STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

110 BARTHOLOMEW AVENUE • HARTFORD, CONNECTICUT 06106-2200

10/19/93

1972 Plan

Legal Aid Society of Hartford County
80 Jefferson Street
Hartford, CT. 06106
Attn: Judith Solomon

Dear Ms. Solomon:

The enclosed material was recently discovered by Pat Wilson-Coker, our current Director of Administrative Hearings and Appeal, and was brought to my attention by Judy Merrill. This document's existence was unknown to the Program Policy unit prior to this.

Inasfar as I can tell, this does apparently constitute the state plan as of 1967 with updates as noted on individual pages. The only word of caution I would like to add is that the "Supplement-D" referred to at the top of the pages constituted the Department's policy for Medicaid to the extent that it was not covered in the main parts of the Public Assistance Manual at that time.

I apologize for not sending you this material sooner. Judy had asked me to forward you a copy after we reviewed it and it somehow got overlooked.

Please call me if you have questions.

Sincerely,

Joseph St. Pierre
Assistant Chief Program Policy

JSP:r

pc: Judy Merrill

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Title XIX - Medical Assistance Programs

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State Plan for Medical Assistance

State of Connecticut

As a condition to the receipt of Federal funds under Title XIX of the Social Security Act, the State Welfare Department submits herewith the State plan for medical assistance, effective July 1, 1966 and hereby agrees to administer the medical assistance program in accordance with the provisions of this State plan, Title XIX of the Social Security Act, and the policies and interpretations as contained in Handbook Supplement D - Medical Assistance Programs, and in related regulations and policies.

The State Welfare Department certifies as follows:

I. State Organization (D-2000)

A. Single State Agency (D-2100)

1. The State Welfare Department is the single State agency with authority to administer the plan.

2. Attached, and made a part hereof, is a certification of the Attorney General of the State of Connecticut identifying the State Welfare Department as the single State agency and citing the legal authority under which such agency administers the State plan on a State-wide basis, including the authority to make rules and regulations governing the administration of the plan by such agency.

B. State-wide Operation (D-2200)

1. The State plan will be in operation, through a system of local offices on a State-wide basis, in accordance with equitable standards for assistance and administration that are mandatory throughout the State.

2. The State Welfare Department, hereinafter referred to as the State agency, will assure that the plan is continuously in operation in all local offices through

   a. Methods for informing staff of State policies, standards, procedures, and instructions; and

   b. Regular planned examination and evaluation of operations in local offices by regularly assigned State staff, including regular visits by such staff; and through reports, controls or other necessary methods.

II. Application, Determination of Eligibility, and Furnishing Assistance (D-3000)

1. All individuals wishing to make application for medical assistance under the plan shall have an opportunity to do so, without delay.

2. A decision will be made promptly on applications, within 30 days, except in unusual situations.

3. Individuals found eligible for medical assistance will qualify for assistance beginning at least with the date of application. Individuals may qualify retroactively to the first of the month prior to the date of application providing medical need existed within the retroactive period covered and eligibility for such period is established.

4. Standards and methods for determination of eligibility will be consistent with the objectives of the program, will respect the rights of individuals under the United States Constitution, the Social Security Act, Title VI of the Civil Rights Act of 1964, and all other relevant provisions of Federal and State laws, and will not result in practices that violate the individual's privacy or personal dignity or harass him or violate his constitutional rights.

5. The policies and procedures of the State agency will assure that eligibility for medical assistance will be determined in a manner consistent with simplicity of administration and the best interests of the recipients.

6. The medical care and services included in the plan will be furnished promptly to eligible individuals without any delay attributable to the agency's administrative processes, which will be simple and in the best interests of the recipient.

7. Where an individual has been determined to be eligible, eligibility will be reconsidered or redetermined: (a) when required on the basis of information the agency had obtained previously about anticipated changes in the individual's situation; (b) promptly, within 30 days, after a report is obtained which indicates that changes in the individual's circumstances may affect the amount of assistance to which he is entitled or may make him ineligible; and (c) periodically, no less often than every 12 months.

III. Coverage and Conditions of Eligibility (D-4000)

A. General (D-4000)

1. Medical assistance will be available to the following individuals as "categorically needy", with medical care and services available in the same amount, duration, and scope for:

   a. All individuals receiving aid or assistance under the State's approved plans under Titles I, IV, X and XIV.

   b. All residents of the State who would be eligible for aid or assistance under one of the other State plans except for the durational residence requirements for the particular program.

   c. All persons who would be eligible for aid or assistance under one of the other State plans except for any other eligibility condition or other requirement in such plan that is specifically prohibited in a program for medical assistance under Title XIX.

