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## Promotion of Independent Living for the Elderly Program

### Sec. 17a-301-1. Definitions

(a) "Applicant" means any person who seeks admission to the Promotion of Independent Living for the Elderly Program.

(b) "Assessment" means a comprehensive written evaluation of an individual's health, social, psychological and economic status, degree of functional impairment and related service needs based on a uniform instrument prescribed by the Department on Aging and initiated by direct personal contact between a case manager and potential client.

(c) "Case Manager" means an Agency Nurse Team Member or an Agency Social Services Coordinator Team Member who meets the requirements set forth in Section 19-13-D94 of the Regulations of Connecticut State Agencies.

(d) "Client" means any individual admitted into or receiving care under the program.

(e) "Community Services" means a social or medical regimen which allows the individual to remain in his or her home. This includes, but is not limited to:

- (1) Adult day care;
- (2) Chore services;
- (3) Companion services;
- (4) Foster care;
- (5) Home delivered meals;
- (6) Home health aide services;
- (7) Homemaker services;
- (8) Mental health counselling;
- (9) Occupational therapy;
- (10) Personal care;
- (11) Physical therapy;
- (12) Respite care;
- (13) Skilled nursing care;
- (14) Transportation; and
- (15) Personal emergency response systems.

(f) "Coordination, Assessment and Monitoring (CAM) Agency" means an agency which:

- (1) is licensed as such by the Department of Health Services (DOHS) pursuant to Section 19-13-D93 to 104 of the Regulations of Connecticut State Agencies; or
- (2) meets all state licensure requirements; and
- (3) has an agreement with the Department on Aging to conduct CAM functions on behalf of the Department.

(g) "Day" means calendar day.

(h) "Department" means the Connecticut State Department on Aging or its authorized agent.

(i) "Elderly" means 60 years of age or older.

(j) "Equal Access" means all eligible persons having the same access to program information, the same opportunity to apply for services, and, other than those who have been identified as members of priority subgroups identified by the Department, the same likelihood of acceptance into the program.

(k) "Inappropriate for the Program," means that the individual does not meet the eligibility criteria identified in Section 17a-301-3 or meets one or more of the criteria for discharge as outlined in Section 17a-301-4 (f) of these regulations.

(l) “Informal supporters” means individuals who provide care on an unpaid basis.

(m) “Legally Liable Relative” means a family member identified in law or regulation as responsible for all or part of the cost of another individual’s care.

(n) “Legal Representative” means a conservator or other individual who has legal authority to act on behalf of a promotion of independent living client of applicant; such authority may include a durable power of attorney or a court-appointed guardianship.

(o) “Liquid Assets” means all resources readily convertible into cash, excluding all real property, and including but not limited to cash, bank accounts, stocks, certificates of deposit, credit union shares, present interests in estates and the cash value of life insurance or burial insurance if the total face value of all life insurance policies exceeds \$1,500.

(p) “Long Term Care Facility” (LTC) means a facility licensed by the Department of Health Services as a chronic and convalescent nursing home or rest home with nursing supervision and certified to participate in the Title XIX medical assistance program, as a nursing facility as evidenced by a Title XIX provider agreement. For the purposes of this regulation the term long term care facility does not include an Intermediate Care Facility specifically for the mentally retarded (ICF/MR) or any other residential or inpatient health care facility.

(q) “Person” means an elderly individual or his or her authorized representative including, but not limited to, relatives, guardians or conservators.

(r) “Plan of Care” means a written plan of community services which specifies for each applicant the type and frequency of all services required to maintain that person in the community, the service providers, the cost of services, and funding sources.

(s) “Planning and Service Area” (PSA) means a geographical portion of the State designated as a unit for the development of services by the Commissioner on Aging pursuant to Section 17a-304 of the Connecticut General Statutes.

(t) “Program” means the Promotion of Independent Living for the Elderly Program.

(u) “Related Party” means an entity which, to a significant extent, is associated with or affiliated with another by common ownership or control. Control of or by another entity exists where an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. Common ownership exists when an individual or individuals possess significant ownership or equity in the provider or organization serving the provider. The Department refers to interpretations of 42 CFR 405.427, when determining whether parties are related.

(v) “Responsible Party” means a person who has been designated by the elderly individual to participate in the client’s plan of care as described in these regulations.

(w) “Risk of inappropriate institutionalization” means that the individual has a need for long term care services due to his or her functional or cognitive status but would be able to remain at home, without the creation of an unacceptable risk to the safety of the individual or others, if community services were provided.

