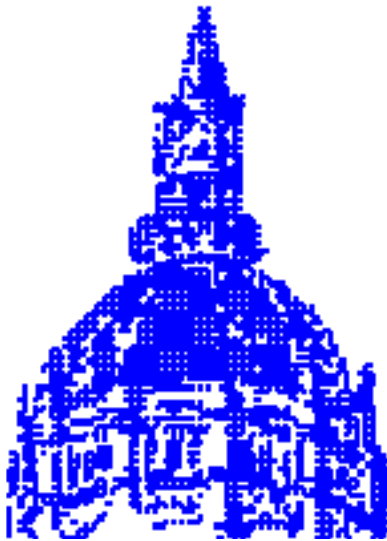


Office of Legislative Research
Connecticut General Assembly



SENIORS



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NOTICE TO READERS

This report provides brief highlights of new laws (public acts) affecting seniors (people age 60 or older) enacted during the 2006 session. At the end of each summary we indicate the bill number or, if one is already available, public act (PA) number. At this point, not all acts have yet been signed by the governor. A number of the new laws were enacted as part of several large acts that are commonly known as the “DSS/DPH Implementer” (SB 703), the “OPM Implementer” (HB 5846), and the “budget act” (HB 5845).

Not all provisions of the acts are included here. Complete summaries of all 2006 public acts will be available in the fall when OLR’s *Public Act Summary* book is published; some are already on OLR’s webpage:

<http://www.cga.ct.gov/olr/OLRPASums.asp>

Readers are encouraged to obtain the full text of acts that interest them from the Connecticut State Library, the House Clerk’s Office, or the General Assembly’s website: <http://www.cga.ct.gov/>

Table of Contents

PRESCRIPTION DRUGS.....	5
DSS Payment for Denied Medicare Part D Plan Nonformulary Drugs and Contract with Entity to Undertake Appeals.....	5
Medicare Part D Advisory Council.....	5
ED Drugs under ConnPACE	6
LONG-TERM CARE (LTC).....	6
LTC Comprehensive Needs Assessment.....	6
Expansion of Under-65 Medicaid Personal Care Assistance (PCA) Waiver For The Disabled	6
Expansion of State-Funded Elderly PCA Pilot.....	7
Medicaid for Employed Disabled Program Age Change	7
Home and Community-Based Services for Younger People with Disabilities.....	7
Money Follows the Person Pilot	8
Home Health Care Prior Authorization	8
Home- and Community-Based Services for People with Psychiatric Disabilities.....	8
Homemaker-Companion Agency Registration.....	9
Alzheimer’s Special Care Units.....	9
OTHER HEALTH CARE.....	10
Hospital-Acquired Infections	10
DPH Breast and Cervical Cancer Programs and Comprehensive Cancer Plan	10
Kidney Disease Testing	11
Direct Access to Physical Therapists	11
END OF LIFE DECISIONS – HEALTH CARE REPRESENTATIVES	12
INSURANCE	12
Imaging Services Copayments.....	12
Health Insurance Coverage for Ultrasound Breast Cancer Screening	12
TAXES	13
Seniors Property Tax Freeze Authorized	13
Property Tax Credit Increase.....	13
Tax Deductions for College Savings.....	13
TRANSPORTATION	14
Increased Grants for Community-Based Regional Transportation Systems for the Elderly	14

FUNERALS AND BURIALS	14
DSS Indigent Funeral and Burial Allowance.....	14
Prepaid and Funeral Service Contracts	15
Closing a Funeral Home.....	15
GRANDPARENTS.....	15
Kinship Navigator Program	15
Grandparent Notification When a Child is Removed from the Home	16
DEPARTMENT ON AGING POSTPONEMENT	16
MISCELLANEOUS.....	16
Social Security Offset.....	16
Accessibility Advisory Board	16
Elderly Nutrition.....	17

PRESCRIPTION DRUGS

DSS Payment for Denied Medicare Part D Plan Nonformulary Drugs and Contract with Entity to Undertake Appeals

The Medicare Part D program, which began January 1, 2006, helps Medicare beneficiaries pay for certain prescription drugs. New state legislation requires the Department of Social Services (DSS) to pay certain claims for “nonformulary” prescription drugs for Medicare Part D beneficiaries if (1) they are also Medicaid or Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE) recipients and (2) their Part D plan denies coverage because the drug is not on the plan’s formulary. DSS’s initial payment must be for a 30-day supply, subject to any applicable copayment. Pending an appeals process outcome, DSS must continue to pay claims for the denied drug until the earlier of when the plan approves the drug or the remainder of the calendar year. If DSS decides that it is not cost-effective to pursue further appeals, the act requires it to pay for the denied drug for the rest of the calendar year if the beneficiary remains enrolled in the same plan. Payments are to be made out of the Medicare Part D Supplemental Needs Fund

established by November 2005 legislation. (The budget act, HB 5845, appropriates \$5 million to the fund.)