The following are other groups of individuals, based on reasonable classifications, that will be included in the program, in accordance with D-4020, item 2:

2. a. Categorically needy

   (1) All persons who meet all the conditions of eligibility, including financial eligibility, of one of the State's approved plans under Title I, IV, X and XIV, but have not applied for such assistance.

   (2) Persons in a medical facility, Convalescent Hospital, Chronic Disease Hospital, General Hospital or an Institution for Mental Diseases, who, if they left such facility would be eligible for financial assistance under another of the State's approved plan.

   (3) All children under 21 who, except for age, would be dependent children under the State AFDC plan.

   (4) All individuals under 21 who qualify on the basis of financial eligibility but do not qualify as dependent children under the State AFDC plan.

   (5) All relatives who are enumerated in Title IV of the Social Security Act as interpreted, with whom a child under 21 is living, if such relative would, except that the child is not attending school or a course of vocational training, be eligible to receive payments within the scope of Federal financial participation under Title IV.

b. Medically needy

(1) All persons who, if in need would be eligible for financial assistance under one of the State's approved plans, and whose income and resources equals or exceeds those levels for maintenance established under the plan for medical assistance but are insufficient to meet their costs of medical and remedial care and services not encompasse with the State plan for medical assistance plus their costs of medical and remedial care and services included in the State plan.

The groups enumerated in 2a (2), (3), (4) and (5) above, who are medically needy.

3. The following are all of the conditions of eligibility that must be met by individuals in all groups specified in item 2 above. They must:

a. Be 65 years of age or over; or

b. Be 18 years of age and under 65 years of age and permanently and totally disabled; or

c. Be under 21 years of age; or

d. Be blind; or

e. Be the relative as defined in the Federal Act living with a child who is deprived of parental support or care by reason of death, incapacity, continued absence, or unemployment of a parent.

f. Meet the financial eligibility requirements of the State plan for medical assistance.

g. Reside in Connecticut. There is no durational requirement for medical assistance under this plan.

h. Must receive reasonable consideration for assignment or transfer of property. If property has been disposed, ineligibility will continue only for that period of time from date of disposition over which the fair value of such property together with other income and resources would furnish support on a reasonable standard of health and decency.

B. Financial Eligibility (D-4200)

1. The following levels of income and resources for maintenance, in total dollar amount, will be used as a basis for establishing financial eligibility for medical assistance, and are in accordance with D-4220,A - Item 1.a, b, c, and d:

a. The gross income levels are as follows:

Size Family	Income
One person	$2300 per year
Two persons (a married couple or an adult and a dependent child under 21)	2900 per year
Three persons	3400 per year
Four persons	4400 per year
Five persons	5000 per year

Each additional dependent family member in the home - $600 per year

b. The maximum personal property resource levels are as follows:

Size Family	Resources
One person	$250.00
Two persons (a married couple or an adult and a dependent child under 21)	500.00

Each additional dependent family member in the home - $100.00

Title XIX recipients who are categorically related to the Adult Assistance Program - that is, those recipients in Eligibility groups NA, NB, or ND are allowed to have a burial reserve up to $600 in addition to the $250.

The NC Supervising Relative, the NC incapacitated parent, and the parent(s) of child(ren) in the NF group whose income and resources are taken into consideration in determining eligibility of the child(ren) are also allowed to have a burial reserve up to $600 each, in addition to the resource limits indicated in item b. above.

A burial reserve may be in the form of:

1. A prepaid funeral contract negotiated with a funeral director who is licensed by the State Insurance Department to enter into such contract

or

2. Money not to exceed $600 deposited in a savings account in trust for burial purposes. To accomplish this the individual selects a relative or friend who is named as "trustee". His name together with the individual's name is put on the passbook and bank account record. This is an arrangement whereby there is an understanding between the two individuals that upon the death of the recipient or the NF parent the trustee will see that the money is used for burial expenses.

If there is no one available or willing to act in this capacity, or if the individual prefers, he may deposit the money in a savings account with the stipulation that it be recorded on the passbook and bank account record that upon death, the money is to be paid to his estate for burial purposes

or

3. An insurance policy which must be made payable to the insured's estate.

The NA, NB and ND applicant or recipient may have an insurance policy of any face or claim value provided the cash surrender value does not exceed $600. If the cash surrender value exceeds $600, but the individual's other liquid assets are less than $250, he may retain the insurance policy providing the cash surrender value together with all other liquid assets does not total more than $850.00.

