



General Assembly

February Session, 2014

Raised Bill No. 254

LCO No. 1427



Referred to Committee on HUMAN SERVICES

Introduced by:
(HS)

AN ACT CONCERNING PRESUMPTIVE MEDICAID ELIGIBILITY FOR THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY.

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

1 Section 1. Section 17b-342 of the 2014 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective July 1, 2014*):

4 (a) The Commissioner of Social Services shall administer the
5 Connecticut home-care program for the elderly state-wide in order to
6 prevent the institutionalization of elderly persons (1) who are
7 recipients of medical assistance, (2) who are eligible for such
8 assistance, (3) who would be eligible for medical assistance if residing
9 in a nursing facility, or (4) who meet the criteria for the state-funded
10 portion of the program under subsection [(i)] (j) of this section. For
11 purposes of this section, a long-term care facility is a facility that has
12 been federally certified as a skilled nursing facility or intermediate care
13 facility. The commissioner shall make any revisions in the state
14 Medicaid plan required by Title XIX of the Social Security Act prior to
15 implementing the program. The annualized cost of the community-
16 based services provided to such persons under the program shall not

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

49 (b) The commissioner shall solicit bids through a competitive
50 process and shall contract with an access agency, approved by the

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

58 (c) The community-based services covered under the program shall
59 include, but not be limited to, [the following] services [to the extent
60 that they are] not available under the state Medicaid plan, including
61 occupational therapy, homemaker services, companion services, meals
62 on wheels, adult day care, transportation, mental health counseling,
63 care management, elderly foster care, minor home modifications and
64 assisted living services provided in state-funded congregate housing
65 and in other assisted living pilot or demonstration projects established
66 under state law. Personal care assistance services shall be covered
67 under the program to the extent that (1) such services are not available
68 under the Medicaid state plan and are more cost effective on an
69 individual client basis than existing services covered under such plan,
70 and (2) the provision of such services is approved by the federal
71 government. Recipients of state-funded services pursuant to
72 subsection (j) of this section and persons who are determined to be
73 functionally eligible for community-based services who have an
74 application for medical assistance pending, or are determined
75 presumptively eligible for Medicaid pursuant to subsection (e) of this
76 section, shall have the cost of home health and community-based
77 services covered by the program, provided they comply with all
78 medical assistance application requirements. Access agencies shall not
79 use department funds to purchase community-based services or home
80 health services from themselves or any related parties.

81 (d) Physicians, hospitals, long-term care facilities and other licensed
82 health care facilities may disclose, and, as a condition of eligibility for
83 the program, elderly persons, their guardians, and relatives shall

84 disclose, upon request from the Department of Social Services, such
85 financial, social and medical information as may be necessary to enable
86 the department or any agency administering the program on behalf of
87 the department to provide services under the program. Long-term care
88 facilities shall supply the Department of Social Services with the names
89 and addresses of all applicants for admission. Any information
90 provided pursuant to this subsection shall be confidential and shall not
91 be disclosed by the department or administering agency.

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

97 (e) Not later than October 1, 2014, the Commissioner of Social
98 Services shall establish a system under which the state shall fund
99 services under the Connecticut home-care program for the elderly for a
100 period of up to ninety days for applicants who require a skilled level of
101 nursing care and who are determined to be presumptively eligible for
102 Medicaid coverage. Such system shall include, but not be limited to: (1)
103 The development of a preliminary screening tool by the Department of
104 Social Services to be used by representatives of the access agency
105 selected pursuant to subsection (b) of this section to determine whether
106 an applicant is functionally able to live at home or in a community
107 setting and is likely to be financially eligible for Medicaid; (2)
108 authorization by the commissioner for such access agency
109 representatives to initiate home-care services not later than five days
110 after such functional eligibility determination for applicants deemed
111 likely to be eligible for Medicaid; (3) a presumptive financial Medicaid
112 eligibility determination for such applicants by the department not
113 later than four days after the functional eligibility determination; and
114 (4) a written agreement to be signed by such applicant attesting to the
115 accuracy of financial and other information such applicant provides
116 and acknowledging that (A) state-funded services shall be provided

117 not later than ninety days from the date on which the applicant applies
118 for Medicaid coverage, and (B) such applicant shall complete a
119 Medicaid application on the date such applicant is screened for
120 functional eligibility or not later than ten days from such screening.
121 The department shall make a final determination as to Medicaid
122 eligibility for presumptive eligibility applicants not later than forty-
123 five days after the date of receipt of a completed Medicaid application
124 from such applicant.

