REPRINT

House Bill No. 7000

Public Act No. 05-280

AN ACT CONCERNING SOCIAL SERVICES AND PUBLIC HEALTH BUDGET IMPLEMENTATION PROVISIONS.

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

Section 1. Section 17b-261 of the general statutes, as amended by public acts 05-1 and 05-43, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (d) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate region of residence and if such person is an institutionalized individual as defined in Section 1917(c) of the Social Security Act, 42 USC 1396p(c), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such disposition shall be treated in accordance with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of property made on behalf of an applicant or recipient or the spouse of

an applicant or recipient by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility. The commissioner shall establish the standards for eligibility for medical assistance at one hundred forty-three per cent of the benefit amount paid to a family unit of equal size with no income under the temporary family assistance program in the appropriate region of residence, pending federal approval, except that the medical assistance program shall provide coverage to persons under the age of nineteen up to one hundred eighty-five per cent of the federal poverty level without an asset limit. Said medical assistance program shall also provide coverage to persons under the age of nineteen and their parents and needy caretaker relatives who qualify for coverage under Section 1931 of the Social Security Act with family income up to one hundred <u>fifty</u> per cent of the federal poverty level without an asset limit, upon the request of such a person or upon a redetermination of eligibility. Such levels shall be based on the regional differences in such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall be applied as may be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. All contracts entered into on and after July 1, 1997, pursuant to this section shall include provisions for collaboration of managed care organizations with the Healthy Families Connecticut Program established pursuant to section 17a-56. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance.

(b) For the purposes of the Medicaid program, the Commissioner of Social Services shall consider parental income and resources as available to a child under eighteen years of age who is living with his or her parents and is blind or disabled for purposes of the Medicaid program, or to any other child under twenty-one years of age who is living with his or her parents.

(c) For the purposes of determining eligibility for the Medicaid program, an available asset is one that is actually available to the applicant or one that the applicant has the legal right, authority or power to obtain or to have applied for the applicant's general or medical support. If the terms of a trust provide for the support of an applicant, the refusal of a trustee to make a distribution from the trust does not render the trust an unavailable asset. Notwithstanding the provisions of this subsection, the availability of funds in a trust or similar instrument funded in whole or in part by the applicant or the applicant's spouse shall be determined pursuant to the Omnibus Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of this subsection shall not apply to special needs trust, as defined in 42 USC 1396p(d)(4)(A).

(d) The transfer of an asset in exchange for other valuable consideration shall be allowable to the extent the value of the other valuable consideration is equal to or greater than the value of the asset transferred.

(e) The Commissioner of Social Services shall seek a waiver from federal law to permit federal financial participation for Medicaid expenditures for families with incomes of one hundred forty-three per cent of the temporary family assistance program payment standard.

[(f) Notwithstanding the provisions of subsection (a) of this section, on or after April 1, 2003, all parent and needy caretaker relatives with incomes exceeding one hundred per cent of the federal poverty level,

who are receiving medical assistance pursuant to this section, shall be ineligible for such medical assistance. On and after February 28, 2003, the Department of Social Services shall not accept applications for medical assistance program coverage under Section 1931 of the Social Security Act from parent and needy caretaker relatives with incomes exceeding one hundred per cent of the federal poverty level until on or after July 1, 2005.**]**

[(g)**]** (f) To the extent permitted by federal law, Medicaid eligibility shall be extended for **[**two years**]** one year to a family that becomes ineligible for medical assistance under Section 1931 of the Social Security Act **[**while**]** due to income from employment by one of its members who is a caretaker relative is employed or due to receipt of child support income. A family receiving extended benefits on the effective date of this section shall receive the balance of such extended benefits, provided no such family shall receive more than twelve additional months of such benefits.

[(h)**]** (g) An institutionalized spouse applying for Medicaid and having a spouse living in the community shall be required, to the maximum extent permitted by law, to divert income to such community spouse in order to raise the community spouse's income to the level of the minimum monthly needs allowance, as described in Section 1924 of the Social Security Act. Such diversion of income shall occur before the community spouse is allowed to retain assets in excess of the community spouse protected amount described in Section 1924 of the Social Security Act. The Commissioner of Social Services, pursuant to section 17b-10, may implement the provisions of this subsection while in the process of adopting regulations, provided the commissioner prints notice of intent to adopt the regulations in the Connecticut Law Journal within twenty days of adopting such policy. Such policy shall be valid until the time final regulations are effective.

[(i) Any person receiving medical assistance pursuant to subsection

(g) of this section who becomes ineligible for such assistance from March 31, 2005, to May 31, 2005, inclusive, shall continue to be eligible for such medical assistance through June 30, 2005. On and after July 1, 2005, such person shall not be eligible for medical assistance provided in accordance with this subsection and the Department of Social Services shall not pay for any such assistance provided to such person on or after July 1, 2005.**]**

(i) The Commissioner of Social Services shall, to the extent permitted by federal law, or, pursuant to an approved waiver of federal law submitted by the commissioner, in accordance with the provisions of section 17b-8, impose the following cost-sharing requirements under the HUSKY Plan, on all parent and needy caretaker relatives with incomes exceeding one hundred per cent of the federal poverty level: (1) A twenty-five-dollar premium per month per parent or needy caretaker relative; and (2) a copayment of one dollar per visit for outpatient medical services delivered by an enrolled Medicaid or HUSKY Plan provider. The commissioner may implement policies and procedures necessary to administer the provisions of this subsection while in the process of adopting such policies and procedures as regulations, provided the commissioner publishes notice of the intent to adopt regulations in the Connecticut Law Journal not later than twenty days after implementation. Policies and procedures implemented pursuant to this subsection shall be valid until the time final regulations are adopted.

Sec. 2. Subsection (b) of section 17b-104 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(b) On July 1, 1988, and annually thereafter, the commissioner shall increase the payment standards over those of the previous fiscal year under the aid to families with dependent children program, temporary family assistance program and the state-administered general

assistance program by the percentage increase, if any, in the most recent calendar year average in the consumer price index for urban consumers over the average for the previous calendar year, provided the annual increase, if any, shall not exceed five per cent, except that the payment standards for the fiscal years ending June 30, 1992, June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June 30, 2002, June 30, 2003, June 30, 2004, **[**and**]** June 30, 2005, June 30, 2006, and June 30, 2007, shall not be increased. On January 1, 1994, the payment standards shall be equal to the standards of need in effect July 1, 1993.

Sec. 3. Section 17b-7a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

The Commissioner of Social Services shall develop a state-wide fraud early detection system. The purpose of such system shall be to identify, investigate and determine if an application for assistance under programs administered by the department, including, but not limited to, (1) the temporary family assistance program, (2) the food stamp program, (3) the child care subsidy program, or **[**(3)**]** (4) the Medicaid program pursuant to Title XIX of the Social Security Act is fraudulent prior to granting assistance. The commissioner shall adopt regulations, in accordance with chapter 54, for the purpose of developing and implementing said system. The commissioner shall submit quarterly reports concerning savings realized through the implementation of the state-wide fraud early detection system to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies.

Sec. 4. Subsection (a) of section 17b-280 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) The state shall reimburse for all legend drugs provided under the Medicaid, state-administered general assistance, ConnPACE and Connecticut AIDS drug assistance programs at the lower of (1) the rate established by the **[**Health Care Finance Administration**]** Centers for Medicare and Medicaid Services as the federal acquisition cost, **[**or, if no such rate is established, the commissioner shall establish and periodically revise the estimated acquisition cost in accordance with federal regulations**]** (2) the average wholesale price minus fourteen per cent, or (3) an equivalent percentage as established under the Medicaid state plan. The commissioner shall also establish a professional fee of three dollars and fifteen cents for each prescription to be paid to licensed pharmacies for dispensing drugs to Medicaid, ConnPACE and Connecticut AIDS drug assistance recipients in accordance with federal regulations; and on and after September 4, 1991, payment for legend and nonlegend drugs provided to Medicaid recipients shall be based upon the actual package size dispensed. Effective October 1, 1991, reimbursement for over-the-counter drugs for such recipients shall be limited to those over-the-counter drugs and products published in the Connecticut Formulary, or the cross reference list, issued by the commissioner. The cost of all over-the-counter drugs and products provided to residents of nursing facilities, chronic disease hospitals, and intermediate care facilities for the mentally retarded shall be included in the facilities' per diem rate. Notwithstanding the provisions of this subsection, no dispensing fee shall be issued for a prescription drug dispensed to a ConnPACE or Medicaid recipient who is a Medicare Part D beneficiary when the prescription drug is a Medicare Part D drug, as defined in Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Sec. 5. Subsection (h) of section 17b-292 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(h) Not more than twelve months after the determination of eligibility for benefits under the HUSKY Plan, Part A and Part B and annually thereafter, the commissioner or the servicer, as the case may be, shall determine if the child continues to be eligible for the plan. The commissioner or the servicer shall mail an application form to each participant in the plan for the purposes of obtaining information to make a determination on eligibility. **[**To the extent permitted by federal law, in determining eligibility for benefits under the HUSKY Plan, Part A and Part B with respect to family income, the commissioner or the servicer shall rely upon information provided in such form by the participant unless the commissioner or the servicer has reason to believe that such information is inaccurate or incomplete.**]** The determination of eligibility shall be coordinated with health plan open enrollment periods.

