensed to provide residential care pursuant
215 to section 17a-227, but not certified to participate in the Title XIX
216 Medicaid program as intermediate care facilities for persons with
217 mental retardation, shall be determined annually by the Commissioner
218 of Social Services, except that rates effective April 30, 1989, shall
219 remain in effect through October 31, 1989. Any facility with real

220 property other than land placed in service prior to July 1, 1991, shall,
221 for the fiscal year ending June 30, 1995, receive a rate of return on real
222 property equal to the average of the rates of return applied to real
223 property other than land placed in service for the five years preceding
224 July 1, 1993. For the fiscal year ending June 30, 1996, and any
225 succeeding fiscal year, the rate of return on real property for property
226 items shall be revised every five years. The commissioner shall, upon
227 submission of a request by such facility, allow actual debt service,
228 comprised of principal and interest, on the loan or loans in lieu of
229 property costs allowed pursuant to section 17-313b-5 of the regulations
230 of Connecticut state agencies, whether actual debt service is higher or
231 lower than such allowed property costs, provided such debt service
232 terms and amounts are reasonable in relation to the useful life and the
233 base value of the property. In the case of facilities financed through the
234 Connecticut Housing Finance Authority, the commissioner shall allow
235 actual debt service, comprised of principal, interest and a reasonable
236 repair and replacement reserve on the loan or loans in lieu of property
237 costs allowed pursuant to section 17-313b-5 of the regulations of
238 Connecticut state agencies, whether actual debt service is higher or
239 lower than such allowed property costs, provided such debt service
240 terms and amounts are determined by the commissioner at the time
241 the loan is entered into to be reasonable in relation to the useful life
242 and base value of the property. The commissioner may allow fees
243 associated with mortgage refinancing provided such refinancing will
244 result in state reimbursement savings, after comparing costs over the
245 terms of the existing proposed loans. For the fiscal year ending June 30,
246 1992, the inflation factor used to determine rates shall be one-half of
247 the gross national product percentage increase for the period between
248 the midpoint of the cost year through the midpoint of the rate year. For
249 fiscal year ending June 30, 1993, the inflation factor used to determine
250 rates shall be two-thirds of the gross national product percentage
251 increase from the midpoint of the cost year to the midpoint of the rate
252 year. For the fiscal years ending June 30, 1996, and June 30, 1997, no
253 inflation factor shall be applied in determining rates. The
254 Commissioner of Social Services shall prescribe uniform forms on

255 which such facilities shall report their costs. Such rates shall be
256 determined on the basis of a reasonable payment for necessary
257 services. Any increase in grants, gifts, fund-raising or endowment
258 income used for the payment of operating costs by a private facility in
259 the fiscal year ending June 30, 1992, shall be excluded by the
260 commissioner from the income of the facility in determining the rates
261 to be paid to the facility for the fiscal year ending June 30, 1993,
262 provided any operating costs funded by such increase shall not
263 obligate the state to increase expenditures in subsequent fiscal years.
264 Nothing contained in this section shall authorize a payment by the
265 state to any such facility in excess of the charges made by the facility
266 for comparable services to the general public. The service component
267 of the rates to be paid by the state to private facilities and facilities
268 operated by regional education service centers which are licensed to
269 provide residential care pursuant to section 17a-227, but not certified
270 to participate in the Title XIX Medicaid programs as intermediate care
271 facilities for persons with mental retardation, shall be determined
272 annually by the Commissioner of Developmental Services in
273 accordance with section 17b-244a. For the fiscal year ending June 30,
274 2008, no facility shall receive a rate that is more than two per cent
275 greater than the rate in effect for the facility on June 30, 2007, except
276 any facility that would have been issued a lower rate effective July 1,
277 2007, due to interim rate status or agreement with the department,
278 shall be issued such lower rate effective July 1, 2007. For the fiscal year
279 ending June 30, 2009, no facility shall receive a rate that is more than
280 two per cent greater than the rate in effect for the facility on June 30,
281 2008, except any facility that would have been issued a lower rate
282 effective July 1, 2008, due to interim rate status or agreement with the
283 department, shall be issued such lower rate effective July 1, 2008. For
284 the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect
285 for the period ending June 30, 2009, shall remain in effect until June 30,
286 2011, except that (1) the rate paid to a facility may be higher than the
287 rate paid to the facility for the period ending June 30, 2009, if a capital
288 improvement required by the Commissioner of Developmental
289 Services for the health or safety of the residents was made to the

290 facility during the fiscal years ending June 30, 2010, or June 30, 2011,
291 and (2) any facility that would have been issued a lower rate for the
292 fiscal years ending June 30, 2010, or June 30, 2011, due to interim rate
293 status or agreement with the department, shall be issued such lower
294 rate. For the fiscal years ending June 30, 2012, and June 30, 2013, rates
295 in effect for the period ending June 30, 2011, shall remain in effect until
296 June 30, 2013, except that [(1)] (A) the rate paid to a facility may be
297 higher than the rate paid to the facility for the period ending June 30,
298 2011, if a capital improvement required by the Commissioner of
299 Developmental Services for the health or safety of the residents was
300 made to the facility during the fiscal years ending June 30, 2012, or
301 June 30, 2013, [and (2)] (B) any facility that would have been issued a
302 lower rate for the fiscal years ending June 30, 2012, or June 30, 2013,
303 due to interim rate status or agreement with the department, shall be
304 issued such lower rate, and (C) any facility that has a significant
305 decrease in land and building costs shall receive a reduced rate to
306 reflect the reduction in land and building costs.