125 (f) To the extent permissible under federal law, the Commissioner of
126 Social Services shall retroactively apply a final determination of
127 Medicaid eligibility for presumptive Medicaid eligibility applicants.
128 State costs during the presumptive eligibility period shall be offset by
129 federal Medicaid reimbursements and savings realized for institutional
130 care that would have been necessary but for the presumptive eligibility
131 system.

132 ~~[(f)]~~ (g) The commissioner may require long-term care facilities to
133 inform applicants for admission of the Connecticut home-care
134 program for the elderly established under this section and to distribute
135 such forms as the commissioner prescribes for the program. Such
136 forms shall be supplied by and be returnable to the department.

137 ~~[(g)]~~ (h) The commissioner shall report annually, by June first, in
138 accordance with the provisions of section 11-4a, to the joint standing
139 committee of the General Assembly having cognizance of matters
140 relating to human services on the Connecticut home-care program for
141 the elderly in such detail, depth and scope as said committee requires
142 to evaluate the effect of the program on the state and program
143 participants. Such report shall include information on (1) the number
144 of persons diverted from placement in a long-term care facility as a
145 result of the program, (2) the number of persons screened, (3) the
146 average cost per person in the program, (4) the administration costs,
147 (5) the estimated savings, and (6) a comparison between costs under
148 the different contracts.

149 [(h)] (i) An individual who is otherwise eligible for services
150 pursuant to this section shall, as a condition of participation in the
151 program, apply for medical assistance benefits pursuant to section 17b-
152 260 when requested to do so by the department and shall accept such
153 benefits if determined eligible.

154 [(i)] (j) (1) On and after July 1, 1992, the Commissioner of Social
155 Services shall, within available appropriations, administer a state-
156 funded portion of the Connecticut home-care program for the elderly
157 for persons (A) who are sixty-five years of age and older and who are
158 not eligible for Medicaid; (B) who are inappropriately institutionalized
159 or at risk of inappropriate institutionalization; (C) whose income is less
160 than or equal to the amount allowed under subdivision (3) of
161 subsection (a) of this section; and (D) whose assets, if single, [do not
162 exceed the minimum community spouse protected amount pursuant
163 to Section 4022.05 of the department's uniform policy manual or, if
164 married, the couple's assets do not exceed one hundred fifty per cent of
165 said community spouse protected amount and on and after April 1,
166 2007, whose assets, if single,] do not exceed one hundred fifty per cent
167 of the minimum community spouse protected amount pursuant to
168 [Section 4022.05 of] 42 USC 1396r-5(f)(2) as set forth in the
169 department's uniform policy manual or, if married, the couple's assets
170 do not exceed two hundred per cent of said community spouse
171 protected amount.

172 (2) Except for persons residing in affordable housing under the
173 assisted living demonstration project established pursuant to section
174 17b-347e, as provided in subdivision (3) of this subsection, any person
175 whose income is at or below two hundred per cent of the federal
176 poverty level and who is ineligible for Medicaid shall contribute seven
177 per cent of the cost of his or her care. Any person whose income
178 exceeds two hundred per cent of the federal poverty level shall
179 contribute seven per cent of the cost of his or her care in addition to the
180 amount of applied income determined in accordance with the
181 methodology established by the Department of Social Services for

182 recipients of medical assistance. Any person who does not contribute
183 to the cost of care in accordance with this subdivision shall be
184 ineligible to receive services under this subsection. Notwithstanding
185 any provision of the general statutes, the department shall not be
186 required to provide an administrative hearing to a person found
187 ineligible for services under this subsection because of a failure to
188 contribute to the cost of care.