Sec. 6. Subsection (g) of section 17b-239 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(g) Effective June 1, 2001, the commissioner shall establish inpatient hospital rates in accordance with the method specified in regulations adopted pursuant to this section and applied for the rate period beginning October 1, 2000, except that the commissioner shall update each hospital's target amount per discharge to the actual allowable cost per discharge based upon the 1999 cost report filing multiplied by sixty-two and one-half per cent if such amount is higher than the target amount per discharge for the rate period beginning October 1, 2000, as adjusted for the ten per cent incentive identified in Section 4005 of Public Law 101-508. If a hospital's rate is increased pursuant to this subsection, the hospital shall not receive the ten per cent incentive identified in Section 4005 of Public Law 101-508. For rate periods beginning October 1, 2001, through March 31, 2008, the commissioner shall not apply an annual adjustment factor to the target amount per

discharge. Effective April 1, 2005, the revised target amount per discharge for each hospital with a target amount per discharge less than three thousand seven hundred fifty dollars shall be three thousand seven hundred fifty dollars. Effective **[**April**]** October 1, 2006, the revised target amount per discharge for each hospital with a target amount per discharge less than four thousand dollars shall be four thousand dollars. Effective **[**April**]** October 1, 2007, the revised target amount per discharge for each hospital with a target amount per discharge less than four thousand two hundred fifty dollars shall be four thousand two hundred fifty dollars.

Sec. 7. Section 17b-295 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) The commissioner shall impose cost-sharing requirements including the payment of a premium or copayment in connection with services provided under the HUSKY Plan, Part B, to the extent permitted by federal law, and in accordance with the following limitations:

(1) On and after **[**October 1, 2003**]** July 1, 2005, the commissioner **[**may**]** shall increase the maximum annual aggregate cost-sharing requirements provided that such cost-sharing requirements shall not exceed five per cent of the family's gross annual income. The commissioner **[**may**]** shall, as a component of the family's cost-sharing responsibility, provided the family's annual combined premiums and copayments do not exceed the maximum annual aggregate cost-sharing requirement, (A) impose a premium requirement on families, whose income exceeds one hundred eighty-five per cent of the federal poverty level **[**as a component of the family's cost-sharing responsibility provided the family's annual combined premiums and copayments do not exceed the maximum annual aggregate cost-sharing requirement**]** but does not exceed two hundred thirty-five per cent of the federal poverty level; and (B) increase the premium

requirement on families whose income exceeds two hundred thirty-five per cent of the federal poverty level, but does not exceed three hundred per cent of the federal poverty level; and

(2) The commissioner shall require each managed care plan to monitor copayments and premiums under the provisions of subdivision (1) of this subsection.

(b) (1) Except as provided in subdivision (2) of this subsection, the commissioner may impose limitations on the amount, duration and scope of benefits under the HUSKY Plan, Part B.

(2) The limitations adopted by the commissioner pursuant to subdivision (1) of this subsection shall not preclude coverage of any item of durable medical equipment or service that is medically necessary.

Sec. 8. Section 17b-277 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) The Commissioner of Social Services shall provide, in accordance with federal law and regulations, medical assistance under the Medicaid program to needy pregnant women and children up to one year of age whose families have an income up to one hundred eighty-five per cent of the federal poverty level.

(b) The commissioner shall **[**implement presumptive**]** expedite eligibility for appropriate pregnant women applicants for the Medicaid program. **[**with an emphasis on pregnant women. Such presumptive eligibility determinations shall be in accordance with applicable federal law and regulations. The commissioner shall provide such presumptive eligibility determinations on a pilot basis, in one district office, beginning June 1, 1991, and shall provide them state-wide effective September 1, 1991.**]** The process for making expedited eligibility determinations concerning needy pregnant women shall

ensure that emergency applications for assistance, as determined by the commissioner, shall be processed no later than twenty-four hours after receipt of all required information from the applicant, and that nonemergency applications for assistance, as determined by the commissioner, shall be processed no later than five calendar days after the date of receipt of all required information from the applicant.

(c) The commissioner shall submit biannual reports to the council, established pursuant to section 17b-28, on the department's compliance with the administrative processing requirements set forth in subsection (b) of this section.

Sec. 9. Section 17b-292 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) A child who resides in a household with a family income which exceeds one hundred eighty-five per cent of the federal poverty level and does not exceed three hundred per cent of the federal poverty level may be eligible for subsidized benefits under the HUSKY Plan, Part B. **[**The services and cost-sharing requirements under the HUSKY Plan, Part B shall be substantially similar to the services and cost-sharing requirements of the largest commercially available health plan offered by a managed care organization, as defined in section 38a-478, offered to residents in this state as measured by the number of covered lives reported to the Insurance Department in the most recent audited annual report.**]**

(b) A child who resides in a household with a family income over three hundred per cent of the federal poverty level may be eligible for unsubsidized benefits under the HUSKY Plan, Part B.

(c) Whenever a court or family support magistrate orders a noncustodial parent to provide health insurance for a child, such parent may provide for coverage under the HUSKY Plan, Part B.

(d) To the extent allowed under federal law, the commissioner shall not pay for services or durable medical equipment under the HUSKY Plan, Part B if the enrollee has other insurance coverage for the services or such equipment.

(e) A newborn child who otherwise meets the eligibility criteria for the HUSKY Plan, Part B shall be eligible for benefits retroactive to his date of birth, provided an application is filed on behalf of the child within thirty days of such date.

(f) The commissioner shall implement presumptive eligibility for children applying for Medicaid. Such presumptive eligibility determinations shall be in accordance with applicable federal law and regulations. The commissioner shall adopt regulations, in accordance with chapter 54, to establish standards and procedures for the designation of organizations as qualified entities to grant presumptive eligibility. Qualified entities shall ensure that, at the time a presumptive eligibility determination is made, a completed application for Medicaid is submitted to the department for a full eligibility determination. In establishing such standards and procedures, the commissioner shall ensure the representation of state-wide and local organizations that provide services to children of all ages in each region of the state.

[(f)**]** (g) The commissioner shall enter into a contract with an entity to be a single point of entry servicer for applicants and enrollees under the HUSKY Plan, Part A and Part B. The servicer shall jointly market both Part A and Part B together as the HUSKY Plan. Such servicer shall develop and implement public information and outreach activities with community programs. Such servicer shall electronically transmit data with respect to enrollment and disenrollment in the HUSKY Plan, Part B to the commissioner.

(h) Upon the expiration of any contractual provisions entered into

pursuant to subsection (g) of this section, the commissioner shall develop a new contract for single point of entry services and managed care enrollment brokerage services. The commissioner may enter into one or more contractual arrangements for such services for a contract period not to exceed seven years. Such contracts shall include performance measures, including, but not limited to, specified time limits for the processing of applications, parameters setting forth the requirements for a completed and reviewable application and the percentage of applications forwarded to the department in a complete and timely fashion. Such contracts shall also include a process for identifying and correcting noncompliance with established performance measures, including sanctions applicable for instances of continued noncompliance with performance measures.