307 Sec. 5. Subsection (g) of section 17b-340 of the 2012 supplement to
308 the general statutes is repealed and the following is substituted in lieu
309 thereof (*Effective July 1, 2012*):

310 (g) For the fiscal year ending June 30, 1993, any intermediate care
311 facility for the mentally retarded with an operating cost component of
312 its rate in excess of one hundred forty per cent of the median of
313 operating cost components of rates in effect January 1, 1992, shall not
314 receive an operating cost component increase. For the fiscal year
315 ending June 30, 1993, any intermediate care facility for the mentally
316 retarded with an operating cost component of its rate that is less than
317 one hundred forty per cent of the median of operating cost
318 components of rates in effect January 1, 1992, shall have an allowance
319 for real wage growth equal to thirty per cent of the increase
320 determined in accordance with subsection (q) of section 17-311-52 of
321 the regulations of Connecticut state agencies, provided such operating
322 cost component shall not exceed one hundred forty per cent of the
323 median of operating cost components in effect January 1, 1992. Any

324 facility with real property other than land placed in service prior to
325 October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a
326 rate of return on real property equal to the average of the rates of
327 return applied to real property other than land placed in service for the
328 five years preceding October 1, 1993. For the fiscal year ending June 30,
329 1996, and any succeeding fiscal year, the rate of return on real property
330 for property items shall be revised every five years. The commissioner
331 shall, upon submission of a request, allow actual debt service,
332 comprised of principal and interest, in excess of property costs allowed
333 pursuant to section 17-311-52 of the regulations of Connecticut state
334 agencies, provided such debt service terms and amounts are
335 reasonable in relation to the useful life and the base value of the
336 property. For the fiscal year ending June 30, 1995, and any succeeding
337 fiscal year, the inflation adjustment made in accordance with
338 subsection (p) of section 17-311-52 of the regulations of Connecticut
339 state agencies shall not be applied to real property costs. For the fiscal
340 year ending June 30, 1996, and any succeeding fiscal year, the
341 allowance for real wage growth, as determined in accordance with
342 subsection (q) of section 17-311-52 of the regulations of Connecticut
343 state agencies, shall not be applied. For the fiscal year ending June 30,
344 1996, and any succeeding fiscal year, no rate shall exceed three
345 hundred seventy-five dollars per day unless the commissioner, in
346 consultation with the Commissioner of Developmental Services,
347 determines after a review of program and management costs, that a
348 rate in excess of this amount is necessary for care and treatment of
349 facility residents. For the fiscal year ending June 30, 2002, rate period,
350 the Commissioner of Social Services shall increase the inflation
351 adjustment for rates made in accordance with subsection (p) of section
352 17-311-52 of the regulations of Connecticut state agencies to update
353 allowable fiscal year 2000 costs to include a three and one-half per cent
354 inflation factor. For the fiscal year ending June 30, 2003, rate period, the
355 commissioner shall increase the inflation adjustment for rates made in
356 accordance with subsection (p) of section 17-311-52 of the regulations
357 of Connecticut state agencies to update allowable fiscal year 2001 costs
358 to include a one and one-half per cent inflation factor, except that such

359 increase shall be effective November 1, 2002, and such facility rate in
360 effect for the fiscal year ending June 30, 2002, shall be paid for services
361 provided until October 31, 2002, except any facility that would have
362 been issued a lower rate effective July 1, 2002, than for the fiscal year
363 ending June 30, 2002, due to interim rate status or agreement with the
364 department shall be issued such lower rate effective July 1, 2002, and
365 have such rate updated effective November 1, 2002, in accordance with
366 applicable statutes and regulations. For the fiscal year ending June 30,
367 2004, rates in effect for the period ending June 30, 2003, shall remain in
368 effect, except any facility that would have been issued a lower rate
369 effective July 1, 2003, than for the fiscal year ending June 30, 2003, due
370 to interim rate status or agreement with the department shall be issued
371 such lower rate effective July 1, 2003. For the fiscal year ending June
372 30, 2005, rates in effect for the period ending June 30, 2004, shall
373 remain in effect until September 30, 2004. Effective October 1, 2004,
374 each facility shall receive a rate that is five per cent greater than the
375 rate in effect September 30, 2004. Effective upon receipt of all the
376 necessary federal approvals to secure federal financial participation
377 matching funds associated with the rate increase provided in
378 subdivision (4) of subsection (f) of this section, but in no event earlier
379 than October 1, 2005, and provided the user fee imposed under section
380 17b-320 is required to be collected, each facility shall receive a rate that
381 is four per cent more than the rate the facility received in the prior
382 fiscal year, except any facility that would have been issued a lower rate
383 effective October 1, 2005, than for the fiscal year ending June 30, 2005,
384 due to interim rate status or agreement with the department, shall be
385 issued such lower rate effective October 1, 2005. Such rate increase
386 shall remain in effect unless: [(A)] (1) The federal financial
387 participation matching funds associated with the rate increase are no
388 longer available; or [(B)] (2) the user fee created pursuant to section
389 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in
390 effect for the period ending June 30, 2006, shall remain in effect until
391 September 30, 2006, except any facility that would have been issued a
392 lower rate effective July 1, 2006, than for the fiscal year ending June 30,
393 2006, due to interim rate status or agreement with the department,