The NC supervising relative, the NC incapacitated parent, the parent(s) of child(ren) in the NF group may each have an insurance policy in any amount of claim/face value provided the cash surrender value does not exceed $600. Thus, these adult persons may retain the cash surrender value up to $600 each as a burial reserve in addition to the allowable liquid assets of $500 for two members plus $100 for each additional dependent family member in the assistance unit. If the cash surrender value exceeds $600, but the other liquid assets are below the level allowed, the adult may still retain this insurance provided:

a. In a case where there is one adult member, the cash surrender value together with all other liquid assets, does not exceed $1100 for a family of two, plus $100 for each additional dependent family member.

b. In a two parent case, the cash surrender value, together with all other liquid assets does not exceed $1800 for a family of three, plus $100 for each additional dependent family member.

Aside from the adult's burial reserve, in no case may the other liquid assets exceed $250 for one person, $500 for a family of two persons, plus $100 for each additional dependent family member.

The burial reserve may be set aside either prior to or subsequent to the date of application for Medical Assistance.

Excess income may be applied to medical costs incurred during the calendar year in which the application for Medical Assistance is made.

All of the remaining excess income will be applied to the costs of medical care included in the Plan.

Real property (used as a home), personal and household effects and an automobile essential for transportation will be excluded in the determination of the amount of resources owned by the applicant and/or the spouse.

If an applicant or recipient has resources in excess of the personal property limitation but has income below the appropriate level, he may, if he chooses, use the amount of the excess in the following manner and thus establish eligibility.

Cash or cash obtained from liquidating or converting a resource which is in excess of the resource limits may be added to the income if it is below the appropriate level. This cash must be used for maintenance costs as soon as the need to use it arises. At the time of the next redetermination the worker verifies that the cash was used. If it has not been used for maintenance, but is still being held by the recipient or individual, ineligibility exists until such time as that money has been used for maintenance and the case is either suspended or discontinued.

If adding the cash to the income would bring the income above the appropriate level, then the cash must be used by the recipient to pay for medical needs.

c. Monthly Income Protected for Maintenance

If the recipient resides in a licensed nursing home, chronic disease hospital or approved medical institution, $5.50 of the monthly gross income is exempted for his maintenance.

If the recipient resides in one of the above medical facilities but is not otherwise separated from the spouse, $[illegible] of the couple's combined monthly gross income is exempted for the support of the spouse outside of the medical facility.

2. There will be a flexible measurement of available income which will be applied in the following order of priority:

   a. First, for maintenance, so that any income in an amount at or below the established level will be protected for maintenance;

   b. Next, income in excess of that needed for maintenance will be applied to costs incurred for necessary medical or remedial care recognized under State law and not encompassed within the State plan for medical assistance;

   c. All of the remaining excess income will be applied to costs of medical assistance included in the State Plan.

3. All income and resources (after all State policies governing the disregard, or setting aside for future needs, of income and resources in the approved State plans under Titles I, IV, X and XIV, have been applied) will be sonsidered in establishing eligibility, and in the flexible application of income to medical cost not in the State Plan and payment toward the medical assistance costs.

4. Only such income and resources as are actually available will be considered; income and resources will be reasonably evaluated; and only such income and resources will be considered as will be "in hand" within a period of 3 months ahead, including the month in which the services were rendered for which payment will be made under the Plan.

5. Financial respnnsibility of any individual for any applicant or recipient of medical assistance will be limited to the responsibility of spuuse for spouse, and parents for children under age 21, or blind, or permanently and totally disabled.

NOTE: - The following items are applicable to the categorically needy in accordance with D-4220 B.

1. The financial eligibility conditions of the pertinent State Plan will apply.

2. Income will be applied first to maintenance costs.

3. Only income and resources which are actually available will be considered and income and resources will be reasonably evaluated.

4. The financial responsibility of any individual for any applicant or recipient of medical assistance will be limited to the responsibility of spouse for spouse and of parents for children under age 21, or blind, or permanently and totally disabled.

C. Blindness (D-4700)

1. The following is the State's definition of blindness in terms of ophthalmic measurement:

Blindness shall be defined to mean total loss of sight in both eyes, or central visual acuity of 20/200 (6/60 metric) or less in the better eye, after correction to the best acuity obtainable with ophthalmic lenses; or visual fields restricted to 20 degrees or less in the widest diameter, without regard to the amount of visual acuity.

2. Blindness is determined by a special eye examination. This examination can be made only by a licensed ophthalmologist (M.D.) or by a licensed optometrist selected by the applicant.