[(g)**]** (i) The single point of entry servicer shall send an application and supporting documents to the commissioner for determination of eligibility of a child who resides in a household with a family income of one hundred eighty-five per cent or less of the federal poverty level. The servicer shall enroll eligible beneficiaries in the applicant's choice of managed care plan. Upon enrollment in a managed care plan, an eligible Husky Plan Part A or Part B beneficiary shall remain enrolled in such managed care plan for twelve months from the date of such enrollment unless (1) an eligible beneficiary demonstrates good cause to the satisfaction of the commissioner of the need to enroll in a different managed care plan, or (2) the beneficiary no longer meets program eligibility requirements.

[(h)**]** (j) Not more than twelve months after the determination of eligibility for benefits under the HUSKY Plan, Part A and Part B and annually thereafter, the commissioner or the servicer, as the case may be, shall determine if the child continues to be eligible for the plan. The commissioner or the servicer shall mail an application form to each participant in the plan for the purposes of obtaining information to

make a determination on eligibility. To the extent permitted by federal law, in determining eligibility for benefits under the HUSKY Plan, Part A and Part B with respect to family income, the commissioner or the servicer shall rely upon information provided in such form by the participant unless the commissioner or the servicer has reason to believe that such information is inaccurate or incomplete. The determination of eligibility shall be coordinated with health plan open enrollment periods.

[(i)**]** (k) The commissioner shall implement the HUSKY Plan, Part B while in the process of adopting necessary policies and procedures in regulation form in accordance with the provisions of section 17b-10.

[(j)**]** (l) The commissioner shall adopt regulations, in accordance with chapter 54, to establish residency requirements and income eligibility for participation in the HUSKY Plan, Part B and procedures for a simplified mail-in application process. Notwithstanding the provisions of section 17b-257b, such regulations shall provide that any child adopted from another country by an individual who is a citizen of the United States and a resident of this state shall be eligible for benefits under the HUSKY Plan, Part B upon arrival in this state.

Sec. 10. Subsection (i) of section 17b-342 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(i) (1) On and after July 1, 1992, the Commissioner of Social Services shall, within available appropriations, administer a state-funded portion of the program for persons (A) who are sixty-five years of age and older; (B) who are inappropriately institutionalized or at risk of inappropriate institutionalization; (C) whose income is less than or equal to the amount allowed under subdivision (3) of subsection (a) of this section; and (D) whose assets, if single, do not exceed the minimum community spouse protected amount pursuant to Section

4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed one hundred fifty per cent of said community spouse protected amount and on and after April 1, 2007, whose assets, if single, do not exceed one hundred fifty per cent of the minimum community spouse protected amount pursuant to Section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed two hundred per cent of said community spouse protected amount.

(2) Any person whose income exceeds two hundred per cent of the federal poverty level shall contribute to the cost of care in accordance with the methodology established for recipients of medical assistance pursuant to Sections 5035.20 and 5035.25 of the department's uniform policy manual.

(3) On and after June 30, 1992, the program shall serve persons receiving state-funded home and community-based services from the department, persons receiving services under the promotion of independent living for the elderly program operated by the Department of Social Services, regardless of age, and persons receiving services on June 19, 1992, under the home care demonstration project operated by the Department of Social Services. Such persons receiving state-funded services whose income and assets exceed the limits established pursuant to subdivision (1) of this subsection may continue to participate in the program, but shall be required to pay the total cost of care, including case management costs.

(4) Services shall not be increased for persons who received services under the promotion of independent living for the elderly program over the limits in effect under said program in the fiscal year ending June 30, 1992, unless a person's needs increase and the person is eligible for Medicaid.

(5) The annualized cost of services provided to an individual under

the state-funded portion of the program shall not exceed fifty per cent of the weighted average cost of care in nursing homes in the state, except an individual who received services costing in excess of such amount under the Department of Social Services in the fiscal year ending June 30, 1992, may continue to receive such services, provided the annualized cost of such services does not exceed eighty per cent of the weighted average cost of such nursing home care. The commissioner may allow the cost of services provided to an individual to exceed the maximum cost established pursuant to this subdivision in a case of extreme hardship, as determined by the commissioner, provided in no case shall such cost exceed that of the weighted cost of such nursing home care.

Sec. 11. (NEW) (*Effective July 1, 2005*) The Commissioner of Social Services shall develop and implement a two-year pilot program for up to one hundred individuals who: (1) Are ages nineteen to twenty-one; (2) reside with a parent or a relative caregiver; (3) have been diagnosed with one or more mental disorders as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders"; (4) have a significant chronic health condition; (5) have a substantial functional impairment as a result of the mental disorder or chronic health condition; and (6) are ineligible for medical assistance under the state-administered general assistance program due to parent or relative caregiver income. An individual who is eligible for benefits under this program, shall cooperate in establishing such individual's eligibility for Medicaid coverage based on disability. For purposes of this section "mental disorder" shall not include mental retardation, learning disorders, motor skill disorder, communication disorders, caffeine-related disorders, relational problems and additional conditions that may be a focus of clinical attention that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

Sec. 12. Subsection (a) of section 16a-46 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) The Secretary of the Office of Policy and Management shall be responsible for the development and implementation of a residential energy conservation service program in accordance with the provisions of this section, sections 16a-46a, 16a-46b and 16a-46c and applicable federal law. Participants in the program shall provide or arrange for low cost energy audits. No participant under subdivision (1) or (3) of section 16a-45a may be required to provide such services outside its authorized service area or area of normal operation. The residential energy conservation service program shall terminate on July 1, **[**2005**]** 2010.

Sec. 13. Subsection (c) of section 17b-192 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(c) On and after October 1, 2003, pharmacy services shall be provided to recipients of state-administered general assistance through the federally qualified health center to which they are assigned or through a pharmacy with which the health center contracts. Prior to said date, pharmacy services shall be provided as provided under the Medicaid program. Recipients who are assigned to a community health center or similar clinic or primary care provider other than a federally qualified health center or to a federally qualified health center that does not have a contract for pharmacy services shall receive pharmacy services at pharmacies designated by the commissioner. The Commissioner of Social Services or the managed care organization or other entity performing administrative functions for the program as permitted in subsection (d) of this section, shall require prior authorization for coverage of drugs for the treatment of erectile dysfunction. The commissioner or the managed care organization or

other entity performing administrative functions for the program may limit or exclude coverage for drugs for the treatment of erectile dysfunction for persons who have been convicted of a sexual offense who are required to register with the Commissioner of Public Safety pursuant to chapter 969.

Sec. 14. Subsection (b) of section 17b-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(b) "Prescription drugs" means (1) legend drugs, as defined in section 20-571, (2) any other drugs which by state law or regulation require the prescription of a licensed practitioner for dispensing, except: (A) **[**products**]** Products prescribed for cosmetic purposes as specified in regulations adopted pursuant to section 17b-494; **[**, and**]** (B) on and after September 15, 1991, diet pills, smoking cessation gum, contraceptives, multivitamin combinations, cough preparations and antihistamines; **[**,**]** and (C) drugs for the treatment of erectile dysfunction for persons who have been convicted of a sexual offense who are required to register with the Commissioner of Public Safety pursuant to chapter 969, and (3) insulin **[**,**]** and insulin syringes. **[**and insulin needles;**]**

Sec. 15. Section 17b-279 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

The Commissioner of Social Services shall verify the propriety and reasonableness of payments to providers for drugs provided to Medicaid recipients through field audit examinations and other reasonable means to the extent possible within available appropriations. To the extent permitted by federal law, the commissioner shall require prior authorization for coverage of drugs for the treatment of erectile dysfunction. To the extent permitted by federal law, the commissioner may limit or exclude coverage for drugs

for the treatment of erectile dysfunction for persons who have been convicted of a sexual offense who are required to register with the Commissioner of Public Safety pursuant to chapter 969. The commissioner shall document financial and utilization statistics as to drugs provided to Medicaid recipients by therapeutic category and shall outline problems encountered in the administration of prescription drug utilization in the Medicaid program, suggested solutions and any recommendations for improvement.

