Sec. 17b-342-3. Service limitations, payment limitations, cost limits, waiting list and fee setting

(a) **Service Limitations**

(1) All home care services provided to individuals under the Connecticut Home Care Program shall be authorized in accordance with procedures established by the department prior to the delivery of the service;

(2) Reimbursement is not available from the department for personnel or agencies providing a home care service when such person or agency is required to be licensed, certified or otherwise regulated and does not fulfill the relevant regulatory requirements including the requirements under sections 17b-342-1 to 17b-342-5 of the Regulations of Connecticut State Agencies;

(3) When two or more providers of community based or home health services offer essentially the same service, the least costly service provider shall be used, provided that the quality of the service is similar;

(4) Providers of services, including subcontractors of the access agency and assisted living service agencies, shall maintain records to support claims made for payment, which shall be subject to audit by the department or its designee for at least seven years;

(5) Reimbursement is not available from the department for services canceled in advance either by phone or in writing;

(6) Reimbursement is not available from the department when an individual does not utilize or refuses to utilize an arranged service;

(7) Reimbursement is not available from the department for any services provided prior to the assessment or the determination of program eligibility or not documented in an approved plan of care;

(8) Reimbursement is not available from the department including, but not limited to, when an individual dies, is hospitalized, enters a nursing facility, moves temporarily or permanently out of state, requests services to be terminated or is determined ineligible;

(9) Reimbursement is not available from the department if the access agency or assisted living service agency is determined not to have followed the requirements and process established by the department for uncollectible mandatory client contribution towards their care;

(10) Reimbursement is not available for home and community based services determined not to have been performed;

(11) Reimbursement is not available for services arranged by program clients or representatives, access agencies, assisted living service agencies or service providers without prior approval by the department or department designee;

(12) Reimbursement is not available for duplication of services or payment; and

(13) Reimbursement is not available from more than one department or state agency program.

(b) **Payment Limitations**

(1) All home care service providers shall bill the usual and customary charge and the department shall pay the lowest of:

(A) The usual and customary charge;

(B) the lowest Medicaid rate;

(C) the amount in the applicable fee schedule as published by the department;

(D) the fee or rate negotiated with the access agency and the assisted living service agency; or

(E) the amount billed by the provider of the community based service to the department.

(2) The access agency shall not use department funds to purchase home care services other than assessment, status reviews and care management from itself or any related parties.

(3) The assisted living service agencies shall not use department funds to purchase home care services other than assisted living services, which include all personal care assistance services and core services, or other allowable charges incurred buy the agency.

(c) **Cost Limits on Individual Plans of Care**

(1) In order to receive home care services under the Connecticut Home Care Program, the elderly person's plan of care shall be within the cost limits related to the person's category of service for both the fee-for-service and the assisted living service components. All state-administered costs of home care services shall be included.

The following are the cost limits which define the categories of services for fee-for-service (to be used only for care managed and self-directed clients):

(A) Category 1 Services:

Home care services may be authorized for up to 25% of the weighted average nursing facility cost for individuals who are at risk of institutional placement but who might not immediately enter a hospital or nursing facility in the absence of the program provided they also meet the financial eligibility criteria for the state-funded portion of the program.

Services for Medicaid recipients who are not functionally eligible for the Medicaid waiver portion of the program will be covered by the state-funded portion of the program.

(B) Category 2 Services:

Home care services may be authorized for up to 50% of the weighted average nursing facility cost for individuals who would otherwise require admission to a nursing facility and who meet the financial eligibility criteria for the state-funded portion of the program.

(C) Category 3 Services:

Home care services may be authorized for up to 100% of the average nursing facility cost for individuals who would otherwise require long term admission to a nursing facility and who also meet the financial eligibility criteria for Medicaid under the federal waiver. The cost of community-based services provided to individuals in category 3 shall not exceed 60% of the weighted average Medicaid rate in a nursing facility.

(2) Under the assisted living service component of the program there are four different levels of service that the assisted living service agency is to use when assigning the appropriate level of service to a client.