3. The examining physician or optometrist submits a report of his findings to the Ophthalmological Consultant who has been designated by the State to be responsible to make the final decision as to whether the findings meet the State's definition of blindness.

D. Permanent and Total Disability (D-4800)

1. The following is the State's definition of permanent and total disability, showing that: (a) "permanently" is related to the duration of the impairment or combination of impairments; and (b) "totally" is related to the degree of disability:

"A permanently and totally disabled person is defined to mean a person who, by reason of a major defect or infirmity of mind or body, whether congenital or acquired by accident, injury or disease, is or reasonably appears to be permanently incapacitated to a degree that prevents him and will continue to prevent him from working in a gainful occupation or from performing his usual activities and responsibilities in the care of his home."

The term "permanently" refers to a demonstrable impairment of mind or body which is verifiable by objective medical findings. The impairment must be of major importance and must be a condition which is not likely to improve or which will continue throughout the lifetime of the individual. A condition which is likely to improve substantially may still be considered permanent if the healing process is characterized by significant tissue alterations, as in tuberculosis. "Permanently" is used not in the sense of "everlasting" or "unchangeable" but in the sense of continuing indefinitely.

The term "totally" refers to the ability of the individual to perform the activities required by a gainful occupation or by homemaking.

2. A determination of Permanent and Total Disability is based on the review and evaluation of medical and social data by a State Medical Review Team composed of a physician and a medical social worker.

IV. Medical Assistance (D-5000)

A. Amount, Duration, and Scope of Assistance (D-5100)

1. The following items of medical and remedial care and services, and the amount and/or duration of each, will be provided:

   a. To the categorically needy defined in D-4000;

   b. To the medically needy defined in D-4000;

      (1) Inpatient hospital services (other than services in an institution for tuberculosis or mental diseases) paid on a reasonable cost basis.

      Medical assistance will be provided in General Hospitals for persons with diagnoses of Tuberculosis or Psychosis if they are otherwise eligible. The plan does not otherwise include the provision of medical assistance to individuals who are patients in public institutions.

      (2) Outpatient hospital services;

      (3) Other laboratory and x-ray services;

      (4) Skilled nursing home services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older.

      (5) Physicians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home, or elsewhere;

      (6) Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

      (7) Home health care services;

      (8) Private duty nursing services;

      (9) Clinic services;

      (10) Dental services;

      (11) Physical therapy and related services;

      (12) Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) Other diagnostic, screening, preventive, and rehabilitation services:

(14) The first three pints of blood, (whole blood and packed red blood cells) when it is not available to the patient from other sources: and

(15) Any other medical care recognized under State law including transportation by ambulance, chaircar and taxi, oxygen, podiatry, and skilled nursing home services provided to patients under 21 years of age.

(16) Inpatient hospital services and skilled nursing home services for individuals 65 years of age or over, in an institution for mental diseases.

(17) Inpatient hospital service for individuals under age 21 in an institution for mental diseases.

(18) Family planning services, drugs, supplies and devices when such services are under the supervision of a physician.

(19) Services of Christian Science Practitioners listed in the Christian Science Journal, published by the First Church of Christ Scientist, Boston, Massachusetts.

(20) Care and services provided in Christian Science Sanatoria operated by, or listed and certified by, the First Church of Christ Scientist, Boston, Massachusetts.

2. The medical and remedial care and services made available to a group (i.e., either the categorically needy or the medically needy) will be equal in amount, duration and scope for all individuals, except that services to persons in institutions for mental diseases are limited to persons 65 years of age or over and early and periodic screening and diagnosis for individuals, and treatment of conditions found, are limited to individuals under 21 years of age.

3. The following is a description of the methods that will be used to assure that the medical and remedial care and services are of high quality, and a description of the standards established by the State to assure high quality care:

The State agency will look to its medical care advisory committee for help in establishing and maintaining high quality medical care and the methods and standards for assuring high quality care. Various steps have already been taken to assure high quality care in this agency and these will be expanded. These steps include the provision for a comprehensive program of medical care as needed without limits on scope and duration and payment of "customary fees" to practitioners (after July, 1967). From the initiation of the program, the Department will provide a wide scope of medical and remedial care and services to all eligible individuals, categorically related or medically needy.

4. The State agency will provide for broadening the scope of the medical and remedial care and services made available under the plan, to the end that, by July 1, 1975, comprehensive medical and remedial care and services will be furnished to all eligible individuals.

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2. The agency will provide for showing that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program for all age groups, through appropriate mental health and public welfare resources, including alternatives to care in public institutions for mental diseases; and will provide for arrangements for joint planning with the State Department of Mental Health for this purpose and for annual reports showing the progress made.