Sec. 16. Subsection (c) of section 17b-274 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(c) The Commissioner of Social Services shall implement a procedure by which a pharmacist shall obtain approval from an independent pharmacy consultant acting on behalf of the Department of Social Services, under an administrative services only contract, whenever the pharmacist dispenses a brand name drug product to a Medicaid, state-administered general assistance, or ConnPACE recipient and a chemically equivalent generic drug product substitution is available. **[**, provided such procedure shall not require approval for other than initial prescriptions for such drug product.**]** The length of authorization for brand name drugs shall be in accordance with section 17b-491a, as amended by this act. In cases where the brand name drug is less costly than the chemically equivalent generic drug when factoring in manufacturers' rebates, the pharmacist shall dispense the brand name drug. If such approval is not granted or denied within two hours of receipt by the commissioner of the request for approval, it shall be deemed granted. Notwithstanding any provision of this section, a pharmacist shall not dispense any initial maintenance drug prescription for which there is a chemically equivalent generic substitution that is for less than fifteen days without the department's granting of prior authorization, provided prior

authorization shall not otherwise be required for atypical antipsychotic drugs if the individual is currently taking such drug at the time the pharmacist receives the prescription. The pharmacist may appeal a denial of reimbursement to the department based on the failure of such pharmacist to substitute a generic drug product in accordance with this section.

Sec. 17. Section 17b-491a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Social Services may **[**establish a plan for the**]** require prior authorization of **[**(1)**]** any **[**initial**]** prescription for a drug covered under the Medicaid, state-administered general assistance, or ConnPACE program**,** **[**that costs five hundred dollars or more for a thirty-day supply, or (2)**]** including (1) any early refill of a prescription drug covered under any of said programs; and (2) brand name drug products when a chemically equivalent generic drug product substitution is available. The authorization for a brand name drug product shall be valid for one year from the date the prescription is first filled. The Commissioner of Social Services shall establish a procedure by which prior authorization under this subsection shall be obtained from an independent pharmacy consultant acting on behalf of the Department of Social Services, under an administrative services only contract. If prior authorization is not granted or denied within two hours of receipt by the commissioner of the request for prior authorization, it shall be deemed granted.

(b) The Commissioner of Social Services**,** **[**shall,**]** to increase cost-efficiency or enhance access to a particular prescription drug, **[**establish a plan under which the commissioner**]** may designate specific suppliers of a prescription drug from which a dispensing pharmacy shall order the prescription to be delivered to the pharmacy and billed by the supplier to the department. For each prescription dispensed through designated suppliers, the department shall pay the dispensing

pharmacy a handling fee not to exceed four hundred per cent of the dispensing fee established pursuant to section 17b-280. In no event shall the provisions of this subsection be construed to allow the commissioner to purchase all prescription drugs covered under the Medicaid, state-administered general assistance, and ConnPACE programs under one contract.

(c) Notwithstanding the provisions of section 17b-262 and any regulation adopted thereunder, on or after July 1, 2000, the Commissioner of Social Services may establish a schedule of maximum quantities of oral dosage units permitted to be dispensed at one time for prescriptions covered under the Medicaid and state-administered general assistance programs based on a review of utilization patterns.

(d) A plan or schedule established pursuant to subsection (a), (b) or (c) of this section and <u>on and after July 1, 2005,</u> any revisions thereto shall be submitted to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies. Within sixty days of receipt of such a plan or schedule or revisions thereto, said joint standing committees of the General Assembly shall approve or deny the plan or schedule or any revisions thereto and advise the commissioner of their approval or denial of the plan or schedule or any revisions thereto. The plan or schedule or any revisions thereto shall be deemed approved unless all committees vote to reject such plan or schedule or revisions thereto within sixty days of receipt of such plan or schedule or revisions thereto.

Sec. 18. Section 17b-274d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) Pursuant to 42 USC 1396r-8, there is established a **[**Medicaid**]** Pharmaceutical and Therapeutics Committee within the Department of Social Services.

(b) The **[**Medicaid**]** Pharmaceutical and Therapeutics Committee shall be comprised as specified in 42 USC 1396r-8 and shall consist of fourteen members appointed by the Governor. Five members shall be physicians licensed pursuant to chapter 370, including one general practitioner, one pediatrician, one geriatrician, one psychiatrist and one specialist in family planning, four members shall be pharmacists licensed pursuant to chapter 400j, two members shall be visiting nurses, one specializing in adult care and one specializing in psychiatric care, one member shall be a clinician designated by the Commissioner of Mental Health and Addiction Services, one member shall be a representative of pharmaceutical manufacturers and one member shall be a consumer representative. The committee may, on an ad hoc basis, seek the participation of other state agencies or other interested parties in its deliberations. The members shall serve for terms of two years from the date of their appointment. Members may be appointed to more than one term. The Commissioner of Social Services, or the commissioner's designee, shall convene the committee following the Governor's designation of appointments. The administrative staff of the Department of Social Services shall serve as staff for said committee and assist with all ministerial duties. The Governor shall ensure that the committee membership includes Medicaid participating physicians and pharmacists, with experience serving **[**all segments of the Medicaid population**]** recipients of medical assistance.

(c) Committee members shall select a chairperson and vice-chairperson from the committee membership on an annual basis.

(d) The committee shall meet at least quarterly, and may meet at other times at the discretion of the chairperson and committee membership. The committee shall comply with all regulations adopted by the department, including notice of any meeting of the committee, pursuant to the requirements of chapter 54.

(e) The Department of Social Services, in consultation with the **[**Medicaid**]** Pharmaceutical and Therapeutics Committee, **[**shall**]** may adopt preferred drug lists for use in the Medicaid, state-administered general assistance and ConnPACE programs. The Department of Social Services, upon entering into a contract for the provision of prescription drug coverage to medical assistance recipients receiving services in a managed care setting as provided by section 17b-266a, shall in consultation with the **[**Medicaid**]** Pharmaceutical and Therapeutics Committee, expand the preferred drug list for use in the HUSKY Plan, Part A and Part B. To the extent feasible, the department shall review all drugs included on the preferred drug lists at least every twelve months, and may recommend additions to, and deletions from, the preferred drug lists, to ensure that the preferred drug lists provide for medically appropriate drug therapies for Medicaid, state-administered general assistance and ConnPACE patients. For the fiscal year ending June 30, 2004, such drug lists shall be limited to use in the Medicaid and ConnPACE programs and cover three classes of drugs, including proton pump inhibitors and two other classes of drugs determined by the Commissioner of Social Services. Not later than June 30, 2005, the Department of Social Services, in consultation with the **[**Medicaid**]** Pharmaceutical and Therapeutic Committee shall expand such drug lists to include other classes of drugs, except as provided in subsection (f) of this section, in order to achieve savings reflected in the amounts appropriated to the department, for the various components of the program, in the state budget act.

(f) **[**Except for mental-health-related drugs**]** Nonpreferred drugs in the classes of drugs included on the preferred drug lists shall be subject to prior authorization. If prior authorization is granted for a drug not included on a preferred drug list, the authorization shall be valid for one year from the date the prescription is first filled. Mental health related and antiretroviral classes of drugs **[**, reimbursement for a drug not included on the preferred drug lists are subject to prior

authorization**]** shall not be included on the preferred drug lists.

(g) The Department of Social Services shall publish and disseminate the preferred drug lists to all Medicaid providers in the state.

(h) The department may negotiate supplemental rebate agreements with manufacturers that are in addition to those required under Title XIX of the Social Security Act. The committee shall ensure that the pharmaceutical manufacturers agreeing to provide a supplemental rebate pursuant to 42 USC 1396r-8(c) have an opportunity to present evidence supporting inclusion of a product on the preferred drug lists unless a court of competent jurisdiction, in a final decision, determines that the Secretary of Health and Human Services does not have authority to allow such supplemental rebates, provided the inability to utilize supplemental rebates pursuant to this subsection shall not impair the committee's authority to maintain preferred drug lists. Upon timely notice, the department shall ensure that any drug that has been approved, or had any of its particular uses approved, by the United States Food and Drug Administration under a priority review classification, will be reviewed by the **[**Medicaid**]** Pharmaceutical and Therapeutics Committee at the next regularly scheduled meeting. To the extent feasible, upon notice by a pharmaceutical manufacturer, the department shall also schedule a product review for any new product at the next regularly scheduled meeting of the **[**Medicaid**]** Pharmaceutical and Therapeutics Committee.