394 shall be issued such lower rate effective July 1, 2006. Effective October
395 1, 2006, no facility shall receive a rate that is more than three per cent
396 greater than the rate in effect for the facility on September 30, 2006,
397 except any facility that would have been issued a lower rate effective
398 October 1, 2006, due to interim rate status or agreement with the
399 department, shall be issued such lower rate effective October 1, 2006.
400 For the fiscal year ending June 30, 2008, each facility shall receive a rate
401 that is two and nine-tenths per cent greater than the rate in effect for
402 the period ending June 30, 2007, except any facility that would have
403 been issued a lower rate effective July 1, 2007, than for the rate period
404 ending June 30, 2007, due to interim rate status, or agreement with the
405 department, shall be issued such lower rate effective July 1, 2007. For
406 the fiscal year ending June 30, 2009, rates in effect for the period
407 ending June 30, 2008, shall remain in effect until June 30, 2009, except
408 any facility that would have been issued a lower rate for the fiscal year
409 ending June 30, 2009, due to interim rate status or agreement with the
410 department, shall be issued such lower rate. For the fiscal years ending
411 June 30, 2010, and June 30, 2011, rates in effect for the period ending
412 June 30, 2009, shall remain in effect until June 30, 2011, except any
413 facility that would have been issued a lower rate for the fiscal year
414 ending June 30, 2010, or the fiscal year ending June 30, 2011, due to
415 interim rate status or agreement with the department, shall be issued
416 such lower rate. For the fiscal years ending June 30, 2012, and June 30,
417 2013, rates in effect for the period ending June 30, 2011, shall remain in
418 effect until June 30, 2013, except (A) any facility that would have been
419 issued a lower rate for the fiscal year ending June 30, 2012, or the fiscal
420 year ending June 30, 2013, due to interim rate status or agreement with
421 the department, shall be issued such lower rate, and (B) any facility
422 that has a significant decrease in land and building costs shall receive a
423 reduced rate to reflect the reduction in land and building costs. For the
424 fiscal years ending June 30, 2012, and June 30, 2013, the Commissioner
425 of Social Services may provide fair rent increases to any facility that
426 has undergone a material change in circumstances related to fair rent
427 and has an approved certificate of need pursuant to section 17b-352,
428 17b-353, 17b-354 or 17b-355. Notwithstanding the provisions of this

429 section, the Commissioner of Social Services may, within available
430 appropriations, increase rates issued to intermediate care facilities for
431 the mentally retarded.

432 Sec. 6. Section 17b-261 of the 2012 supplement to the general statutes
433 is amended by adding subsection (j) as follows (*Effective July 1, 2012*):

434 (NEW) (j) A veteran, as defined in section 27-103, and any member
435 of his or her family, who applies for or receives assistance under the
436 Medicaid program, shall apply for all benefits for which he or she may
437 be eligible through the Veterans' Administration or the United States
438 Department of Defense.

439 Sec. 7. Subsection (a) of section 17b-365 of the general statutes is
440 repealed and the following is substituted in lieu thereof (*Effective July*
441 *1, 2012*):

442 (a) The Commissioner of Social Services may, within available
443 appropriations, establish and operate a pilot program to allow
444 individuals to receive assisted living services, provided by an assisted
445 living services agency licensed by the Department of Public Health in
446 accordance with chapter 368v. In order to be eligible for the program,
447 an individual shall: (1) Reside in a managed residential community, as
448 defined in section 19a-693; (2) be ineligible to receive assisted living
449 services under any other assisted living pilot program established by
450 the General Assembly; and (3) be eligible for services under the
451 Medicaid waiver portion of the Connecticut home-care program for
452 the elderly established under section 17b-342. The total number of
453 individuals enrolled in said pilot program, when combined with the
454 total number of individuals enrolled in the pilot program established
455 pursuant to section 17b-366, as amended by this act, shall not exceed
456 [seventy-five] one hundred twenty-five individuals. The
457 Commissioner of Social Services shall operate said pilot program in
458 accordance with the Medicaid rules established pursuant to 42 USC
459 1396p(c), as from time to time amended.

460 Sec. 8. Subsection (a) of section 17b-366 of the general statutes is

461 repealed and the following is substituted in lieu thereof (*Effective July*
462 *1, 2012*):

463 (a) The Commissioner of Social Services may, within available
464 appropriations, establish and operate a pilot program to allow
465 individuals to receive assisted living services, provided by an assisted
466 living services agency licensed by the Department of Public Health, in
467 accordance with chapter 368v. In order to be eligible for the pilot
468 program, an individual shall: (1) Reside in a managed residential
469 community, as defined in section 19a-693; (2) be ineligible to receive
470 assisted living services under any other assisted living pilot program
471 established by the General Assembly; and (3) be eligible for services
472 under the state-funded portion of the Connecticut home-care program
473 for the elderly established under section 17b-342. The total number of
474 individuals enrolled in said pilot program, when combined with the
475 total number of individuals enrolled in the pilot program established
476 pursuant to section 17b-365, as amended by this act, shall not exceed
477 [seventy-five] one hundred twenty-five individuals. The
478 Commissioner of Social Services shall operate said pilot program in
479 accordance with the Medicaid rules established under 42 USC
480 1396p(c), as from time to time amended.

481 Sec. 9. Section 17b-605a of the general statutes is repealed and the
482 following is substituted in lieu thereof (*Effective July 1, 2012*):

483 (a) The Commissioner of Social Services shall seek a waiver from
484 federal law to establish a personal care assistance program for persons
485 eighteen years of age or older with disabilities funded under the
486 Medicaid program. Such a program shall be limited to a specified
487 number of slots available for eligible program recipients and shall be
488 operated by the Department of Social Services within available
489 appropriations. Such a waiver shall be submitted to the joint standing
490 committees of the General Assembly having cognizance of matters
491 relating to appropriations and the budgets of state agencies and
492 human services in accordance with section 17b-8 no later than January
493 1, 1996.