3. The State agency will make written agreements with the State Department of Mental Health that set forth the respective responsibilities of the State Agency and the State Department of Mental Health with respect to the recipient-patients for whom assistance payments are made, specifically including:

   a. Provisions to assure a plan of treatment and care that serves the best interests of each individual patient, i.e., maintains the patient at, or restores him to, the greatest possible degree of health and independent functioning, including:

      (1) Initial and periodic review of his medical, psychiatric and social needs;

      (2) Appropriate medical treatment by the institution;

      (3) Periodic joint determination of his need for continued treatment in the institution every 3 months and for alternate care arrangements; and

      (4) Provision of social services.

   b. Provision for access by appropriate representatives of the State agency to the medical facility, the patient, and the patient's records as necessary for carrying out the State agency's responsibilities.

   c. Provision for arrangements that assure necessary readmittance to the institution without undue delay.

   d. With respect to agreements with the State Mental Health Department provision for the development of alternate methods of care and for joint planning for aged recipients who otherwise would need care in a mental institution and for the release of patients no longer requiring institutional care to appropriate alternate plans of care.

   e. Provision for necessary recording, reporting, and other procedures.

4. The State agency will provide for appropriate utilization of the currently available alternate mathods of care, and the development or extension of alternate care arrangements, to assure ready availability of appropriate alternate care when needed.

5. The State agency will provide for making available appropriate social services, as specified in D-5230 E, item 3, to all aged recipients in such alternate care arrangements.

6. The State agency will maintain caseload standards not exceeding sixty per worker, supervisory standards not exceeding five workers per supervisor and a standard for visits as often as necessary but at least every month in respect to all such aged recipients in alternate care arrangements, defining, where appropriate, the types of situations that require less frequent visits.

7. The State agency will provide for the progressive development of resources to meet fully the medical assistance and financial needs of aged recipients in alternate care arrangements.

8. The State agency will establish methods of determining the reasonable cost of institutional care for such patients, with the cost of care for each institution computed on the basis of costs related to different types of treatment and care.

9. The State agency will establish methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out.

C. Payment for Medical and Remedial Care and Services (D-5300)

1. Fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population.

2. Participation in the program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structures.

D. Limitation on Charges to Recipients (Prohibiting Deductibles, Cost Sharing, and Similar Charges) and Payment of Title XVIII-A Deductibles (D-5400)

1. No deductions, cost sharing, or similar charge will be imposed on either the individual receiving a money payment or the medically needy individual with respect to inpatient hospital services furnished him under this plan and no deduction, cost sharing, or similar charge will be imposed under this plan with respect to any other medical assistance furnished thereunder. No enrollment fee, premium, or similar charge will be imposed under the plan.

2. In the case of eligible individuals 65 years of age or older who incur deductible or coinsurance liabilities through use of benefits provided by Part A of Title XVIII, the State will meet the full cost of any such deductible or coinsurance for all eligible persons receiving money payments and for all eligible medically needy persons in accordance with scope, amount, and duration of medical assistance under the plan.

E. Use of Fiscal Agent Contract (D-5500)

The State plan provides part or all of its medical assistance through contracts with fiscal agents and as a minimum, the contract will:

1. Include the type of functions to be performed by the contractor, the amount to be paid the contractor by the State agency for performing the functions, the basis for the amount, and provision for renegotiation of the amount.

2. Provide that the contractor will make payments for medical care in accordance with the rules and regulations established by the State agency.

3. Provide for duly authorized representatives of the Federal agency and the State to be allowed free access to the contractor's expenditure records relating to the administration of the medical care program for audit and other purposes.

4. Include the period of time the contract will be in effect, together with provisions for termination.

F. Assistance to Residents Out of the State (D-5600)

1. Medical assistance will be furnished to eligible individuals who are residents of the State, but are absent therefrom, to the same extent that such assistance is furnished under the plan to meet the cost of medical care and services rendered to eligible individuals in the State at least to the extent that medical care and services are needed in any other State under any of the following circumstances:

   a. Where an emergency arises from accident or illness;

   b. Where the health of the individual would be endangered if the care and services are postponed until he returns to the State in which he resides or

   c. Where his health would be endangered if he undertook travel to return to such State.

2. Medical care and services will be provided outside the State to eligible residents of the State, at least in the following situations:

   a. When it is general practice for residents of a particular locality to use medical resources outside the State or

   b. When the medical care and services available, or the availability of needed supplementary resources, make it desirable for the individual to use medical facilities outside the State for short or long periods in accordance with plans developed jointly by the agency and the individual, consistent with medical advice.