(i) Factors considered by the department and the **[**Medicaid**]** Pharmaceutical and Therapeutics Committee in developing the preferred drug lists shall include, but not be limited to, clinical efficacy, safety and cost effectiveness of a product.

(j) The **[**Medicaid**]** Pharmaceutical and Therapeutics Committee may also make recommendations to the department regarding the prior authorization of any prescribed drug. **[**covered by Medicaid in

accordance with the plan developed and implemented pursuant to section 17b-491a.**]**

[(k) Medicaid recipients may appeal any department preferred drug list determinations utilizing the Medicaid fair hearing process administered by the Department of Social Services established pursuant to chapter 54.**]**

(k) A recipient who is denied a nonpreferred drug may request an administrative hearing in accordance with section 17b-60.

(l) The Commissioner of Social Services may contract with a pharmacy benefits organization or a single entity qualified to negotiate with pharmaceutical manufacturers for supplemental rebates, available pursuant to 42 USC 1396r-8(c), for the purchase of drugs listed on the preferred drug lists established pursuant to subsection (e) of this section.

Sec. 19. (NEW) (*Effective July 1, 2005*) On and after the effective date of the Medicare Part D program established pursuant to Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, no Medicaid prescription drug coverage shall be provided to a Medicaid recipient eligible for Medicare Part D for Medicare Part D Drugs, as defined in said act. Medicaid coverage will be provided for prescription drugs that are not Medicare Part D drugs, as defined in said act.

Sec. 20. Section 17b-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

As used in sections 17b-490 to 17b-498, inclusive:

(a) "Pharmacy" means a pharmacy licensed under section 20-594 or a pharmacy located in a health care institution, as defined in subsection (a) of section 19a-490, which elects to participate in the

program;

(b) "Prescription drugs" means (1) legend drugs, as defined in section 20-571, (2) any other drugs which by state law or regulation require the prescription of a licensed practitioner for dispensing, except products prescribed for cosmetic purposes as specified in regulations adopted pursuant to section 17b-494, and on and after September 15, 1991, diet pills, smoking cessation gum, contraceptives, multivitamin combinations, cough preparations and antihistamines, and (3) insulin **[**,**]** and insulin syringes; **[**and insulin needles;**]**

(c) "Reasonable cost" means the cost of the prescription drug determined in accordance with the formula adopted by the Commissioner of Social Services in regulations for medical assistance purposes plus a dispensing fee equal to the fee determined by said commissioner for medical assistance purposes;

(d) "Resident" means a person legally domiciled within the state for a period of not less than one hundred eighty-three days immediately preceding the date of application for inclusion in the program. Mere seasonal or temporary residences within the state, of whatever duration, shall not constitute domicile;

(e) "Disabled" means a person over eighteen years of age who is receiving disability payments pursuant to either Title 2 or Title 16 of the Social Security Act of 1935, as amended;

(f) "Commissioner" means the Commissioner of Social Services;

(g) "Income" means adjusted gross income as determined for purposes of the federal income tax plus any other income of such person not included in such adjusted gross income minus Medicare Part B premium payments. The amount of any Medicaid payments made on behalf of such person or the spouse of such person shall not constitute income;

(h) "Program" means the Connecticut **[**pharmaceutical assistance contract to the elderly and the disabled program**]** Pharmaceutical Assistance Contract to the Elderly and the Disabled Program otherwise known as ConnPACE;

(i) "Pharmaceutical manufacturer" means any entity holding legal title to or possession of a national drug code number issued by the federal Food and Drug Administration;

(j) "Average manufacturer price" means the average price paid by a wholesaler to a pharmaceutical manufacturer, after the deduction of any customary prompt payment discounts, for a product distributed for retail sale;

(k) "Assets" means a person's resources, as defined by Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;

(l) "Low income subsidy" means a premium and cost-sharing subsidy for low-income individuals, as defined by Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;

(m) "Medicare Part D covered prescription drugs" means drugs that are included in Medicare Part D plan's formulary or are treated as being included in a Medicare Part D plan's formulary, as defined by Public Law 108-173, the Medicare Prescription Drug, Improvement and Modernization Act of 2003;

(n) "Medicare Part D plan" means a Medicare Part D plan, as defined by Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;

(o) "Gap in standard Medicare Part D coverage" means a drug obtained after a Medicare Part D beneficiary's initial coverage limit has

been exceeded but before the beneficiary's annual out-of-pocket threshold has been met, as defined by Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Sec. 21. Subsection (a) of section 17b-491 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) There shall be a "Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program" which shall be within the Department of Social Services. The program shall consist of payments by the state to pharmacies for the reasonable cost of prescription drugs dispensed to eligible persons minus a copayment charge. The pharmacy shall collect the copayment charge from the eligible person at the time of each purchase of prescription drugs, and shall not waive, discount or rebate in whole or in part such amount. **[**Except for a replacement prescription dispensed pursuant to section 17b-492, the**]** The copayment for each prescription shall **[**be as follows:**]** not exceed sixteen dollars and twenty-five cents.

[(1) Sixteen dollars and twenty-five cents if the participant is (A) not married and has an annual income of less than twenty thousand three hundred dollars, or (B) married and has an annual income that, when combined with the participant's spouse, is less than twenty-seven thousand five hundred dollars.

(2) Upon the granting of a federal waiver to expand the program in accordance with section 17b-492, the copayment shall be twenty dollars for a participant who is (A) not married and has an annual income that equals or exceeds twenty thousand three hundred dollars, or (B) married and has an annual income that, when combined with the participant's spouse, equals or exceeds twenty-seven thousand five hundred dollars.**]**

Sec. 22. Section 17b-492 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) Eligibility for participation in the program shall be limited to any resident (1) who is sixty-five years of age or older or who is disabled, (2) whose current annual income at the time of application or redetermination, if unmarried, is less than twenty thousand eight hundred dollars or whose annual income, if married, when combined with that of the resident's spouse is less than twenty-eight thousand one hundred dollars, (3) who is not insured under a policy which provides full or partial coverage for prescription drugs once a deductible is met, except for a Medicare prescription drug discount card endorsed by the Secretary of Health and Human Services in accordance with Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, **[**once a deductible amount is met**]** or coverage under Medicare Part D pursuant to said act, and (4) on and after September 15, 1991, who pays an annual thirty-dollar registration fee to the Department of Social Services. **[**Effective January 1, 2002, the commissioner shall commence accepting applications from individuals who will become eligible to participate in the program as of April 1, 2002.**]** On January 1, 1998, and annually thereafter, the commissioner shall increase the income limits established under this subsection over those of the previous fiscal year to reflect the annual inflation adjustment in Social Security income, if any. Each such adjustment shall be determined to the nearest one hundred dollars.

(b) (1) Payment for a prescription under the program shall be made only if no other plan of insurance or assistance is available to an eligible person for such prescription at the time of dispensing, except for benefits received from an endorsed Medicare prescription drug discount card or benefits provided under Medicare Part D. The pharmacy shall make reasonable efforts to ascertain the existence of

other insurance or assistance, including the subsidy provided by an endorsed Medicare prescription drug discount card or benefits provided under Medicare Part D. A Medicare prescription drug discount card beneficiary shall be responsible for the payment of any Medicare prescription drug discount card coinsurance requirements, provided such requirements do not exceed the ConnPACE program copayment requirements. If a Medicare prescription drug discount card beneficiary's coinsurance requirements exceed the ConnPACE copayment requirements, the Department of Social Services shall make payment to the pharmacy to cover costs in excess of the ConnPACE copayment amount. If the cost to such beneficiary exceeds the remaining available Medicare prescription drug discount card subsidy, the beneficiary shall not be responsible for any payment in excess of the amount of the ConnPACE program copayment requirement. In such cases, the Department of Social Services shall make payment to the pharmacy to cover costs in excess of the ConnPACE copayment amount.