494 (b) The Commissioner of Social Services shall amend the waiver
495 specified in subsection (a) of this section to enable persons eligible for
496 or receiving medical assistance under section 17b-597 to receive
497 personal care assistance. Such amendment shall not be subject to the
498 provisions of section 17b-8 provided such amendment shall consist
499 only of modifications necessary to extend personal care assistance to
500 such persons.

501 (c) Effective April 1, 2013, upon reaching sixty-five years of age, any
502 person served under the program shall be transitioned to the
503 Connecticut home-care program for the elderly, established under
504 section 17b-342.

505 Sec. 10. Subsection (a) of section 17b-650a of the 2012 supplement to
506 the general statutes is repealed and the following is substituted in lieu
507 thereof (*Effective July 1, 2012*):

508 (a) There is created a Bureau of Rehabilitative Services. [, which
509 shall be within the Department of Social Services for administrative
510 purposes only.] The Department of Social Services shall provide
511 administrative support services to said bureau until the bureau
512 requests cessation of such services, or until June 30, 2013, whichever is
513 earlier. Said bureau shall be responsible for: (1) Providing services to
514 the deaf and hearing impaired; (2) providing services for the blind and
515 visually impaired; and (3) providing rehabilitation services in
516 accordance with the provisions of the general statutes concerning said
517 bureau.

518 Sec. 11. Section 17b-733 of the general statutes is repealed and the
519 following is substituted in lieu thereof (*Effective July 1, 2012*):

520 The Department of Social Services shall be the lead agency for child
521 day care services in Connecticut. The department shall: (1) Identify,
522 annually, existing child day care services and maintain an inventory of
523 all available services; (2) provide technical assistance to corporations
524 and private agencies in the development and expansion of child day
525 care services for families at all income levels, including families of their

526 employees and clients; (3) study and identify funding sources available
527 for child day care including federal funds and tax benefits; (4) study
528 the cost and availability of liability insurance for child day care
529 providers; (5) provide, in conjunction with the Departments of
530 Education and Higher Education, ongoing training for child day care
531 providers including preparing videotaped workshops and distributing
532 them to cable stations for broadcast on public access stations, and seek
533 private donations to fund such training; (6) encourage child day care
534 services to obtain accreditation; (7) develop a range of financing
535 options for child care services, including the use of a tax-exempt bond
536 program, a loan guarantee program and establishing a direct revolving
537 loan program; (8) promote the colocation of child day care and school
538 readiness programs pursuant to section 4b-31; (9) establish a
539 performance-based evaluation system; (10) develop for
540 recommendation to the Governor and the General Assembly measures
541 to provide incentives for the private sector to develop and support
542 expanded child day care services; (11) provide, within available funds
543 and in conjunction with the temporary family assistance program as
544 defined in section 17b-680, child day care to public assistance
545 recipients; (12) [develop and implement, with the assistance of the
546 Child Day Care Council and the Departments of Public Health, Social
547 Services, Education, Higher Education, Children and Families,
548 Economic and Community Development and Consumer Protection, a
549 state-wide coordinated child day care and early childhood education
550 training system (A) for child day care centers, group day care homes
551 and family day care homes that provide child day care services, and
552 (B) that makes available to such providers and their staff, within
553 available appropriations, scholarship assistance, career counseling and
554 training, advancement in career ladders, as defined in section 4-124bb,
555 through seamless articulation of levels of training, program
556 accreditation support and other initiatives recommended by the
557 Departments of Social Services, Education and Higher Education; (13)]
558 plan and implement a unit cost reimbursement system for state-
559 funded child day care services such that, on and after January 1, 2008,
560 any increase in reimbursement shall be based on a requirement that

561 such centers meet the staff qualifications, as defined in subsection (b)
562 of section 10-16p; [(14)] (13) develop, within available funds, initiatives
563 to increase compensation paid to child day care providers for
564 educational opportunities, including, but not limited to, (A) incentives
565 for educational advancement paid to persons employed by child day
566 care centers receiving state or federal funds, and (B) support for the
567 establishment and implementation by the Labor Commissioner of
568 apprenticeship programs for child day care workers pursuant to
569 sections 31-22m to 31-22q, inclusive, which programs shall be jointly
570 administered by labor and management trustees; [(15)] (14) evaluate
571 the effectiveness of any initiatives developed pursuant to subdivision
572 [(14)] (13) of this section in improving staff retention rates and the
573 quality of education and care provided to children; and [(16)] (15)
574 report annually to the Governor and the General Assembly in
575 accordance with the provisions of section 11-4a on the status of child
576 day care in Connecticut. Such report shall include (A) an itemization of
577 the allocation of state and federal funds for child care programs; (B) the
578 number of children served under each program so funded; (C) the
579 number and type of such programs, providers and support personnel;
580 (D) state activities to encourage partnership between the public and
581 private sectors; (E) average payments issued by the state for both part-
582 time and full-time child care; (F) range of family income and
583 percentages served within each range by such programs; and (G) age
584 range of children served.

585 Sec. 12. Section 17b-737 of the general statutes is repealed and the
586 following is substituted in lieu thereof (*Effective July 1, 2012*):

587 The Commissioner of [Social Services] Education shall establish a
588 program, within available appropriations, to provide grants to
589 municipalities, boards of education and child care providers to
590 encourage the use of school facilities for the provision of child day care
591 services before and after school. In order to qualify for a grant, a
592 municipality, board of education or child care provider shall guarantee
593 the availability of a school site which meets the standards set by the
594 Department of Public Health in regulations adopted under sections

595 19a-77, 19a-79, 19a-80 and 19a-82 to 19a-87a, inclusive, and shall agree
596 to provide liability insurance coverage for the program. Grant funds
597 shall be used by the municipality, board of education or child care
598 provider for the maintenance and utility costs directly attributable to
599 the use of the school facility for the day care program, for related
600 transportation costs and for the portion of the municipality, board of
601 education or child care provider liability insurance cost and other
602 operational costs directly attributable to the day care program. The
603 municipality or board of education may contract with a child day care
604 provider for the program. The Commissioner of [Social Services]
605 Education may adopt regulations, in accordance with the provisions of
606 chapter 54, for purposes of this section. [The commissioner may utilize
607 available child care subsidies to implement the provisions of this
608 section and encourage association and cooperation with the Head Start
609 program established pursuant to section 10-16n.]