3. The agency will facilitate the meeting of medical needs within the State for residents from other States.

G. Liens and Recoveries (D-5700)

1. No lien or encumbrance of any kind will be required from or be imposed against the property of any individual prior to his death because of medical assistance paid or to be paid on his behalf or at any time if he was under 65 years of age when he received such assistance (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual).

2. There will be no adjustment or recovery of medical assistance correctly paid, except from the estate of an individual who was 65 years of age or older when he received such assistance, and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or is blind or permanently and totally disabled.

V. Administration (D-6000)

A. Methods of Administration (D-6100)

The State agency will provide for such methods of administration as are found necessary for the proper and efficient operation of the plan, as set forth in Handbook Supplement D.

B. Social Services (D-6200)

The State agency will provide for the development of necessary social services to the end that, by July 1, 1975, families and individuals included in the plan will have (a) needed assistance in having access to and making maximum and appropriate use of medical care and services, and (b) rehabilitation and other services to assist them in attaining or retaining capability for independence or self-care to the fullest possible extent.

C. Relationship with Health and Vocational Rehabilitation Agencies (D-6300)

1. The State agency will make written agreements with the State Health and State Vocational Rehabilitation agencies which clearly establish the working relationship between the agencies involved.

2. The following is a description of the cooperative agreements with the State Health and State Vocational Rehabilitation agencies by means of which the services administered or supervised by those agencies will be utilized to the maximum degree and will be coordinated with the medical care and services provided by the State agency under the plan:

   The agreement between the State agency and the rehabilitation agencies will include the following: mutual objectives and respective responsibilities of the agenices involved, the services each offers, and in what circumstances, and the way they will work together at the State level, and as appropriate, the kinds of service they may expect from the local agencies. The agreement will be directed toward using the resources of both agencies to the best advantage.

   The agreements will provide for the following services: reciprocal referral services; exchange of reports of services; coordination of plans for the individual client; joint evaluation of policies that affect the cooperative work of both agencies; joint planning for any changes that may be needed to achieve the joint goals, continuous liaison by means of social service staff of both agencies at the district level. At the State level the appropriate directors will meet as required to coordinate the plans and activities of both agencies in respect to the cooperative agreement.

In addition to the above components, the agreement with the State Health Department will assure that the services supervised and administered by both agencies will be coordinated with the medical care and services provided by the Title XIX plan. With respect to the Crippled Children's Program and Maternal and Child Health Services, the agreement will provide that the Title XIX agency will refer all children with the kinds of medical conditions for which the Crippled Children's Program can provide services and for the Crippled Children's agency to accept such children, within the limitations of available resources.

The use of Title XIX funds will assure the strengthening of the Crippled Children's Program by permitting a much broader scope of services.

D. Standard-Setting Authority for Institution (D-6400)

1. The following are the types or kinds of institutions in which medical care and services may be provided under the plan by such institutions: a) licensed general hospitals, b) licensed chronic disease hospitals; c) licensed chronic and convalescent hospitals.

2. The types of institutions specified herein are subject to the following standard-setting authority:

   a. The standard-setting authority for licensure of the above institutions is the responsibility of the Connecticut State Department of Health.

   b. The following citations to State legislation show (a) that the authority is a State authority, as distinguished from a local authority; and (b) that the authority is empowered and has the duty to establish and maintain standards for the types of institutions where medical care and services may be provided under the State plan:

      The Public Health Code of the State of Connecticut, established in accordance with Section 19-13 of the General Statutes, September, 1965 Chapter 4, Section 19-13 - D 1 through Section 19-13 - D 18 (attachment IV).

3. Attached, and made a part hereof, is a copy of the standards to be utilized by such State authority for these medical institutions, which include standards related to the factors specified in D-6420, item 3.

4. The State agency will provide for cooperative arrangements with the standard-setting authority to upgrade and extend needed institutional care.

5. The standard-setting authority for licensure of the State Mental Hospitals is the State Department of Mental Health.

   a. The following citations show that the standard-setting authority is a State authority and that the authority is empowered and has the duty to establish and maintain standards for the State Institutions:

      The 1965 Supplement to the General Statutes, Chapter 306 "Mentally Ill Persons" Sec. 17-176 to Sec. 17-229a.

   b. Attached is a copy of Rules and Regulations of the Department of Mental Health which cover all factors listed in Handbook D-6420 page 2 item 3.

E. Fair Hearings (D-6500)

1. The State agency will be responsible for fulfillment of fair hearings provisions; the hearing authority will be the Hearing Officer.