The act requires ConnPACE and Medicaid beneficiaries to appoint the DSS commissioner as their representative for appealing Part D denials and for certain other purposes. It requires the commissioner to contract with an entity specializing in Medicare appeals and reconsiderations so it can exhaust remedies for pursuing payment from Part D plans for denied nonformulary drugs. Reimbursement the entity secures from a Part D plan must be returned to DSS.

(SB 703, effective July 1, 2006)

Medicare Part D Advisory Council

The legislature created a 22-member council to advise the DSS commissioner on Medicare Part D administration and implementation. The council is to advise on Part D’s effect on the ConnPACE and Medicaid programs, full-benefit Medicare-Medicaid dually eligible beneficiaries, pharmacists, and physicians. It must also advise on administration of the state’s Medicare Part D Supplemental Needs Fund and make legislative recommendations and annual reports to the General Assembly.

(HB 5639, effective on passage)

ED Drugs under ConnPACE

This act prohibits the ConnPACE program from paying for drugs for erectile dysfunction (ED) treatment unless prescribed to treat a condition other than sexual or erectile dysfunction, for which the Food and Drug Administration has approved it.

(**SB 703**, effective July 1, 2006)

LONG-TERM CARE (LTC)

LTC Comprehensive Needs Assessment

The legislature transferred the duty to conduct a comprehensive needs assessment of unmet long-term care (LTC) needs and project future demand for such services from the Office of Policy and Management to the General Assembly. It required the General Assembly to contract for the assessment after consulting with the Commission on Aging, the Long-Term Care Advisory Council, and the Long-Term Care Planning Committee. The act specifies numerous items that the assessment must include:

1. the number of people presently at risk for having unmet LTC needs and potentially at risk over the next 30 years;
2. projected costs of, and public and private resources available to meet, the LTC needs, including the adequacy of current resources and

- projected resources needed to address these needs over the next 30 years;
3. services now available to people with LTC needs;
4. existing and potential future models of public and private LTC service delivery systems;
5. state government's programmatic structure to meet people's LTC needs;
6. strategies that may help families provide for their own LTC needs at reasonable cost;
7. service needs of the state's elderly population with LTC needs with emphasis on healthcare, housing, transportation, nutrition, employment, prevention, and recreation services; and
8. recommendations on qualitative and quantitative changes needed in programs or service delivery systems, including new programs or service delivery systems.

(**SB 703**, effective July 1, 2006)

Expansion of Under-65 Medicaid Personal Care Assistance (PCA) Waiver For The Disabled

This act removes the upper age limit in the state's Medicaid PCA waiver program for disabled people aged 18 to 64. This change allows (1) participants to continue on the program even after turning age 65 and (2) new

applicants age 65 or over to enter the program if they qualify for the Medicaid waiver. Previously, people who “aged out” of this program could continue their PCA services only by applying for the purely state-funded 150-person pilot elderly PCA program for people age 65 and older (see below).

PCA services are a “consumer-directed” alternative to nursing homes or home care through an agency. In such a program, the client chooses his own assistant to help him with personal care and activities of daily living. The client employs, trains, supervises, and may fire the attendant, but a financial intermediary takes care of the paperwork.

Removing the age cap also applies to working disabled people currently receiving PCA services because they are participating in the Medicaid for Employed Disabled (MED) “buy in” program (see below).

(**SB 703**, effective July 1, 2006)

Expansion of State-Funded Elderly PCA Pilot

This act increases the maximum number of participants from 150 to 250 in the state-funded “consumer-directed” PCA pilot program that, since 2000, has allowed seniors to hire their own attendant instead of going through a home health care agency. To be eligible, people must be age 65 or over and meet the same

functional and financial qualifications as are required under the Connecticut Home Care Program for Elders, which provides home health care and homemaker-companion services through home health care agencies.

(**SB 703**, effective July 1, 2006)

Medicaid for Employed Disabled Program Age Change

This act lets DSS allow older, working individuals to participate in the MED “buy-in” program. Previously, the law limited eligibility to adults under age 65. The MED program is designed to provide affordable health care coverage to working people (including those working part-time) with severe disabilities. (Medicare pays for most of these individuals’ health care; Medicaid generally covers everything else.)