610 Sec. 13. Section 19a-495a of the general statutes is repealed and the
611 following is substituted in lieu thereof (*Effective July 1, 2012*):

612 (a) (1) The Commissioner of Public Health shall adopt regulations,
613 [as provided in subsection (d) of this section] in accordance with the
614 provisions of chapter 54, to require each residential care home, as
615 defined in section 19a-490, that admits residents requiring assistance
616 with medication administration, and each home health care agency, as
617 defined in section 19a-490, that serves clients requiring assistance with
618 medication administration in the Money Follows the Person
619 demonstration project, established by section 17b-369, to (A) designate
620 unlicensed personnel to obtain certification for the administration of
621 medication, and (B) to ensure that such unlicensed personnel receive
622 such certification.

623 (2) The regulations shall establish criteria to be used by such homes
624 and agencies in determining (A) the appropriate number of unlicensed
625 personnel who shall obtain such certification, and (B) training
626 requirements, including on-going training requirements for such
627 certification. Training requirements shall include, but shall not be

628 limited to: Initial orientation, resident rights, identification of the types
629 of medication that may be administered by unlicensed personnel,
630 behavioral management, personal care, nutrition and food safety, and
631 health and safety in general.

632 (b) Each residential care home, as defined in section 19a-490, shall
633 ensure that, on or before January 1, 2010, an appropriate number of
634 unlicensed personnel, as determined by the residential care home,
635 obtain certification for the administration of medication. Each home
636 health care agency, as defined in section 19a-490, shall ensure that, on
637 or before January 1, 2013, an appropriate number of unlicensed
638 personnel, as determined by the home health care agency, obtain
639 certification for the administration of medication. Certification of such
640 personnel shall be in accordance with regulations adopted pursuant to
641 this section. Unlicensed personnel obtaining such certification may
642 administer medications that are not administered by injection to
643 residents of such homes, or clients enrolled in the Money Follows the
644 Person demonstration project, unless a resident's or client's physician
645 specifies that a medication only be administered by licensed personnel.
646 The administration of medication by certified personnel of such
647 agencies shall be limited to those clients enrolled in the Money Follows
648 the Person demonstration project.

649 (c) On and after October 1, 2007, unlicensed assistive personnel
650 employed in residential care homes, as defined in section 19a-490, may
651 (1) obtain and document residents' blood pressures and temperatures
652 with digital medical instruments that (A) contain internal decision-
653 making electronics, microcomputers or special software that allow the
654 instruments to interpret physiologic signals, and (B) do not require the
655 user to employ any discretion or judgment in their use; (2) obtain and
656 document residents' weight; and (3) assist residents in the use of
657 glucose monitors to obtain and document their blood glucose levels.

658 (d) The Commissioner of Public Health may implement policies and
659 procedures necessary to administer the provisions of this section while
660 in the process of adopting such policies and procedures as regulation,

661 provided the commissioner prints notice of intent to adopt regulations
662 in the Connecticut Law Journal not later than twenty days after the
663 date of implementation. Policies and procedures implemented
664 pursuant to this section shall be valid until the time final regulations
665 are adopted.

666 (e) A nurse licensed pursuant to the provisions of chapter 378 who
667 delegates the task of medication administration to unlicensed
668 personnel pursuant to this section shall not be subject to disciplinary
669 action based on the performance of the unlicensed personnel to whom
670 medication administration is delegated unless the unlicensed
671 personnel is acting pursuant to specific instructions from the nurse or
672 the nurse fails to leave instructions when the nurse should have done
673 so.

674 Sec. 14. Subsection (c) of section 17b-242 of the 2012 supplement to
675 the general statutes is repealed and the following is substituted in lieu
676 thereof (*Effective July 1, 2012*):

677 (c) The home health services fee schedule shall include a fee for the
678 administration of medication, which shall apply when the purpose of a
679 nurse's visit is limited to the administration of medication.
680 Administration of medication may include, but is not limited to, blood
681 pressure checks, glucometer readings, pulse rate checks and similar
682 indicators of health status. The fee for medication administration shall
683 include administration of medications while the nurse is present, the
684 pre-pouring of additional doses that the client will self-administer at a
685 later time and the teaching of self-administration. The department
686 shall not pay for medication administration in addition to any other
687 nursing service at the same visit. The fee schedule for the
688 administration of medication by licensed nurses in effect for the fiscal
689 year ending June 30, 2012, shall remain in effect for the fiscal year
690 ending June 30, 2013, except for any increase approved by the
691 Commissioner of Social Services. The department may establish prior
692 authorization requirements for this service. Before implementing such
693 change, the Commissioner of Social Services shall consult with the

694 chairpersons of the joint standing committees of the General Assembly
 695 having cognizance of matters relating to public health and human
 696 services.