(x) “Unacceptable Risk” means a situation which places an individual’s life or health in immediate jeopardy. In determining whether an unacceptable risk exists (such as may support a finding of ineligibility for program services, see Sections 17a-301-3a and 17a-301-4f herein), the CAM Agency shall take into account its agency’s professional standards, as well as the client’s needs and his or her informed viewpoint with regard to the potential risk.

(Effective June 2, 1992)

**Sec. 17-301-2. Program operation**

(a) The Department shall contract in each PSA with one CAM agency for administration of the Program. Each CAM agency with which the Department has contracted will assume responsibility for the administration of the Program, including screening, determination of eligibility for admission, assessment and care planning, service procurement and quality assurance.

(b) Funds for the Program will be allocated to PSAs based on the proportion of the target population which resides in each PSA.

(c) The Program is not an entitlement program. Payments for services are limited to amounts appropriated by the Connecticut General Assembly, allocations from the Social Services Block Grant, and any other non-State funds which may be available to the Department. In the event that funding is insufficient to provide services to all eligible persons, the number of persons admitted to the Program will be limited to those for whom sufficient funding is available.

(d) The rate of payment for services, including case management, shall not exceed the rate established for such services by the Commissioner of Income Maintenance pursuant to Section 17-314c of the Connecticut General Statutes, or by the Commission on Hospitals and Health Care pursuant to Section 19a-151 (b) of the Connecticut General Statutes.

(e) The Department shall not enter into a contract with any CAM agency unless it is able to provide for necessary services for individuals who are non-English speaking, hearing impaired or who have other special needs.

(f) The Department and the CAM agency shall use their best efforts to insure that all eligible elderly persons have equal access to services.

(Effective June 2, 1992)

**Sec. 17a-301-3. Eligibility**

(a) To be eligible for the Program an individual must meet all the following criteria:

(1) Be 60 years of age or older;

(2) Be a resident of Connecticut;

(3) Be inappropriately institutionalized or at risk of inappropriate institutionalization as defined by these regulations based upon the individual's functional, psychological and social status;

(4) Have an income at or below 300 percent of the current maximum Supplemental Security Income benefit for an individual living independently or in the case of a married couple, 300 percent of the current maximum Supplemental Security Income benefit for a married couple living independently. Married applicants will be subject to the income provisions for single individuals if each spouse maintains a separate residence and neither spouse has access to, or receives support from, the other's income.

(b) Persons whose income levels are between 150 percent of the federal poverty level and the maximum income limit for the program or whose liquid assets are greater than the minimum community spouse protected amount as defined in the Connecticut Department of Income Maintenance Uniform Policy Manual must contribute towards the cost of their care on the basis of a fee scale specified by the Department. The Department may establish policies providing for exceptions to this requirement, limited to situations where combined co-payments and necessary living expenses exceed available income, circumstances make it impossible to collect co-

payments or the cost of collecting co-payments is greater than the sum of the required client payments.

(c) The Department may from time to time establish priorities which insure that persons with the greatest social and economic need receive timely assistance.

(d) Any individual applying for services on or after July 1, 1989, who may be eligible for medical assistance benefits pursuant to Section 17-134a of the Connecticut General Statutes and in need of medical services that could be covered by Medicaid shall, as a condition of participation in the program, apply for such benefits, cooperate with all application requirements, and accept such benefits if determined eligible.

(1) The Department may grant exceptions to this requirement, limited to situations in which a severe hardship exists and refusal to provide services will leave the individual unable to obtain services which are necessary to maintain physical and mental health. In order to be considered for such an exception, the applicant or the case manager must apply directly to the Commissioner on Aging stating the specific hardship conditions which exist. Examples of such hardship situations include: the applicant is mentally incompetent and is unable to take the steps necessary to complete the Medicaid application and no other responsible party has yet been designated, or legal proceedings prevent the individual's access to information necessary to complete an application.

(2) All exceptions will be valid for a period not to exceed two months. An extension may only be granted by the Department following a specific request for an extension which explains the reasons for the continued hardship. In general, all requests for exceptions and extensions must include a plan for subsequent application for Medicaid benefits. The decision to grant exceptions and extensions shall be at the sole discretion of the Department.

(Effective June 2, 1992)

#### **Sec. 17a-301-4. The coordination, assessment and monitoring process**

(a) **Screening.** Referrals shall be reviewed within 5 work days after they are received, using a form approved by the Commissioner on Aging.