189 (3) Any person who resides in affordable housing under the assisted
190 living demonstration project established pursuant to section 17b-347e
191 and whose income is at or below two hundred per cent of the federal
192 poverty level [] shall not be required to contribute to the cost of care.
193 Any person who resides in affordable housing under the assisted
194 living demonstration project established pursuant to section 17b-347e
195 and whose income exceeds two hundred per cent of the federal
196 poverty level [] shall contribute to the applied income amount
197 determined in accordance with the methodology established by the
198 Department of Social Services for recipients of medical assistance. Any
199 person whose income exceeds two hundred per cent of the federal
200 poverty level and who does not contribute to the cost of care in
201 accordance with this subdivision shall be ineligible to receive services
202 under this subsection. Notwithstanding any provision of the general
203 statutes, the department shall not be required to provide an
204 administrative hearing to a person found ineligible for services under
205 this subsection because of a failure to contribute to the cost of care.

206 (4) The annualized cost of services provided to an individual under
207 the state-funded portion of the program shall not exceed fifty per cent
208 of the weighted average cost of care in nursing homes in the state,
209 except an individual who received services costing in excess of such
210 amount under the Department of Social Services in the fiscal year
211 ending June 30, 1992, may continue to receive such services, provided
212 the annualized cost of such services does not exceed eighty per cent of
213 the weighted average cost of such nursing home care. The
214 commissioner may allow the cost of services provided to an individual

215 to exceed the maximum cost established pursuant to this subdivision
216 in a case of extreme hardship, as determined by the commissioner,
217 provided in no case shall such cost exceed that of the weighted cost of
218 such nursing home care.

219 [(j)] (k) The Commissioner of Social Services may implement revised
220 criteria for the operation of the program while in the process of
221 adopting such criteria in regulation form, provided the commissioner
222 prints notice of intention to adopt the regulations in [the Connecticut
223 Law Journal] accordance with the provisions of chapter 54 within
224 twenty days of implementing the policy. Such criteria shall be valid
225 until the time final regulations are effective.

226 [(k)] (l) The commissioner shall notify any access agency or area
227 agency on aging that administers the program when the department
228 sends a redetermination of eligibility form to an individual who is a
229 client of such agency.

230 [(l)] (m) In determining eligibility for the program described in this
231 section, the commissioner shall not consider as income Aid and
232 Attendance pension benefits granted to a veteran, as defined in section
233 27-103, or the surviving spouse of such veteran.

234 (n) The commissioner shall adopt regulations, in accordance with
235 the provisions of chapter 54, to (1) define "access agency", (2)
236 implement and administer the Connecticut home-care program for the
237 elderly, (3) implement and administer the presumptive Medicaid
238 eligibility system, (4) establish uniform state-wide standards for the
239 program and a uniform assessment tool for use in the screening
240 process, and (5) specify conditions of eligibility.

241 Sec. 2. Subsection (a) of section 17b-253 of the 2014 supplement to
242 the general statutes is repealed and the following is substituted in lieu
243 thereof (*Effective July 1, 2014*):

244 (a) The Department of Social Services shall seek appropriate
245 amendments to its Medicaid regulations and state plan to allow

246 protection of resources and income pursuant to section 17b-252. Such
247 protection shall be provided, to the extent approved by the federal
248 Centers for Medicare and Medicaid Services, for any purchaser of a
249 precertified long-term care policy and shall last for the life of the
250 purchaser. Such protection shall be provided under the Medicaid
251 program or its successor program. Any purchaser of a precertified
252 long-term care policy shall be guaranteed coverage under the
253 Medicaid program or its successor program, to the extent the
254 individual meets all applicable eligibility requirements for the
255 Medicaid program or its successor program. Until such time as
256 eligibility requirements are prescribed for Medicaid's successor
257 program, for the purposes of this subsection, the applicable eligibility
258 requirements shall be the Medicaid program's requirements as of the
259 date its successor program was enacted. The Department of Social
260 Services shall count insurance benefit payments toward resource
261 exclusion to the extent such payments (1) are for services paid for by a
262 precertified long-term care policy; (2) are for the lower of the actual
263 charge and the amount paid by the insurance company; (3) are for
264 nursing home care, or formal services delivered to insureds in the
265 community as part of a care plan approved by an access agency
266 approved by the Office of Policy and Management and the
267 Department of Social Services as meeting the requirements for such
268 agency as defined in regulations adopted pursuant to subsection [(e)]
269 (n) of section 17b-342, as amended by this act; and (4) are for services
270 provided after the individual meets the coverage requirements for
271 long-term care benefits established by the Department of Social
272 Services for this program. The Commissioner of Social Services shall
273 adopt regulations, in accordance with chapter 54, to implement the
274 provisions of this subsection and sections 17b-252, 17b-254 and 38a-
275 475, as amended by this act, relating to determining eligibility of
276 applicants for Medicaid, or its successor program, and the coverage
277 requirements for long-term care benefits.