697 Sec. 15. Sections 17b-688j and 19a-617c of the general statutes are
 698 repealed. (*Effective July 1, 2012*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	17b-239
Sec. 2	<i>July 1, 2012</i>	17b-282c(a)
Sec. 3	<i>from passage</i>	17b-239c(b)
Sec. 4	<i>July 1, 2012</i>	17b-244(a)
Sec. 5	<i>July 1, 2012</i>	17b-340(g)
Sec. 6	<i>July 1, 2012</i>	17b-261
Sec. 7	<i>July 1, 2012</i>	17b-365(a)
Sec. 8	<i>July 1, 2012</i>	17b-366(a)
Sec. 9	<i>July 1, 2012</i>	17b-605a
Sec. 10	<i>July 1, 2012</i>	17b-650a(a)
Sec. 11	<i>July 1, 2012</i>	17b-733
Sec. 12	<i>July 1, 2012</i>	17b-737
Sec. 13	<i>July 1, 2012</i>	19a-495a
Sec. 14	<i>July 1, 2012</i>	17b-242(c)
Sec. 15	<i>July 1, 2012</i>	Repealer section

Statement of Legislative Commissioners:

The new language in section 2(a) was moved for statutory consistency and clarity and in section 11 a reference to section 11-4a was added for statutory consistency.

HS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect
Department of Social Services	GF - Implements the Budget

Note: GF=General Fund

Municipal Impact: None

Explanation

Sections 1 and 15 of the bill eliminate statutory provisions concerning Medicaid hospital rate setting. There is no fiscal impact as this rate setting methodology has been superseded by more recent statutory provisions.

Section 2 specifies that Medicaid dental benefit limitations are specific to the Medicaid client, regardless of how many providers serve the client. This provision would presumably reduce utilization of dental services. The Department of Social Services (DSS) spends approximately \$185 million on dental benefits annually. sHB 5014, (the Budget Bill), as favorably reported by the Appropriations Committee, includes savings of \$1.74 million for this initiative.

Section 3 extends the period for which DSS can use federal fiscal year 2009 data in setting Medicaid and disproportionate share hospital (DSH) payments. While this provision may alter the amount paid to individual hospitals, it does not change the aggregate amount the state pays out of the DSH or Medicaid program.

Sections 4 and 5 allow DSS to lower reimbursement rates for community living arrangements (CLA's) and intermediate care facilities for the mentally retarded (ICF/MR's) when facilities experience significant reductions in land and building costs. sHB 5014

assumes savings of \$5.2 million from these reductions.

Section 6 requires veterans and their families who apply for or receive Medicaid to also apply for federal Veteran's Administration or Department of Defense benefits. Should this result in federal benefits supplanting Medicaid benefits, the state would realize savings. It is not known how many Medicaid clients could be affected by the change. No savings were included in sHB 5014 for this policy.

Sections 7 and 8 expand the private pay assisted living pilot from 75 to 125 individuals. This expansion is expected to cost the state funded Connecticut Home Care Program for the Elders (CHCPE) approximately \$950,000 when annualized (\$19,000 per slot). However, it is expected to result in an equal level of savings in the Medicaid program by diverting individuals from more expensive nursing home care. sHB 5014 transfers funding between Medicaid and CHCPE to reflect this expansion.

Section 9 requires enrollees of the Medicaid Personal Care Assistance (PCA) Waiver program to enroll in the CHCPE upon reaching the age of 65. This will allow the PCA waiver program to serve additional individuals who are currently on a wait list. sHB 5014 includes funding of \$600,000 to reflect the provision of additional services.

Section 10 requires DSS to continue to provide administrative support to the new Bureau of Rehabilitative Services until June 30, 2013 or until the bureau requests the cessation of such services. There is no net state cost from this provision as it specifies which agency provides administrative services.

Sections 11 and 12 remove certain child care related responsibilities from DSS and require the State Department on Education (SDE), not DSS, to make certain before and afterschool grants. Although HB 5014 originally transferred \$3.3 million in child care and quality enhancement funding from DSS to SDE, the substitute language in sHB 5014 did not transfer these funds.

Section 13 requires certain home health care agencies to provide for the administration of non-injectible medications by staff other than licensed nurses, at the discretion of the treating physician. This policy would be limited to recipients of the Money Follow the Person (MFP) program. Approximately 300 clients transitioned onto the MFP program in FY 11. It is anticipated that the Medicaid program would realize savings through this use of unlicensed personnel rather than nurses to administer medications¹. However, it is not known how many MFP clients utilize this service. Additionally, section 14 specifies that the fee schedule in effect for FY 12 for nurse medication administration shall not be reduced in FY 13. As this limits DSS's discretion to reduce rates as it can otherwise under current law, potential savings are forgone. DSS currently spends approximately \$113 million annually on home health medication administration.

sHB 5014 assumed savings of \$10.3 million related to reduced home health medication administration services through utilization of an Administrative Service Organization and the use of assistive technology.

Section 15, which has no fiscal impact, repeals a statutory reference to a two year pilot program for reliable transportation. The pilot had a sunset date of 2000.

The Out Years

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

Sources: Department of Social Services Caseload Information

¹ The average per visit rate is assumed to be reduced from \$54 for nurses to \$26 for unlicensed personnel.

OLR BILL ANALYSIS**SB 30*****AN ACT IMPLEMENTING PROVISIONS OF THE BUDGET CONCERNING HUMAN SERVICES.*****SUMMARY:**

This bill makes changes in human services programs, most of which the Department of Social Services (DSS) administers. Specifically, it:

1. eliminates a statutory formula DSS has used to set hospital inpatient rates;
2. provides that Medicaid dental service limits are per-client limits and apply regardless of the number of providers the client sees;
3. extends by one year the process DSS uses to calculate interim hospital disproportionate share payments;
4. permits DSS to reduce the amount it reimburses certain facilities that serve people with disabilities when their land and building costs go down;
5. requires veterans and their families who apply for or receive Medicaid to apply for any federal veterans' benefits for which they might qualify;
6. increases the number of private assisted living pilot program slots;
7. requires individuals participating in the Medicaid Personal Care Assistance (PCA) waiver program to move into the Connecticut Home Care Program for Elders in order to continue receiving PCA services once they turn 65;
8. makes the new Bureau of Rehabilitative Services a stand-alone

state agency;

9. moves from DSS to the State Department of Education certain child care functions;
10. requires certain unlicensed home health care employees to be certified to administer medications by January 1, 2013; and
11. repeals (a) an obsolete “reliable transportation” pilot program and (b) a rate-setting formula for certain hospitals, consistent with the bill’s elimination of DSS’ current inpatient hospital rate-setting formula, and makes a conforming statutory change.