(A) The assisted living levels of service 1,2,3 and 4 are based on the client's nursing or personal care needs. Each level of service is reimbursed at a per diem rate established by the department. There may be different per diem rates for each of the assisted living services components depending on the negotiated rate by the assisted living service agency with the department. Refer to subsection (c)(1)(A) to (c)(1)(C), inclusive, of this section for specifics relating to the description of assisted living cost limits for categories of service.

(B) Additional cost for core services is allowed if the program client needs these supplemental services.

(C) The program client's cost for assisted living services cannot exceed the assigned service package and additional cost for core services which shall be specified on the client's plan of care and cost worksheet.

(3) Elders enrolled in the program have the ability to move from one service category to another within fee-for-service if care managed or self-directed, and from one level of service to another under the assisted living component. When the elderly person's functional or financial eligibility changes, the information shall be reviewed by department staff and a determination shall be made regarding the appropriateness of the change in service category and funding source for the services under the program.

(4) The agency that oversees an elder's plan of care shall be responsible for applying and monitoring the Connecticut Home Care Program cost limits in accordance with the following regulations:

(A) The agency shall first determine if the state-administered public funds to be expended for home care services in accordance with the elderly person's plan of care exceed the cost limits related to the individual's category of services or service package level cost. If the costs do not exceed the limit on a monthly basis, the person may receive services under the Connecticut Home Care Program, provided the program is accepting new applicants at the level for which the person is applying.

(B) If the monthly cost of state-administered public funds for home care services required to be provided under an individual's plan of care exceeds the cost limits related to the individual's category of services (fee-for-service only under the program), the agency shall project the cost of those services for the individual over a 12-month period. If the projected annualized cost of those services falls within the cost limits, the individual may receive services under this program provided that the program is accepting new applicants at the category of service for which the individual is applying.

(C) Clients participating in the assisted living services component whose needs cannot be met within the assisted living service package levels, may be referred to the access agency to determine if their needs can be met and the necessary services are available within the cost limits of the category of services provided under the fee-for-services delivery system. Once the client is care-managed, the client may be referred to the access agency as described under this subparagraph.

(D) If the agency does not have information on the actual cost of services being provided to the elder through other state administered programs, the agency shall estimate the cost based upon payments made for similar services. Information on all services provided under the requirements of an individual's approved plan of care shall be reported to the department.

(E) The agency shall be responsible for determining that the amount of state-administered public funds expended to provide services required under the person's plan of care continues to meet the cost limits set forth in this subsection and as described in subsection (c)(1)(A) to (C), inclusive, of this section.

(F) When the rates for home care services (including care management and assisted living services, such as personal care assistance and core services), covered by the Connecticut Home Care Program are increased, the access agency, assisted living service agency or department designee shall update the plans of care to reflect those increases upon receipt of the new rates. The access agency, assisted living service agency and other

providers shall be liable for charges in excess of the cost limit following that transition period unless the case is under appeal or an exception to the cost limits is granted in accordance with subparagraph (G) or (H) of this subdivision or by the department Commissioner or his or her designee.

(G) Clients who were above the cost limits prior to July 1, 1992, shall continue to receive services to the extent that they qualify in accordance with section 17b-342(i) of the Connecticut General Statues.

(H) Any person who requires a care plan that shall place the client above the cost limits may request an exception to the cost limits from the Commissioner or his or her designee. Approvals shall be based on extreme hardship, shall be time-limited (not to exceed three months), shall in no case exceed 100% of the average nursing facility cost and shall be home health service related.

(I) Requests for exceptions to the cost limits are not allowed when a client is pending Medicaid, when the client loses his or her Medicaid eligibility because of changes to their income or assets, loses Medicare coverage or is an assisted living service participant.

(d) **Waiting List**

(1) The state funded portion of the program is subject to availability of funds.

The portion of the program funded under the federal waiver is subject to continued approval of the Medicaid waiver and to any limits on expenditures or the number of persons who can be served under the federal waiver application.