(1) The CAM agency shall either schedule an assessment, place the applicant on a waiting list if available funding or workload do not permit immediate assessment, or reject the applicant as inappropriate for the program.

(2) In the event that an assessment is not scheduled, the individual shall be notified of the disposition of the application (waiting list or rejection) and the reasons for the action taken within 72 hours of screening by the CAM agency. The individual shall be referred to other agencies for assistance if appropriate.

(b) **Assessment.**

(1) An assessment is scheduled and shall be performed within seven days, if there is available funding and staff or when an individual's name has been reached on the waiting list.

(2) The assessment will be performed using the instrument specified by the Department to assess the functional, psychological, cognitive, social, environmental, financial and health status of the individual, and the extent to which informal supporters are available or active in the individual's care. The assessment shall be performed by a case manager.

(3) The CAM agency shall use its best efforts to obtain relevant information from any other health or social service agencies or professionals which have provided services or care to the individual. The CAM agency shall first obtain signed releases from the individual or responsible party.

(4) Upon completion of the assessment, the CAM agency shall discuss with the individual, or responsible party, the findings of the agency and send a written notice to the individual or responsible party making a referral. The notice shall state:

(A) Whether the individual is eligible for admission to the Program; or

(B) The reason for a determination of ineligibility if applicable;

(C) In the event of a determination of ineligibility, notice of appeal rights, including the procedure to be used and any deadlines and the name and telephone number of a person to contact for more information on the appeals process.

(c) **Individualized Plan of Care.**

(1) Upon admission into the Program, an individualized plan of care shall be developed for each client by the case manager assigned to the client. The plan of care shall include all services the client needs to safely remain in the community. The plan of care includes services to be provided by informal supporters and any services to be funded by third party payers.

(2) The case manager shall involve the client and any key informal supporters identified during the assessment in developing the plan of care. The client, or other responsible party, must indicate approval of the plan of care prior to implementation.

(3) The case manager shall determine which services will meet the needs of the client. When more than one type of service will equally meet the identified needs, the case manager shall choose the type with the lower cost. When more than one person or agency provides a necessary service of equal quality, the case manager shall choose the one offering the lower cost.

(4) The case manager shall obtain funding for necessary services from all third party funding sources available. Program funds will be used only when no other funding source is available. In no event shall the cost to the Department exceed 60 percent of the annualized weighed average daily rate for skilled and intermediate nursing care in Connecticut in effect on January 1st, as determined by the Commissioner of Income Maintenance.

(5) In the event that a person other than a legally liable relative agrees to assume responsibility for the client's share of the costs, amounts paid by such person shall not be counted as income to the client for the purposes of determining eligibility or required contributions.

(d) **Individualized Plan of Care Implementation.**

(1) Services other than assessment and case management will be obtained from community service providers.

(2) Services paid for with Program funds will be procured through subcontracts and individual service orders.

(3) The CAM agency shall not use Department funds to purchase community services from itself or any related parties.

(4) Services paid for through other funding sources will be arranged by the case manager, who will assist the client in completing applications and any necessary intake processes.

(e) **Monitoring and Case Management.**

(1) Clients who require ongoing case management shall be monitored by the case manager as follows:

(A) Reviewing the care plan at least every 60 days,

(B) Making a home visit to the client at least every six months to determine the appropriateness of the service plan and to assess changes in the client's condition. The case manager shall conduct a formal reassessment of the client's health, functional and financial status and service needs every twelve (12) months,

(C) monitoring service delivery, including reviewing provider reports and records of service delivery, and

(D) responding to changes in client needs as they occur, making appropriate changes in the type, frequency, cost or provider of services needed for the client to remain in the community.

(E) In accordance with any additional requirements established under the agency's licensure.

(2) Ongoing monitoring by a case manager may be suspended for a client who, at the time of the sixty (60) day care plan review, meets the following criteria:

(A) The client's functional and cognitive status have been determined to be stable (this can include the presence of chronic health problems if the conditions are under control and do not require intervention by a case manager), and

(B) No changes in the total plan of care are anticipated during the following sixty (60) days with the exception of changes in the particular individuals who are providing care or scheduled terminations of short-term services, and

(C) The client or a legal representative has signed a consent form accepting the suspension of monitoring services and indicating that either the client or a responsible party will regularly monitor the client's needs and promptly report changes therein to the case manager.