EFFECTIVE DATE: Various, see below

§ 1 — MEDICAID INPATIENT HOSPITAL RATES

The bill eliminates the inpatient hospital rate-setting formula DSS currently uses to calculate Medicaid payment amounts. That formula includes a hospital-specific target amount per discharge component that the commissioner can adjust for accuracy or for hospitals serving disproportionate numbers of low-income patients. It appears that DSS intends to replace its current statutory formula with a cost-neutral, acuity-based, rate-setting method phased in over time. PA 11-44 directed the commissioner to submit a plan for doing so to the Appropriations and Human Services committees by January 1, 2012. (The department has not done so.)

EFFECTIVE DATE: Upon passage

§ 2 — DENTAL SERVICES FOR ADULT MEDICAID RECIPIENTS

The law (1) subjects most nonemergency Medicaid dental services to prior authorization and (2) directs the DSS commissioner to limit nonemergency dental services provided to adult recipients. This latter provision includes allowing for one periodic dental exam, one dental cleaning, and one set of x-rays yearly for healthy adults. The bill provides that these dental benefit limitations apply to each client regardless of how many providers serve the client.

DSS is in the process of establishing client-centered medical homes that include a dental home that coordinates a client's dental care.

EFFECTIVE DATE: July 1, 2012

§ 3 — INTERIM DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS

The bill extends from October 1, 2012 to October 1, 2013, the period in which the DSS commissioner must use FFY 09 data, adjusted for accuracy, to make interim Medicaid disproportionate share (DSH) payments to short-term general hospitals. Federal law requires states to make such payment adjustments for hospitals that serve a disproportionate share of low-income patients. Beginning on October 1, 2013, he must use the most recent federal fiscal year data available. The law prohibits DSH payments to Connecticut Children's Medical Center and John Dempsey Hospital.

EFFECTIVE DATE: Upon passage

§§ 4 & 5 — DSS PAYMENTS TO PRIVATE FACILITIES OPERATED BY REGIONAL EDUCATION SERVICE CENTERS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES AND AUTISM AND INTERMEDIATE CARE FACILITIES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (ICF-MR)

The bill permits DSS to reduce the amount it reimburses (1) private facilities operated by regional education service centers for individuals with developmental disabilities and autism and (2) ICF-MRs if these facilities experience a "significant" decrease in their land and building costs to reflect these cost reductions. (The bill does not define significant.) PA 11-44 (1) froze the payments to these facilities for FYs 12 and 13 unless they made a required capital improvement for resident safety and (2) allowed DSS to make lower payments over previous years to facilities for which it had issued interim rates.

EFFECTIVE DATE: July 1, 2012

§ 6 — VETERANS REQUIRED TO APPLY FOR FEDERAL BENEFITS

The bill requires veterans and their families who apply for or receive Medicaid benefits to apply for any benefits for which they might be eligible through the federal Veteran's Administration (VA) or Department of Defense. VA medical benefits are available to all veterans who served honorably for at least two years in any branch of the military (See BACKGROUND).

The law defines veterans as individuals honorably discharged from, or released under honorable conditions from, active service in the armed forces.

EFFECTIVE DATE: July 1, 2012

§ 7 & 8 — EXPANSION OF PRIVATE ASSISTED LIVING SERVICES PILOT

The bill increases, from 75 to 125, the total number of people who can participate in two private assisted living pilot programs (one Medicaid- and one state-funded, administered by DSS). The programs help pay for assisted living services, but not room and board, for people living in private assisted living facilities who have used up their own resources. (Participants must use their own funds to pay their room and board costs.)

To qualify, applicants must:

1. be Connecticut residents at least age 65;
2. reside in a private assisted living facility;
3. need help with one or more activities of daily living, such as bathing, dressing, eating, or taking medication; and
4. qualify functionally and financially for the Connecticut Homecare Program for Elders (CHCPE).

EFFECTIVE DATE: July 1, 2012.

§ 9 — PEOPLE TRANSITIONING FROM PERSONAL CARE ASSISTANCE WAIVER AT AGE 65

The Medicaid Personal Care Assistance (PCA) Waiver Program offers PCA services to adults with severe disabilities age 18 and older who meet the program's eligibility criteria (e.g., income no higher than \$2,094 per month). PCAs help clients perform activities of daily living, enabling them to remain in their communities and, when possible, work.

The bill requires program participants who turn 65 to be transitioned to the CHCPE to receive these services. CHCPE is a Medicaid- and state-funded program that provides home- and community-based services to frail individuals age 65 and older.

In 2006, the legislature removed the PCA Waiver Program's upper age limit and directed DSS to amend the waiver to allow individuals to continue receiving benefits once they turned 65. The state's current waiver allows individuals to either stay on the PCA waiver program or transition to the CHCPE.