(2) In the event that the state appropriation or the upper limits under the federal waiver are insufficient to provide services to all eligible persons, the number of persons admitted to the program may be limited. When these limits are reached, the department may establish a waiting list. If a waiting list is established, the department shall serve applicants from the waiting list who meet all program requirements in order of their application except as otherwise provided in subdivision (d)(4) of this section.

(i) If there is a waiting list for either portion of the program and the applicant's name is reached, but the applicant is not eligible for benefits at the time the opening becomes available, the applicant's name may be placed in a "hold" position, unless the applicant is removed from the waiting list. The "hold" status enables the applicant to retain the position on the waiting list until such time as the applicant meets the requirements of the program. The applicant shall inform the department when the applicant meets the program requirements.

(ii) If the department learns that an applicant is deceased, or becomes enrolled in the Medicaid waiver portion of the program, the applicant shall be removed from the waiting list.

(iii) If the department learns that an applicant has entered a nursing facility or has moved out of state, or if the applicant requests removal from the waiting list, the department may remove the applicant's name from the waiting list.

(aa) The department shall notify the applicant that it intends to remove the applicant's name from the waiting list and the reason it intends to remove the applicant's name.

(bb) The applicant shall be provided with the opportunity to request that the name not be removed from the waiting list. It is the responsibility of the applicant to inform the department of the applicant's current address. If the applicant does not respond to the

department, the applicant's name shall be removed from the waiting list.

(iv) If an applicant is removed from the waiting list in error, the applicant may be restored to the waiting list in the original place.

(3) Available openings within the program shall be allocated based on the proportion of the region's elder population adjusted to take into consideration the ratio of elders who are poor, minority, impaired or living in rural areas.

(4) If funds are available under the state-funded portion of the program, the department may from time to time establish priorities which ensure that persons with the greatest medical, social and economic need receive timely assistance. The department will only establish priorities under extreme circumstances.

(e) **Rate Setting**

(1) General Provisions

(A) The department shall, in accordance with section 17b-343 of the Connecticut General Statutes, establish a fee schedule for assessment, care management and other home and community based services as they are defined in section 17b-342-1(b)(7) of the Regulations of Connecticut State Agencies. The Commissioner may annually increase any rate in the rate schedule based on an increase in the cost of services. The department shall specify the rates for these services in the Request for Proposals (RFP).

(B) All financial and clinical records of providers shall be accessible at the request of the department and are fully subject to fiscal and programmatic audit by the department or its designees.

(2) Rates for Assessment and Care Management

(A) All access agencies wishing to provide assessment and care management services, and receive reimbursement for the same under contract with the department, shall submit bids to the department in response to the RFP. These bids shall be filed with the department on a date set by the department for the initial year of the contract.

(B) The rates for assessment and care management services shall be established by the department based on the responses to the RFP. In no event may a payment exceed the usual and customary charges of the access agency. In addition, the department shall not contract for any fees determined unreasonable or in excess of the fees set by the department.

(3) Rates for Status Reviews

The department shall establish a rate for status reviews.

(4) Rates for Other Community Based Services

(A) For the Connecticut Home Care Program, rates for other home and community based services (excluding assessment and care management) shall be set by the department in accordance with section 17b-343 of the Connecticut General Statutes. The rates to be charged for other home and community based services shall be set by a contract between the access agency and the service provider even when the services are provided without care management by the access agency. In no event may a contracted rate exceed the usual and customary charge of the provider or the rate set by the department.

(B) For the Connecticut Home Care Program, under no circumstances shall an access agency or assisted living service agency select a provider whose services do not meet the standards of quality established in section 17b-342-2(h) of the Regulations of Connecticut State Agencies.

(C) For the Connecticut Home Care Program, under no circumstances shall an assisted living service agency charge the department at a rate not approved by the department. The approved and enrolled assisted living service agency shall charge the approved rate established by the department and only for those allowable services.

(5) Rates for State-Funded Home Health Services

The rates for home health services provided to eligible persons, as defined in section 17b-342-2(h) of the Regulations of Connecticut State Agencies shall be the same as those paid under the Medicaid program. Home health services shall be paid only under fee-for-service for care managed or self-directed care program clients. For ALSA clients, these services are included in the rate.

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