(3) When ongoing monitoring by a case manager has been suspended, the client may continue to receive other home care services through this program. The department shall require renewals of service orders at least every six months and annual redeterminations of eligibility in order to continue services. If the client's condition becomes unstable and the client continues to reside in the community, the CAM agency shall reinstate monitoring services within seven days.

(f) **Discharge.**

(1) A client must be discharged from the Program under any of the following conditions:

(A) The client has been institutionalized in an acute or long term care facility for a period exceeding 90 days; or

(B) It has been determined that a client who has been institutionalized in an acute or long term care facility for less than 90 days will not be able to return to the community within that period of time; or

(C) The client is no longer eligible for the program (see Sec. 17a-301-3a); or

(D) The client's condition improves to the point where he or she is no longer in need of case management or other services funded by the department; or

(E) The client is admitted to the Nursing Home Preadmission Screening and Community Based Services Program or is enrolled in the Protective Services for the Elderly Program for 90 days or more; or

(F) The client or family fails to make mandatory co-payments; provided clients will not be discharged if: (1) a provider agrees to absorb the client's share of costs, or (2) if a charitable, religious or other non-state funding source agrees to make co-payments on the client's behalf, or (3) the client qualifies for an exception to the co-payment requirement as determined under Section 17a-301-3 of these regulations.

(G) The client takes up residence in another state.

(H) The client voluntarily withdraws from the program or refuses all services.

(2) The CAM agency will develop a discharge plan which ensures the continued well being of the client to the maximum extent possible.

(3) When a client is to be discharged, the client or responsible party will be given at least ten (10) days notice and will be notified of the reason for discharge

and the client's right to appeal. The reason for discharge will be entered into the client's file with all relevant documentation.

(4) CAM agencies will have written discharge policies and will notify the client or responsible party of these policies at the time of admission.

(5) Nothing in these regulations shall be deemed to require the CAM agency or any provider to provide services if it has determined that continued participation would constitute an unacceptable risk to the safety the client or others.

(Effective June 2, 1992)

### **Sec. 17a-301-5. Community services**

(a) Community services shall be included as part of the individualized plan of care developed by the CAM agency. The plan must specify the frequency and provider of such services. Services contained in the plan must be based upon documented needs found in the assessment or reassessment of the individual's needs and shall be provided only when needed in order to avoid inappropriate institutionalization.

(b) The Program shall not:

(1) Reimburse for personnel or services delivered by a person or agency required by the State of Connecticut to be licensed, certified or otherwise approved unless that person or agency can show satisfactory evidence of such licensing, certification or approval. In the event that a CAM agency purchases services from a provider not required to be licensed and which

is not otherwise subject to quality assurance regulation, the CAM agency shall take such reasonable measures as are necessary prior to purchase to ensure the quality of services delivered; or

(2) Pay any claim to a provider of community services which cannot produce adequate records to document such claim for payment; or

(3) Pay for any cancelled services; or

(4) Pay for a service when the client does not receive the service, notwithstanding any prior notice of cancellation requirement of the provider; or

(5) Reimburse for services not included in the individualized plan of care.

(c) Provider payments shall be made at the lowest of:

(1) The Provider's usual and customary charge to the public;

(2) The fee or rate established by any State agency having the authority to establish such fee or rate;

(3) The amount billed by the provider; or

(4) The fee or rate negotiated by the CAM agency.

(d) The commissioner may make money payments directly to persons entitled to receive payments for services under the department's jurisdiction if these persons had been receiving such payments prior to transfer from the department of human resources. The payments shall be made from available department on aging funds and at intervals determined by the commissioner.

(1) If the department makes direct money payments, there shall be no payment for any service not expressly authorized by the commissioner or her designee. There shall be no payment for any service incurred by, or paid by, the recipient prior to the date of payment authorization.

(2) If the department makes direct money payments, the payment shall be for the gross amount of the service payment as authorized by the commissioner, with no deductions for social security (FICA), federal unemployment tax (FUTA) or state unemployment compensation tax (UC) payments.

(Effective June 2, 1992)

**Sec. 17a-301-6. Forms**

The Department on Aging shall promulgate a uniform assessment tool and all required Program-related forms.

(Effective June 2, 1992)

**Sec. 17a-301-7. Reporting**

All CAM agencies and community services providers shall comply with reporting and audit procedures established by the Department for purposes of monitoring and evaluating the Program.

(Effective June 2, 1992)

**Secs. 17a-301-8—17a-301-12. Reserved**