(2) A Medicare Part D beneficiary shall be responsible for the payment of Medicare Part D copayments, coinsurance and deductible requirements for Medicare Part D covered prescription drugs, as defined in Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, to the extent such requirements do not exceed the ConnPACE program copayment requirements. The Department of Social Services shall pay Medicare Part D monthly beneficiary premiums on behalf of the beneficiary. If a Medicare Part D beneficiary's out-of-pocket copayment, coinsurance or deductible requirements exceed the ConnPACE copayment requirements, the department shall make payment to the pharmacy to cover costs in excess of the ConnPACE copayment amount. The department shall be responsible for payment of a Medicare Part D covered prescription drug obtained during the gap in standard Medicare Part D coverage. To the extent permitted under said act, such

payment may be made by the department for a prescription at (A) the lowest price established by the Medicare Part D plan for a preferred drug in the same therapeutic class and category that is dispensed by a preferred pharmacy with the client responsible for any cost differential beyond the department's payment; (B) the lower of the price that would be paid under the ConnPACE program or the negotiated price established by the beneficiary's Medicare Part D plan pursuant to Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or (C) in consultation with the Secretary of the Office of Policy and Management, at the price that would be paid under the ConnPACE program. Payment shall be made under the ConnPACE program for prescription drugs that are not Medicare Part D drugs, as defined in said act.

[(2)**]** (3) Payment for a replacement prescription under the program shall be made only if the eligible person signs a statement, on such form as the commissioner prescribes and subject to penalty under section 17b-497, that the prescription drug is lost or was stolen or destroyed and the person has made a good faith effort to recover the prescription drug, except that payment for a replacement prescription shall not be made on behalf of a person more than twice in a calendar year. **[**No copayment shall be required for such replacement prescription.**]**

(c) Any eligible resident who (1) is insured under a policy, including an endorsed Medicare prescription drug discount card, which provides full or partial coverage for prescription drugs, and (2) expects to exhaust such coverage, may apply to participate in the program prior to the exhaustion of such coverage. Such application shall be valid for the applicable income year. To be included in the program, on or after the date the applicant exhausts such coverage, the applicant or the applicant's designee shall notify the department that such coverage is exhausted and, if required by the department, shall submit evidence

of exhaustion of coverage. Not later than ten days after an eligible resident submits such evidence, such resident shall be included in the program. The program shall, except for those beneficiaries with an endorsed Medicare prescription drug discount card, (A) cover prescriptions that are not covered by any other plan of insurance or assistance available to the eligible resident and that meet the requirements of this chapter, and (B) retroactively cover such prescriptions filled after or concurrently with the exhaustion of such coverage. Nothing in this subsection shall be construed to prevent a resident from applying to participate in the program as otherwise permitted by this chapter and regulations adopted pursuant to this chapter.

(d) (1) As a condition of eligibility for participation in the ConnPACE program, a resident with an income at or below one hundred thirty-five per cent of the federal poverty level, who is Medicare Part A or Part B eligible, shall obtain annually an endorsed Medicare prescription drug discount card designated by the Commissioner of Social Services for use in conjunction with the ConnPACE program. The commissioner shall be the authorized representative of such resident for the purpose of enrolling a resident in the transitional assistance program of Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. As the authorized representative for this purpose, the commissioner may sign required forms and enroll such resident in an endorsed Medicare prescription drug discount card on **[**his or her**]** the resident's behalf. Such resident shall have the opportunity to select an endorsed Medicare prescription drug discount card designated by the commissioner for use in conjunction with the ConnPACE program, and shall be notified of such opportunity by the commissioner. In the event that such resident does not select an endorsed Medicare prescription drug discount card designated by the commissioner for use in conjunction with the ConnPACE program within a reasonable

period of time, as determined by the commissioner, the department shall enroll the resident in an endorsed Medicare prescription drug discount card designated by the commissioner. The provisions of this subdivision shall remain in effect until the effective date of the Medicare Part D program pursuant to Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(2) The commissioner may require, as a condition of eligibility for participation in the ConnPACE program, that a resident with an income above one hundred thirty-five per cent of the federal poverty level, who is Medicare Part A or Part B eligible, obtain an endorsed Medicare prescription drug discount card designated by the commissioner for use in conjunction with the ConnPACE program if obtaining such discount card is determined by the commissioner to be cost-effective to the state. In such an event, the commissioner may provide payment for any Medicare prescription drug discount card enrollment fees. The provisions of this subdivision shall remain in effect until the effective date of the Medicare Part D program pursuant to Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(e) On and after the effective date of the Medicare Part D program pursuant to Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, enrollment in the Medicare Part D program, for individuals eligible for such program in accordance with said act, shall be a condition of eligibility for the ConnPACE program. The ConnPACE program shall cover the financial costs of Medicare Part D participation for ConnPACE recipients enrolled in Medicare Part D in accordance with subsection (b) of this section. Effective July 1, 2005, a ConnPACE recipient shall, as a condition of eligibility, provide information regarding the recipient's assets and income, as defined by said act, and that of the recipient's

spouse, provided said spouse resides in the same household, as required by the Department of Social Services in order to determine the extent of benefits for which the recipient is eligible under Medicare Part D.

(f) The Commissioner of Social Services shall be the authorized representative of a ConnPACE applicant or recipient for the purpose of submitting an application to the Social Security Administration to obtain the low income subsidy benefit provided under Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. As the authorized representative for this purpose, the commissioner may also sign required forms and enroll the applicant or recipient in a Medicare Part D plan on the applicant or recipient's behalf. The applicant or recipient shall have the opportunity to select a Medicare Part D plan and shall be notified of such opportunity by the commissioner. In the event that such applicant or recipient does not select a Medicare Part D plan within a reasonable period of time, as determined by the commissioner, the department shall enroll the applicant or recipient in a Medicare Part D plan designated by the commissioner in accordance with said act. The applicant or recipient shall appoint the commissioner as such applicant's or recipient's representative for the purpose of appealing any denial of Medicare Part D benefits and for any other purpose allowed under said act and deemed necessary by the commissioner.

[(e)**]** (g) The Commissioner of Social Services may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of subsection (c) of this section. Such regulations may provide for the electronic transmission of relevant coverage information between a pharmacist and the department or between an insurer and the department in order to expedite applications and notice. The commissioner may implement the policies and procedures necessary to carry out the provisions of this section while in the

process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published not later than twenty days after the date of implementation. Such policies and procedures shall be valid until the time the final regulations are adopted.

Sec. 23. Section 17b-264 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

All of the provisions of sections 17b-22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-103, inclusive, and 17b-600 to 17b-604, inclusive, are extended to the medical assistance program except such provisions as are inconsistent with federal law and regulations governing Title XIX of the Social Security Amendments of 1965 and sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to **[**17b-362**]** 17b-361, inclusive.

Sec. 24. Subsection (a) of section 17b-266 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) The Commissioner of Social Services may, when **[**he**]** the commissioner finds it to be in the public interest, fund part or all of the cost of benefits to any recipient under sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, 17b-357 to **[**17b-362**]** 17b-361, inclusive, 17b-289 to 17b-303, inclusive, and section 16 of public act 97-1 of the October 29 special session*, through the purchase of insurance from any organization authorized to do a health insurance business in this state or from any organization specified in subsection (b) of this section.

Sec. 25. Subsection (a) of section 17b-267 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) If any group or association of providers of medical assistance services wishes to have payments as provided for under sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to **[**17b-362**]** 17b-361, inclusive, to such providers made through a national, state or other public or private agency or organization and nominates such agency or organization for this purpose, the Commissioner of Social Services is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization, subject to such review by the Commissioner of Social Services as may be provided for by the agreement, of the payments required to be made to such providers at the rates set by the hospital cost commission, and for the making of such payments by such agency or organization to such providers. Such agreement may also include provision for the agency or organization to do all or any part of the following: With respect to the providers of services which are to receive payments through it, (1) to serve as a center for, and to communicate to providers, any information or instructions furnished to it by the Commissioner of Social Services, and to serve as a channel of communication from providers to the Commissioner of Social Services; (2) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this section; and (3) to perform such other functions as are necessary to carry out the provisions of sections 17b-267 to 17b-271, inclusive.

Sec. 26. Section 17b-272 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

Effective July 1, 1998, the Commissioner of Social Services shall permit patients residing in nursing homes, chronic disease hospitals and state humane institutions who are medical assistance recipients under sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to **[**17b-362**]** 17b-361, inclusive, to have a

monthly personal fund allowance of fifty dollars. Effective July 1, 1999, the commissioner shall increase such allowance annually to reflect the annual inflation adjustment in Social Security income, if any.