EFFECTIVE DATE: July 1, 2012

§10 — BUREAU OF REHABILITATIVE SERVICES

The bill makes the Bureau of Rehabilitative Services, created by PA 11-44, a stand-alone entity rather than a bureau within DSS for administrative purposes. Under that act, the bureau was authorized to perform all of the administrative and programmatic functions of the Board of Education and Services for the Blind, the Commission on Deaf and Hearing Impaired, and a workers' compensation rehabilitation program for employees injured on the job.

The bill requires DSS to provide the bureau administrative support services until (1) the bureau's request that the department no longer do so or (2) June 30, 2013, whichever is earlier.

EFFECTIVE DATE: July 1, 2012

§§ 11 & 12 — MOVING CERTAIN DSS CHILD CARE FUNCTIONS TO STATE DEPARTMENT OF EDUCATION (SDE)

By law, DSS is the state's lead agency for child day care services.

The bill removes the department's responsibility for developing and implementing a statewide coordinated child day care and early childhood education training system for licensed child care facilities that makes available to them and their staff scholarship assistance, career counseling, training, and other assistance. (Presumably, the SDE takes over this responsibility.)

The bill also makes the SDE commissioner, instead of the DSS commissioner, responsible for providing grants to local school districts that use school facilities to provide before- and after-school child care and allows SDE to adopt regulations. As a corollary, it also removes the DSS commissioner's authority to (1) use available child care subsidies to implement the grant program and (2) encourage cooperation with the Head Start grant program. DSS continues to consult with the SDE commissioner on the latter grant program.

EFFECTIVE DATE: July 1, 2012

§ 13 — MEDICATION ADMINISTRATION BY UNLICENSED PERSONNEL

The bill requires home health care agencies with clients who (1) need medication administration assistance and (2) participate in the federal Money Follows the Person (MFP) demonstration program (see BACKGROUND) to ensure that by January 1, 2013, an appropriate number of their unlicensed personnel are certified by the Department of Public Health (DPH) to administer non-injectible medication to MFP clients. The agency must designate the number of unlicensed personnel to be certified, ensure certification, and follow the criteria DPH sets in regulations adopted under the Uniform Administrative Procedure Act (UAPA). Nurses and other licensed personnel currently perform these functions and will continue to do so for clients (1) not participating in MFP or (2) whose physician specifies that a medication be administered only by licensed personnel.

The law already allows residential care homes (RCHs) that admit residents requiring medication administration assistance, regardless of MFP status, to employ a sufficient number of certified, unlicensed

personnel to perform this function in accordance with DPH regulations.

DPH Regulations

Current law requires the DPH commissioner to establish regulations governing medication administration by unlicensed personnel in RCHs. The regulations must include criteria that homes must use to determine the appropriate number of unlicensed personnel who will obtain certification. They must also establish ongoing training requirements including initial orientation, residents' rights, behavioral management, personal care, and general health and safety. The bill expands these regulations to include medication administration to MFP clients by unlicensed personnel in home health care agencies and requires DPH to use UAPA procedures to promulgate the amended regulations. (This is not required for current DPH regulations.)

Disciplinary Action Against Licensed Nurses

The bill prohibits DPH-licensed nurses working for either a home health care agency or RCH from being disciplined for delegating medication administration to a certified, unlicensed employee unless (1) the employee acts under the nurse's specific instructions or (2) the nurse fails to leave instructions when he or she should have done so.

EFFECTIVE DATE: October 1, 2012

§ 14 — NURSE MEDICATION ADMINISTRATION FEE FOR HOME HEALTH SERVICES

The bill freezes at FY 12 levels, the nurse medication administration fee DSS pays in FY 13 for home health services for clients unless the DSS commissioner approves an increase (see BACKGROUND).

EFFECTIVE Date: October 1, 2012

§ 15 — REPEALERS

The bill repeals an obsolete two-year "reliable transportation" pilot program to help workers and job seekers secure reliable transportation to travel to employment, educational programs, job training, and child

care facilities. The pilot sunsetted in 2000 (CGS § 17b-688j). To conform with § 1 of the bill, it also repeals a related hospital rate-setting statute.

EFFECTIVE DATE: July 1, 2012

BACKGROUND

Veterans' Medical Benefits

DSS' Medicaid eligibility determination form requires applicants to self-report information about household members who are veterans. Additionally, DSS' Fraud and Recoveries unit uses a federal matching system to identify individuals receiving both Medicaid and federal veterans' medical benefit and recovers Medicaid funds improperly paid. (The Medicaid program serves as a "wrap around" program for those services that the federal veteran programs do not cover.) Since 2009, DSS and the Department of Veteran's Affairs have had a memorandum of agreement for sharing data on mutual clients to ensure that federal veterans' benefits are exhausted before Medicaid pays.

Money Follows the Person (MFP)

MFP is a federal demonstration program that allows states to move people out of nursing homes or other institutional settings into less-restrictive, community-based settings. The recent federal health care reform law extends the demonstration period to 2016.

To qualify, an individual must have lived in a nursing home or other institution for at least 90 days and, if not for the community-based services provided under the demonstration, would have to remain in the institution. For the first 12 months the participant lives in the community, the federal government pays an enhanced federal Medicaid match. (In Connecticut, the normal Medicaid match is 50%, and the enhanced demonstration match is up to 75%).

Nurse Medication Administration Fee For Home Health Services

By law, DSS must establish a home health fee schedule which lists what the state will pay home health care and homemaker-home health

aide agencies for services provided to Medicaid beneficiaries. This schedule must include a fee for a nurse who makes a home visit solely to administer medication. It applies when the nurse's visit is limited to checking blood pressure, glucometer readings, pulse, and similar health status indicators. Medication administration also includes pre-pouring a dose for a client's later use and teaching the client to self-administer it.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute

Yea 17 Nay 0 (03/13/2012)