(**SB 703**, effective July 1, 2006)

Home and Community-Based Services for Younger People with Disabilities

The budget act contains \$400,000 to begin providing home health care equivalent to the Connecticut Home Care Program for Elders (CHCPE, which serves only people age 65 or older) for younger people with multiple sclerosis or AIDS who need the same services. Previously, these people were eligible for the age 18 to 64 PCA program but not the CHCPE,

which provides home health care and other services through home care agencies.

(**HB 5845**, effective July 1, 2006)

Money Follows the Person Pilot

Under this act, the DSS commissioner may submit an application to the federal government to establish a “Money Follows the Person” demonstration project, as authorized in the federal Deficit Reduction Act of 2005. If the state is selected to participate and DSS elects to do so, the act restricts the project to 100 participants and requires it to include PCA services. It allows the commissioner to apply for a Medicaid waiver or to modify an existing waiver, if needed to implement the demonstration.

The “money follows the person” concept allows funding that would otherwise be spent on institutional long-term care to be spent on services people need to live in the community. The new federal demonstration project allows states to compete for federal grants for projects aimed at (1) increasing home and community-based, rather than institutional, LTC services; (2) eliminating barriers that prevent or restrict the flexible use of Medicaid funds to enable people to receive needed services in the setting they choose; (3) providing service continuity for people moving from an institution to the community; and (4) ensuring and improving service quality.

(**SB 703**, effective July 1, 2006)

Home Health Care Prior Authorization

By law, the DSS commissioner must establish prior authorization (PA) procedures for home health care in the Medicaid program. Prior law specified that (1) PA is required for more than two skilled nursing visits per week and (2) providers cannot be required to submit PA requests more than once a month unless the PA was revised during that month.

This act adds PA for home health aide visits that exceed 14 hours per week. (DSS policy allowed up to 20 hours of home health aide services per week without PA.) And it allows providers to submit monthly PA requests if they are for the same client.

(**SB 703**, effective July 1, 2006)

Home- and Community-Based Services for People with Psychiatric Disabilities

This act allows the DSS commissioner to seek to amend the state Medicaid plan or obtain a Medicaid waiver, whichever approach is most expeditious, to offer Medicaid home- and community-based services to adults with severe and persistent psychiatric disabilities, regardless of age, who are diverted or discharged from nursing homes. The services can

include housing assistance if needed. She must do this in consultation with the Department of Mental Health and Addiction Services (DMHAS) commissioner and the Community Mental Health Strategy Board. She must annually report to the Public Health Committee on the status of the waiver or plan amendment and the program's implementation, starting by January 1, 2007.

The act requires spending up to \$1,725,000 of the DMHAS FY 07 appropriation for the Community Mental Health Strategy Board to establish this program.

(SB 703, effective on passage with the funding provision effective July 1, 2006)

Homemaker-Companion Agency Registration

This act requires homemaker-companion agencies to register annually with the Department of Consumer Protection (DCP). Under the act, these agencies must require new employees hired on or after October 1, 2006 to undergo comprehensive background checks and answer questions in writing about their criminal convictions or certain disciplinary actions against them. They must provide clients with written individualized contracts or service plans that identify the anticipated services' scope, type, frequency, and duration. Agencies that provide such services without registering

or that make certain misrepresentations face penalties. The DCP commissioner must adopt implementing regulations and report on the implementation to the Aging Committee and the governor by January 1, 2008.

(HB 5846, effective October 1, 2006)

Alzheimer's Special Care Units

This act requires Alzheimer's special care units or programs to disclose in writing to people who will live in them or their legal representative or other responsible party information about the unit's philosophy, costs, admission, and discharge procedures; care planning and assessment; staffing; physical environment; residents' activities; and family involvement. Disclosure must begin by January 1, 2007 and be signed by the patient or responsible party. The disclosure must explain what additional care and treatment or specialized program the Alzheimer's unit will provide that is distinct from the care and treatment required by the applicable licensing rules and regulations.

The act requires each special care unit or program to annually provide Alzheimer's- and dementia-specific training to all licensed and registered staff who provide direct patient care in these units or programs. This must include (1) at least eight hours of dementia-specific training, completed within six

months after beginning employment, followed by three hours of such training annually and (2) at least two hours a year of training in pain recognition and administration of pain management techniques.