Sec. 27. Section 53a-290 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

A person commits vendor fraud when, with intent to defraud and acting on such person's own behalf or on behalf of an entity, such person provides goods or services to a beneficiary under sections 17b-22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-103, inclusive, 17b-180a, 17b-183, 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, 17b-357 to **[**17b-362**]** 17b-361, inclusive, 17b-600 to 17b-604, inclusive, 17b-749, 17b-807 and 17b-808 or provides services to a recipient under Title XIX of the Social Security Act, as amended, and, (1) presents for payment any false claim for goods or services performed; (2) accepts payment for goods or services performed, which exceeds either the amounts due for goods or services performed, or the amounts authorized by law for the cost of such goods or services; (3) solicits to perform services for or sell goods to any such beneficiary, knowing that such beneficiary is not in need of such goods or services; (4) sells goods to or performs services for any such beneficiary without prior authorization by the Department of Social Services, when prior authorization is required by said department for the buying of such goods or the performance of any service; or (5) accepts from any person or source other than the state an additional compensation in excess of the amount authorized by law.

Sec. 28. (NEW) (*Effective July 1, 2005*) The Commissioner of Mental Retardation, or the commissioner's designee, may be the authorized representative of an applicant or recipient of services provided by the Department of Mental Retardation for the purpose of submitting an application to the Social Security Administration to obtain the low income subsidy benefit provided under Public Law 108-173, the

Medicare Prescription Drug, Improvement, and Modernization Act of 2003. As the authorized representative for this purpose, the commissioner, or the commissioner's designee, may also sign required forms and enroll the applicant or recipient in a Medicare Part D plan on the applicant's or recipient's behalf. The applicant or recipient shall have the opportunity to select a Medicare Part D plan and shall be notified of such opportunity by the commissioner. In the event that such applicant or recipient does not select a Medicare Part D plan within a reasonable period of time, as determined by the commissioner, the department shall enroll the applicant or recipient in a Medicare Part D plan designated by the commissioner in accordance with said act. The applicant or recipient shall appoint the commissioner, or the commissioner's designee, as such applicant's or recipient's authorized representative for the purpose of appealing any denial of Medicare Part D benefits and for any other purpose allowed under said act and deemed necessary by the commissioner.

Sec. 29. (NEW) (*Effective July 1, 2005*) The Commissioner of Mental Heath and Addiction Services, or the commissioner's designee, may be the authorized representative of an applicant or recipient of services provided by the Department of Mental Health and Addiction Services for the purpose of submitting an application to the Social Security Administration to obtain the low income subsidy benefit provided under Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. As the authorized representative for this purpose, the commissioner, or the commissioner's designee, may also sign required forms and enroll the applicant or recipient in a Medicare Part D plan on the applicant's or recipient's behalf. The applicant or recipient shall have the opportunity to select a Medicare Part D plan and shall be notified of such opportunity by the commissioner. In the event that such applicant or recipient does not select a Medicare Part D plan within a reasonable period of time, as determined by the commissioner, the department

shall enroll the applicant or recipient in a Medicare Part D plan designated by the commissioner in accordance with said act. The applicant or recipient shall appoint the commissioner, or the commissioner's designee, as such applicant's or recipient's authorized representative for the purpose of appealing any denial of Medicare Part D benefits and for any other purpose allowed under said act and deemed necessary by the commissioner.

Sec. 30. (*Effective July 1, 2005*) Not later than January 1, 2007, the Commissioner of Social Services shall submit an interim status report, in accordance with section 11-4a of the general statutes, relative to the implementation of the Medicare Part D program established pursuant to Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies.

Sec. 31. Section 17a-218 of the general statutes is amended by adding subsection (g) as follows (*Effective July 1, 2005*):

(NEW) (g) Any person who is in or is seeking a placement through the Department of Mental Retardation or is receiving any support or service that is included within or covered by any federal program being administered and operated by the Department of Social Services and the Department of Mental Retardation, and who meets the eligibility criteria for the federal program, shall enroll in such program in order to continue in the existing placement or to remain eligible for a placement or continue to receive such support or service. Any person who is ineligible for such federal program due to excess income or assets may continue in existing placement, or continue to receive existing supports and services through the Department of Mental Retardation while spending down available excess income and assets until such person qualifies for enrollment in the applicable federal

program. The Commissioner of Mental Retardation may make exceptions to the requirements of this provision and provide or continue to provide, within available appropriations, placement, support or services to individuals who are not eligible for enrollment in such federal programs and for whom it is determined there is a legal requirement to serve pursuant to state or federal law or court order.

Sec. 32. Section 17a-485c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) The Commissioner of Mental Health and Addiction Services, in collaboration with the Commissioners of Social Services, Children and Families and Economic and Community Development and the Connecticut Housing Finance Authority, shall establish a Supportive Housing **[**Pilots**]** Initiative to provide additional units of affordable housing and support services to eligible persons. The Supportive Housing Initiative shall be implemented in two phases with the first phase to be known as the Supportive Housing Pilots Initiative and the second phase to be known as the Next Steps Initiative.

(b) The Supportive Housing Pilots Initiative shall provide up to six hundred fifty additional units of affordable housing and support services to eligible households, as defined in section 17a-484a, and to persons with serious mental health needs who are community-supervised offenders supervised by the executive or judicial branch. Such housing shall be permanent supportive housing or transitional living programs, and the permanent supportive housing may include both individuals and families with special needs and individuals and families without such needs.

[(b)**]** (c) **[**The Supportive Housing Pilots Initiative shall provide up to six hundred fifty dwelling units.**]** Not later than January 1, 2002, the Secretary of the Office of Policy and Management and the Commissioner of Mental Health and Addiction Services shall enter

into a memorandum of understanding with the Departments of Social Services and Economic and Community Development and the Connecticut Housing Finance Authority. The memorandum of understanding shall provide that: (1) A collaborative plan shall be submitted with specific timetables to create up to six hundred fifty dwelling units of supportive housing, which may include the construction of up to three hundred new units of supportive housing; (2) the Department of Social Services may provide project-based rental subsidy certificates; (3) the Connecticut Housing Finance Authority and the Department of Economic and Community Development shall provide grants, mortgage loans and tax credits that offer a viable financing package, including capitalized operating reserves, for the construction of up to three hundred new units of supportive housing; (4) the Department of Mental Health and Addiction Services shall provide annual grants to the projects for supportive services during the term of any mortgage loan; (5) there shall be a plan for private and federal predevelopment financing and financing from nonstate sources for grants and loans from private investment through federal and state tax credit programs and federal project-based rental subsidies; and (6) not later than July 1, 2002, the Connecticut Housing Finance Authority shall issue a request for proposals by persons or entities interested in participating in such initiative with priority given to applicants that include organizations deemed qualified to provide services by the Department of Mental Health and Addiction Services pursuant to a request for qualifications. The Connecticut Housing Finance Authority shall review and underwrite projects developed under the Supportive Housing Pilots Initiative.

(d) The Next Steps Initiative shall provide up to five hundred additional units of affordable housing and support services to: (1) Eligible households, as defined in section 17a-484a; (2) families who are eligible under the state plan for the federal temporary assistance for needy families program; (3) adults who are eighteen to twenty-

three years of age, inclusive, and who are homeless, or at risk for becoming homeless because they are transitioning from foster care or other residential programs; and (4) persons with serious mental health needs who are community-supervised offenders supervised by the executive or judicial branch. Such housing shall be permanent supportive housing and may include both individuals and families with special needs and individuals and families without such needs.