2. An opportunity for a fair hearing before the State agency will be granted to any individual requesting a hearing because his claim for medical assistance is denied, is not acted upon with reasonable promptness, or because he is aggrieved by any other agency action affecting his receipt of medical assistance or by agency policy as it affects his situation.

3. Decisions by the hearing authority rendered in the name of the State agency will be binding on the State agency.

4. The hearings will be conducted by an impartial official of the State agency.

5. Hearings procedures will be issued and publicized, by the State agency, for the guidance of all concerned.

6. Every individual will be informed in writing of his right to and the method for obtaining a fair hearing; that he may be represented by others, including legal counsel.

7. The hearing will be conducted at a time, date, and place convenient to the claimant, and adequate preliminary written notice will be given.

8. When the hearing involves medical issues, a medical assessment other than that of the person or persons involved in making the original decision will be obtained and made a part of the record if the hearing officer or appellant considers it necessary.

9. Prompt, definitive, and final administrative action will be taken within 90 days between the request for a fair hearing and the rendering of the decision in the name of the State agency, and the claimant will be notified of the decision and, of his right to judicial review.

10. The claimant will have the opportunity (a) to examine all documents and records used at the hearing; (b) at his option, to present his case himself or with the aid of others, including legal counsel; (c) to bring witnesses; (d) to establish all pertinent facts and circumstances; (e) to advance any arguments without undue interference; and (f) to question or refute any testimony or evidence.

11. The verbatim transcript of testimony and exhibits, or an official report by the hearing officer, containing the substance of what transpired at the hearing, together with all papers and requests filed in the proceeding, and the Hearing Officer's recommendation, will constitute the exclusive record for decision and will be available to the claimant at any reasonable time.

F. Safeguarding Information (D-6600)

1. Pursuant to State statute which imposes adequate legal sanctions:

   a. The use of disclosure of information concerning applicants and recipients will be limited to purposes directly connected with the administration of the medical assistance program;

   b. The State agency has authority to implement and enforce the provisions for safeguarding information about applicants and recipients; and

   c. Publication of lists or names of applicants and recipients will be prohibited.

2. The State agency will provide clearly defined criteria which govern (a) the types of information that are safeguarded, and (b) the conditions under which such information may be released and used.

3. The State agency will publish provisions governing the confidential nature of information about applicants and recipients, including the legal sanctions imposed for improper disclosure and use.

4. All material sent or distributed to applicants, recipients or medical vendors will be directly related to the administration of the medical assistance program and will not have political implications.

G. Reports and Maintenance of Records (D-6700)

1. The State agency will maintain administrative and case records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, and the provision of medical assistance and social services; and statistical, fiscal and other records necessary for reporting and accountability required by the Secretary.

2. The State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports.

H. Fraud (D-6800)

1. The State agency will establish and maintain methods for identifying situations in which a question of fraud in the program may exist and referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced.

2. The State agency will provide for methods of investigation of situations in which there is a question of fraud that do not infringe on the legal rights of persons involved.

VI. Personnel Administration (D-7000)

A. Personnel Administration on a Merit Basis (D-7100)

1. The State agency will establish and maintain methods of personnel administration as are set forth in the "Standards for a Merit System of Personnel Administration," issued by the Department of Health, Education, and Welfare, the Department of Labor, and the Department of Defense.

2. The following materials have been accepted in the approved plan for Titles I, IV, X, and XIV and are current.

   a. Civil service laws and merit system laws, affecting State operations of merit systems.

   b. Civil Service Commission rules and regulations and agency personnel regulations governing policy to provide assurance of conformity to the merit system standards.

   c. Classification and compensation plans applicable to State administration.

B. Staffing for Administration of Medical Assistance Programs (D-7200)

1. The State agency will establish a medical assistance unit in the State agency office which will include as a minimum:

   a. A full-time director (1) graduated from an accredited institution with a graduate degree in medical care administration, public health, or hospital administration, or social work, or who is a physician, and has appropriate experience in an administrative capacity in a recognized medical care or health service program; or (2) who has a bachelor's degree from an accredited college, and substantial experience in an administrative capacity in a recognized medical care or health service program; or (3) who has substantial appropriate experience which demonstrates competence comparable to that of an individual meeting (1) or (2);

   b. If the director is not a physician, at least half-time services of a physician graduated from an accredited school, who is licensed to practice medicine, and, if a specialist, is Board eligible or certified in his speciality;

   c. A full-time social worker graduated from an accredited school of social work with a master's degree, who has administrative, supervisory, or consultative experience in medical care and health programs;

d. Part-time services of a dentist graduated from an accredited dental school and licensed to practice dentistry;

e. Part-time services of a pharmacist graduated from an accredited school of pharmacy and licensed to practice pharmacy;

f. Additional technical and professional staff, determined necessary by the State, who meet the educational requirements established by the State through license or registration, or based on standards set by the respective technical or professional associations.