Under the act, an “Alzheimer’s special care unit or program” is any nursing, assisted living, or adult congregate living facility; residential care home; adult day care center; hospice; or adult foster home that locks, secures, segregates, or provides a special program or unit for residents with a diagnosis of probable Alzheimer’s disease, dementia, or similar disorder. The unit or program must prevent or limit a resident’s access outside the designated or separated area and advertise or market itself as providing specialized Alzheimer’s disease or dementia care or services.

(**sSB 317**, effective October 1, 2006 for the disclosure provisions; upon passage for the training requirements)

OTHER HEALTH CARE

Hospital-Acquired Infections

This act creates an 11-member Committee on Healthcare Associated Infections and directs it to develop, operate, and monitor a mandatory reporting system for patient infections that (1) occur in a healthcare setting; (2) were not found when the patient was admitted, unless related to a

previous admission to the same setting; and (3) if the setting is a hospital, meet specified National Centers for Disease Control criteria. It requires the Department of Public Health to implement the committee’s recommendations.

(**sSB 160**, effective on passage)

DPH Breast and Cervical Cancer Programs and Comprehensive Cancer Plan

Breast and Cervical Cancer Programs. Under current law, DPH can apply for and receive money from public, private, and federal sources for a breast and cervical cancer early detection and treatment referral program. The act also allows DPH to use this money for a comprehensive cancer program. Previously, any money the state received from a court settlement for use for women’s health had to be deposited in a DPH account for breast and cervical cancer treatment services. The act requires any such money to be deposited in a DPH account for comprehensive cancer initiatives.

The act expands the breast cancer program’s public education and outreach initiative to include publicizing the benefits of early detection and the recommended frequency of screening services, including clinical breast examinations and mammography.

Under prior law, DPH had to provide unserved and underserved populations with

annual mammograms, pap tests, and follow-up tests at varying frequencies depending on their age and medical history. This act instead substitutes the provision of clinical breast examinations, screening mammograms, and pap tests as recommended in the most current breast and cervical cancer screening guidelines of the U.S. Preventive Services Task Force, for the woman's age and medical history. It retains the 60-day pap test follow-up for sexual assault victims and the every six-month test for HIV positive women.

DPH Comprehensive Cancer Plan. The act requires DPH, within available appropriations, to establish a comprehensive cancer plan. The plan must provide for (1) a statewide smoking cessation plan that targets Medicaid recipients, (2) development and implementation of (a) a program that encourages people to get colorectal screenings and (b) a statewide clinical trials network, (3) identification of, and provision of services to, cancer survivors, and (4) identification and provision of services to organizations offering hospice or palliative care education. The budget act appropriates \$5.5 million to support the costs of implementing the plan.

(**sSB 317**, effective July 1, 2006 for the use of money to fund a comprehensive cancer program, upon passage for the changes to the breast and cervical cancer program, and

October 1, 2006 to establish the comprehensive cancer plan)

Kidney Disease Testing

The act imposes certain requirements, beginning September 1, 2006, on licensed physicians, hospitals, and clinical laboratories concerning testing of patients age 18 and older for kidney disease. It requires physicians to order a serum creatinine test as part of each patient's annual physical examination if the patient has not had such a test within the preceding 12 months. And it requires that for each serum creatinine test performed on a hospital inpatient, the ordering provider must request at least once during the patient's stay that the laboratory report an estimated glomerular filtration rate (eGFR) if the patient has not had the test in the year preceding the hospitalization. eGFR measures how effectively the kidneys are removing waste and excess fluid from the blood. It is calculated based on a blood test for creatinine.

(**HB 5616**, amended by sSB 317, effective on passage)

Direct Access to Physical Therapists

This act allows patients to go to a physical therapist who meets certain standards without first being referred by another health care practitioner, except in cases involving workers' compensation injuries and a specific kind of

spinal manipulation. The act specifies procedures a physical therapist must follow in treating patients directly, and it specifies that “physical therapy” does not include surgery; prescribing drugs; or diagnosing disease, injury, or illness.

(**sSB 164**, amended by sSB 317, effective October 1, 2006)

END OF LIFE DECISIONS – HEALTH CARE REPRESENTATIVES

The legislature amended and updated Connecticut law on health care decision-making by, among other actions, (1) combining the authority of the health care agent and attorney-in-fact for health care decisions into a unified proxy known as the “health care representative”; (2) expanding the scope of a living will to include any aspect of health care; (3) authorizing the health care representative to make all health care decisions for a person incapable of expressing those wishes himself; (4) specifying that advance directives properly executed before October 1, 2006 remain valid; and (5) providing for recognition of advance directives validly executed elsewhere that are not contrary to Connecticut policy.