278 Sec. 3. Subdivision (1) of subsection (g) of section 17b-354 of the
279 general statutes is repealed and the following is substituted in lieu

280 thereof (*Effective July 1, 2014*):

281 (g) (1) A continuing care facility which guarantees life care for its
 282 residents, as defined in subsection (b) of this section, (A) shall arrange
 283 for a medical assessment to be conducted by an independent physician
 284 or an access agency approved by the Office of Policy and Management
 285 and the Department of Social Services as meeting the requirements for
 286 such agency as defined by regulations adopted pursuant to subsection
 287 [(e)] (n) of section 17b-342, as amended by this act, prior to the
 288 admission of any resident to the nursing facility and shall document
 289 such assessment in the resident's medical file, and (B) may transfer or
 290 discharge a resident who has intentionally transferred assets in a sum
 291 which will render the resident unable to pay the cost of nursing facility
 292 care in accordance with the contract between the resident and the
 293 facility.

294 Sec. 4. Subsection (a) of section 17b-617 of the general statutes is
 295 repealed and the following is substituted in lieu thereof (*Effective July*
 296 *1, 2014*):

297 (a) The Commissioner of Social Services shall, within available
 298 appropriations, establish and operate a state-funded pilot program to
 299 allow not more than fifty persons with disabilities (1) who are age
 300 eighteen to sixty-four, inclusive, (2) who are inappropriately
 301 institutionalized or at risk of inappropriate institutionalization, and (3)
 302 whose assets do not exceed the asset limits of the state-funded home
 303 care program for the elderly, established pursuant to subsection [(i)] (j)
 304 of section 17b-342, as amended by this act, to be eligible to receive the
 305 same services that are provided under the state-funded home care
 306 program for the elderly. At the discretion of the Commissioner of
 307 Social Services, such persons may also be eligible to receive services
 308 that are necessary to meet needs attributable to disabilities in order to
 309 allow such persons to avoid institutionalization.

310 Sec. 5. Section 38a-475 of the 2014 supplement to the general statutes
 311 is repealed and the following is substituted in lieu thereof (*Effective July*

312 1, 2014):

313 The Insurance Department shall only precertify long-term care
 314 insurance policies which (1) alert the purchaser to the availability of
 315 consumer information and public education provided by the
 316 Department on Aging pursuant to section 17b-251; (2) offer the option
 317 of home and community-based services in addition to nursing home
 318 care; (3) in all home care plans, include case management services
 319 delivered by an access agency approved by the Office of Policy and
 320 Management and the Department of Social Services as meeting the
 321 requirements for such agency as defined in regulations adopted
 322 pursuant to subsection [(e)] (n) of section 17b-342, as amended by this
 323 act, which services shall include, but need not be limited to, the
 324 development of a comprehensive individualized assessment and care
 325 plan and, as needed, the coordination of appropriate services and the
 326 monitoring of the delivery of such services; (4) provide inflation
 327 protection; (5) provide for the keeping of records and an explanation of
 328 benefit reports on insurance payments which count toward Medicaid
 329 resource exclusion; and (6) provide the management information and
 330 reports necessary to document the extent of Medicaid resource
 331 protection offered and to evaluate the Connecticut Partnership for
 332 Long-Term Care. No policy shall be precertified if it requires prior
 333 hospitalization or a prior stay in a nursing home as a condition of
 334 providing benefits. The commissioner may adopt regulations, in
 335 accordance with chapter 54, to carry out the precertification provisions
 336 of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2014	17b-342
Sec. 2	July 1, 2014	17b-253(a)
Sec. 3	July 1, 2014	17b-354(g)(1)
Sec. 4	July 1, 2014	17b-617(a)
Sec. 5	July 1, 2014	38a-475

HS

Joint Favorable C/R

APP