2. The State agency will establish a formula which will provide for obtaining sufficient qualified staff, on a progressive basis, by July 1, 1975, in the State medical assistance unit and local units.

3. Provide for the establishment of an advisory committee to the State agency director on health and medical care services, appointed by the director of the State agency or a higher State authority.

C. Staffing for Administration of Assistance for Aged Individuals in Institutions for Mental Disease (D-7300)

1. The State agency will provide the following staff in the State agency office:

a. A full-time social worker graduated from an accredited school of social work with a master's degree, who has administrative, supervisory, or consultative experience related to mental health problems and services; and

b. The part-time services of a psychiatrist who is certified to practice psychiatry or is Board eligible, with professional experience which shall include consultation on or administration of mental health services.

2. The State agency will provide sufficient qualified social work and supporting staff, based on a formula, to serve as liaison with individual institutions for mental diseases and provide consultation to District Office staff.

D. Staff Development (D-7500)

1. The State agency will provide for a staff development program which includes:

a. An organized program of in-service training available to all staff in State and local agencies administering the medical assistance program:

b. Technical and professional education for medical, technical, and other professional staff necessary for the administration of the medical assistance program, including:

(1) Paid educational leave for employees, under a progressive plan which includes provision for

(a) continued entitlement to employee rights and benefits, and retention of position rights, and

(b) appropraite reduction of duties for employees on less-than-full-time educational leave.

(2) Policies governing payments for the various types of leave and the conditions relating to work with the agency.

(3) Provision that leave for attendance at educational institutions will be granted only if the institution is accredited by the appropriate accrediting organization.

2. The State agency will provide for progressive extension of staff development activities, including progressive increase in the number of individuals on educational leave, to the end that, by July 1, 1975, there will be qualified staff in all positions under the medical assistance program.

3. The State agency will establish a formula for increasing the number of staff development personnel with appropriate educational qualifications and experience, so that, by July 1, 1970, there will be sufficient staff with such qualifications, having responsibility for planning, directing and administering the staff development program described in item 1, above.

VII. Fiscal Administration (D-8000)

A. State Financial Participation (D-8100)

State funds are used to pay all of the non-Federal share of expenditures under the plan.

State and Federal funds will be administered on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

B. Fiscal Policies and Accountability (D-8300)

The State agency, in discharging its fiscal accountability, will maintain an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements.

C. Cost Allocation (D-8400)

The State agency will establish and maintain a cost allocation plan that:

1. Is effective from the effective date of the plan approved under Title XIX;

2. Enables the State agency to claim Federal financial participation in the cost of administration, services, and training under Title XIX only for such expenditures under the plan as are properly chargeable to the medical assistance program under established policy;

3. Identifies, within the total amount of expenditures under the plan subject to Federal financial participation under Title XIX, the amount that is subject to 75 percent Federal financial participation under established policy;

4. Precludes including in the claim for Federal financial participation for costs of administration, services, and training under any of the other public assistance titles, any such costs as are properly chargeable to Title XIX under established policy.

VIII. Related Responsibilities (D-9000)

Nondiscrimination in Federally Assisted Programs (D-9300)

Attached, and made a part hereof, are:

1. A statement certifying the applicability of both the Statement of Compliance (Form CB-FS 5022) and the State agency's implementing methods of administration to the medical assistance program, submitted on March 2, 1965, and

2. A statement including such additional methods in the specified areas of administration as may be necessary to assure that the medical assistance program will be operated in compliance with all applicable requirements.

Note: See attachment to Civil Rights Materials

* * * * *

Revised date: April 18, 1967

(Bernard Shapiro)
Signature

Commissioner
Title of Head of Single State Agency

State Welfare Department
Name of Single State Agency

State of Connecticut

Attachments:

1. Governor's Letter of Designation
2. Statement of Attorney General (I A 2)
3. Letter of July 1, 1966 to Doctors, Dentists and Pharmacists
4. Contract with Fiscal Agent
5. Public Health Code
6. Organization Chart
7. Civil Rights Materials VIII
8. Rules and Regulations of Department of Mental Health regarding Licensure of Hospitals for Mentally Ill Persons
9. Medical Services Card