(**sSB 317**, effective October 1, 2006)

INSURANCE

Imaging Services Copayments

This act limits the copayments that a person must make for imaging services performed in-network. It limits the copayments for (1) magnetic resonance imaging (MRI) and computed axial tomography (CAT) scans to no more than \$375 for all such services annually and \$75 for each and (2) positron emission tomography (PET) scans to no more than \$ 400 for all scans annually and \$ 100 for each. These limits apply only if the physician ordering the service or someone in the same practice group does not perform it.

The limits do not apply to high deductible health plans designed to be compatible with federally qualified health savings accounts or to Medicare.

(**sHB 5372**, effective October 1, 2006)

Health Insurance Coverage for Ultrasound Breast Cancer Screening

This act changes when private health insurance policies must provide coverage for a comprehensive ultrasound screening of a woman’s entire breast or breasts. Under prior law, a policy had to provide coverage if a physician recommended the screening for a woman classified as category 2, 3, 4, or 5 on the American

College of Radiology's Breast Imaging Reporting and Database System (BI-RADS) mammogram reading scale. The act instead requires coverage if (1) a mammogram shows heterogeneous or dense breast tissue based on BI-RADS or (2) a woman is considered at increased risk because of family history, her own prior breast cancer history, positive genetic testing, or other indications. As under prior law, coverage is subject to any policy provisions applicable to other covered services.

(**SB 422**, effective October 1, 2006)

TAXES

Seniors Property Tax Freeze Authorized

This act allows towns to freeze property taxes on homes owned by people age 70 or older who have lived in the state at least one year. The freeze can also apply to a surviving spouse who is at least age 62 when the homeowner dies. Homeowners must meet the income limits for the "circuit breaker" program, which gives elderly homeowners a credit against their property taxes. Those income limits are currently \$27,700 for individuals and \$33,900 for married couples and are adjusted annually for inflation. People whose taxes are frozen can still qualify for other property tax relief programs.

Unlike the circuit breaker program, the act does not provide state reimbursement for revenue a town loses by freezing taxes, but it allows the town to put a lien on the property and to set asset limits for eligibility.

(**sHB 5093**, effective October 1, 2006, and applicable to assessment years beginning on or after that date)

Property Tax Credit Increase

The budget act increases the maximum property tax credit against the income tax from \$400 to \$500 starting in the 2006 tax year.

(**HB 5845**, effective July 1, 2006 and applicable to tax years starting on or after January 1, 2006)

Tax Deductions for College Savings

The budget act also allows taxpayers to deduct contributions to the Connecticut Higher Education Trust (CHET), the state-sponsored college savings plan, from their adjusted gross income for state income tax purposes. Grandparents are allowed to establish or contribute to accounts for their grandchildren. The act allows joint filers to deduct \$10,000 a year and single filers \$5,000 and to carry forward any unused deductions for the five following years as long as each deduction does not exceed the annual maximums.

(**HB 5845**, effective July 1, 2006 and applicable to tax years beginning on or after January 1, 2006.)

TRANSPORTATION

Increased Grants for Community-Based Regional Transportation Systems for the Elderly

The act increases the maximum grant for the four towns DSS selects to provide community-based regional transportation for the elderly from a one-time \$25,000 for each in FY 06 to \$50,000 each during the two-year period covering FY 06 and FY 07. It also permits DSS to use any grant funds it did not spend in FY 06 during FY 07.

The four towns, which must have populations of at least 25,000, or nonprofit organizations located in them must use the grants to develop and plan financially self-sustaining, community-based regional transportation systems that, through a combination of private donations and user fees, provide transportation to elderly people. They must, to the extent practicable, model their systems on the "ITNAmerica" model, which obtains its operating funds through membership fees; riders' fares; and private support. It uses a combination of volunteers and paid drivers to provide unrestricted, on-demand transportation to seniors in

passenger automobiles. Before receiving the grant, a selected municipality must demonstrate to the DSS commissioner's satisfaction that it has secured at least \$25,000 in matching private funds.

(**SB 703**, effective on passage)

FUNERALS AND BURIALS

DSS Indigent Funeral and Burial Allowance

The act increases, from \$1,200 to \$1,800, the maximum amount DSS can pay toward funeral and burial expenses for people who are indigent or on welfare and do not have enough money to pay for their burial.

By law, this maximum amount is reduced by the amount of any revocable or irrevocable funeral fund, prepaid funeral contract, or the face value of the person's life insurance. For welfare recipients who have some money when they die, the law allows using up to this maximum amount of the estate for burial expenses before the state claims remaining assets owed it. The law also allows other people to contribute up to \$2,800 to the funeral and burial costs without diminishing the state's obligation to pay. If people are only enrolled in Medicaid and not cash assistance, but do not have enough money for a funeral, the state pays up to the same limit through the State-Administered General Assistance program.

(**SB 703**, effective July 1, 2006)

Prepaid and Funeral Service Contracts

This act requires pre-need funeral service contracts to be written and include certain provisions that describe the parties, identify the goods and services to be provided, state the amount paid or to be paid, and designate an escrow agent who will hold the prepaid funds. It requires funeral homes to (1) keep copies of the contracts and (2) inform contract purchasers whenever they change majority ownership or close.

The law requires a funeral home to deposit money provided under pre-need funeral service contracts into an escrow account within 15 days after receiving it. The act requires the escrow agent to notify the purchaser within 10 days of receiving an initial deposit and when transferring funds in the account. It prohibits transfers to an insurance contract except under specified conditions. It also revises the restriction on investing escrow accounts in insurance contracts.

Finally, the act requires Medicaid beneficiaries to notify DSS when revoking certain pre-need funeral service contracts.

(**PA 06-87**, effective October 1, 2006)

Another act requires every funeral home to maintain at its address of record for inspection

purposes copies of all records relating to funeral service contracts, prepaid funeral contracts, or escrow accounts for at least three years after the death of the person for whom the funeral services were provided.

(**sSB 317**, effective October 1, 2006)

Closing a Funeral Home

The act requires a funeral home operator to notify owners of prepaid funeral contracts, people for whom it is holding cremated remains, and DPH when more than 50% of the business is transferred or the business is discontinued or terminated. The operator must also give DPH, within 10 days of the transfer, discontinuance, or termination, a list of all unclaimed cremated remains the home held at that time.

(**sSB 317**, effective October 1, 2006)

GRANDPARENTS

Kinship Navigator Program

This act requires the Department of Children and Families (DCF), in consultation with DSS, DMHAS, and the Department of Mental Retardation (DMR) to establish, within available appropriations, a kinship navigator program to help relative caregivers find services. The program must ensure that grandparents and other relative caregivers get

information on the array of state services and benefits for which they may qualify, including the subsidized guardianship program. It also assumes DCF's role to tell relative caregivers how they can become foster parents. The DCF commissioner must ensure, within available appropriations, that the program's information is available through 2-1-1 Infoline. The DCF commissioner must report on the program to the Human Services Committee by January 1, 2008.

(**sHB 5532**, effective October 1, 2006)

***Grandparent Notification
When a Child is Removed from
the Home***

This act requires the DCF commissioner to use her best efforts to identify and notify a child's grandparents when she removes him from a parent's home. She must do so within 15 days after the removal. Under the act, grandparents may give the commissioner their contact information in order to be notified about the removal of a child (1) currently the subject of an abuse or neglect investigation or (2) who has been, or is, under DCF care or supervision.

(**PA 06-37**, effective October 1, 2006)

**DEPARTMENT ON AGING
POSTPONEMENT**

This act postpones, from January 1, 2007 to July 1, 2007, the effective date of the 2005 law that requires establishment of a Department on Aging.

(**SB 703**, effective on passage)

MISCELLANEOUS

Social Security Offset

This act eliminates the deduction of Social Security retirement benefits from workers' compensation wage replacement benefits thus allowing a worker injured after the act's effective date to receive both benefits with no offset. Under prior law, a person eligible for workers' compensation total disability payments received workers' compensation only if it exceeded his Social Security retirement benefit, and he received only the amount of workers' compensation over the Social Security benefit.

(**sSB 25**, effective on passage)

Accessibility Advisory Board

This act allows the Office of Protection and Advocacy for Persons with Disabilities director to establish an accessibility advisory board, comprised of design professionals, people with disabilities and their family members, and others with insight on accessibility relating to

housing, transportation,
government programs and
services, and other related
matters.

(**PA 06-56**, effective October 1,
2006)

Elderly Nutrition

The budget act contains an
additional \$800,000 in funding
for elderly nutrition to replace
lost federal funding and enhance
provision of elderly congregate
meals and meals on wheels
services through area agencies
on aging and community action
agencies.

(**HB 5845**, effective July 1,
2006)

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