(e) Not later than October 1, 2005, the Secretary of the Office of Policy and Management and the Commissioner of Mental Health and Addiction Services shall enter into a memorandum of understanding with the Departments of Social Services, Children and Families and Economic and Community Development and the Connecticut Housing Finance Authority. The memorandum of understanding shall provide that: (1) A collaborative plan shall be submitted with specific timetables to create up to five hundred dwelling units of supportive housing under the Next Steps Initiative; (2) the Department of Social Services may provide subsidies, including, but not limited to, project-based rental subsidy certificates during the term of any mortgage loan; (3) the Connecticut Housing Finance Authority and the Department of Economic and Community Development shall provide grants, mortgage loans or tax credits that offer a viable financing package, including capitalized operating reserves; (4) after January 1, 2006, the State Treasurer and the Secretary of the Office of Policy and Management may enter into a debt service agreement to provide funding for debt service costs for Section 501 (c)(3) of the Internal Revenue Code bonds issued by the Connecticut Housing Finance Authority; (5) the Departments of Mental Health and Addiction Services, Social Services and Children and Families shall provide annual grants to the projects for supportive services during the term of any mortgage loan; and (6) there shall be a plan for private and federal predevelopment financing and financing from nonstate sources for grants and loans from private investment through federal and state tax

credit programs and federal project-based rental subsidies. Not later than January 1, 2006, the Connecticut Housing Finance Authority shall issue one or more requests for proposals by persons or entities interested in participating in such initiative. The Connecticut Housing Finance Authority shall review and underwrite projects developed under the Supportive Housing Initiative.

[(c)**]** (f) Not later than January 1, **[**2004**]** 2006, the Commissioners of Mental Health and Addiction Services, Children and Families, Social Services and Economic and Community Development and the Connecticut Housing Finance Authority shall submit an interim status report relative to the Supportive Housing **[**Pilots**]** Initiative established under this section to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, finance, revenue and bonding and appropriations and the budgets of state agencies. Not later than January 1, **[**2006**]** 2007, the Commissioners of Mental Health and Addiction Services and Economic and Community Development and the Connecticut Housing Finance Authority shall submit a final report to said committees with respect to the Supportive Housing **[**Pilots**]** Initiative and the report shall include, but not be limited to, information indicating (1) the number and location of the units of supportive housing created, (2) the number of individuals served, (3) the number and type of services offered, and (4) the estimated amount of cost avoidance achieved as a direct result of such initiative.

Sec. 33. (NEW) (*Effective July 1, 2005*) (a) For purposes of this section "state assistance" means a payment by the state of actual debt service, comprised on principal, interest and reasonable operating reserves.

(b) The state, acting by and through the Secretary of the Office of Policy and Management and State Treasurer, may enter into a contract or contracts with the Connecticut Housing Finance Authority that provide the state shall pay actual debt service, comprised on principal,

interest and reasonable operating repair and replacement reserves to the authority on mortgage loans made by the authority pursuant to the provisions of section 17a-485c of the general statutes, as amended by this act. Any such contract entered into pursuant to this section shall include provisions that the Secretary of the Office of Policy and Management and the State Treasurer find: (1) Necessary to assure the effectuation of the Supportive Housing Initiative, (2) appropriate for repayment of the state assistance to the state as a result of payment of mortgage loans made by the authority from federal or other sources of revenues, if any, and (3) in the best interests of the state to allow that such state assistance be paid by the state directly to the trustee or paying agent for any bonds or refunding bonds, as applicable, with respect to which the state assistance is provided. Any provision of such a contract entered into providing for payments equal to annual debt service shall be deemed a contract of the state with the holders of any bonds or refunding bonds, as applicable, and appropriation of all amounts necessary to meet punctually the terms of such provision is hereby made and the State Treasurer shall pay such amount as the same become due. The Connecticut Housing Finance Authority may pledge such state assistance as security for the payment of such bonds or refunding bonds issued by said authority. Any bonds so issued for the Supportive Housing Initiative by the Connecticut Housing Finance Authority and at any time outstanding may at any time or from time to time be refunded, in whole or in part, by the Connecticut Housing Finance Authority by the issuance of its refunding bonds in such amounts as the authority may deem necessary or appropriate but not exceeding an amount sufficient to refund the principal amount of the bonds to be so refunded, any unpaid interest thereon, and any premiums, commissions and costs of issuance necessary to be paid in connection therewith. Any such refunding may be effected whether the bonds to be refunded shall have matured or shall thereafter mature.

Sec. 34. Section 17b-812 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) The Commissioner of Social Services shall implement and administer a program of rental assistance for low-income families living in privately-owned rental housing. For the purposes of this section, a low-income family is one whose income does not exceed fifty per cent of the median family income for the area of the state in which such family lives, as determined by the commissioner.

(b) Housing eligible for participation in the program shall comply with applicable state and local health, housing, building and safety codes.

(c) In addition to an element in which rental assistance certificates are made available to qualified tenants, to be used in eligible housing which such tenants are able to locate, the program may include a housing support element in which rental assistance for tenants is linked to participation by the property owner in other municipal, state or federal housing repair, rehabilitation or financing programs. The commissioner shall use rental assistance under this section so as to encourage the preservation of existing housing and the revitalization of neighborhoods or the creation of additional rental housing.

(d) The commissioner may designate a portion of the rental assistance certificates available under the program for tenant-based and project-based supportive housing units. To the extent practicable rental assistance certificates issued for supportive housing shall adhere to the requirements of the federal Housing Choice Voucher program, 42 USC 1437f(o), relative to calculating the tenant's share of the rent to be paid.

[(d)**]** (e) The commissioner shall administer the program under this section to promote housing choice for certificate holders and

encourage racial and economic integration. The commissioner shall establish maximum rent levels for each municipality in a manner that promotes the use of the program in all municipalities. Any certificate issued pursuant to this section may be used for housing in any municipality in the state. The commissioner shall inform certificate holders that a certificate may be used in any municipality and, to the extent practicable, the commissioner shall assist certificate holders in finding housing in the municipality of their choice.

[(e)**]** (f) Nothing in this section shall give any person a right to continued receipt of rental assistance at any time that the program is not funded.

[(f)**]** (g) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 to carry out the purposes of this section. The regulations shall establish maximum income eligibility guidelines for such rental assistance and criteria for determining the amount of rental assistance which shall be provided to eligible families.

Sec. 35. (*Effective from passage*) The Department of Mental Retardation shall, within available appropriations, contract for a unit cost study for the Birth-To-Three Early Intervention Program under sections 17a-248 to 17a-248g, inclusive, of the general statutes. The study shall examine operational costs for both contracted services and for services provided by state employees and may include a computation of such costs as salary, benefits, contracted services, administrative support, rent, vehicles, equipment, travel, materials and supplies, utilities, insurance and training. The contract shall provide for input by private provider representatives who are current providers in the program. The study shall be completed by February 1, 2006, and the Commissioner of Mental Retardation shall report, in accordance with section 11-4a of the general statutes, to the Governor and the joint standing committees of the General Assembly having

cognizance of matters relating to public health and appropriations and the budgets of state agencies on the results of the study by March 1, 2006.

Sec. 36. (*Effective July 1, 2005*) The joint standing committee of the General Assembly having cognizance of matters relating to insurance and real estate shall conduct a study on the potential implementation of a public-private partnership to be called the Nutmeg Health Partnership Insurance Plan. The committee shall investigate ideas to accomplish the following goals: Increase the number of residents of this state who have health insurance, provide broader access to health care and make health care more affordable to residents of this state. The committee shall develop a plan to achieve these goals and shall issue a report to the General Assembly in accordance with the provisions of section 11-4a of the general statutes no later than February 1, 2006, that contains the specifics of such plan and that contemplates legislation to implement the plan as soon as is practicable.

Sec. 37. (*Effective from passage*) Notwithstanding the provisions of section 3-125a of the general statutes, the provisions of the settlement agreement in the action Emily J. et al. v. M. Jodi Rell, et al., United States District Court, District of Connecticut, Civil Action No. 3:93CV1944 (RNC), requiring expenditure from the General Fund budget in excess of two million five hundred thousand dollars and submitted by the Attorney General to this Assembly for approval on June 7, 2005, are approved.

Sec. 38. Subsection (a) of section 17b-106 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) On July 1, 1985, the Commissioner of Social Services shall increase the adult payment standards for the state supplement to the

federal Supplemental Security Income Program by four and three-tenths per cent over the standards for the fiscal year ending June 30, 1985, provided the commissioner shall apply the appropriate disregards. Notwithstanding the provisions of any regulation to the contrary, effective July 1, 1994, the commissioner shall reduce the appropriate unearned income disregard for recipients of the state supplement to the federal Supplemental Security Income Program by seven per cent, provided if sufficient funds are available within accounts in the Department of Social Services and are transferred to the old age assistance account, the aid to the blind account and the aid to the disabled account, the commissioner shall increase the unearned income disregard for recipients of the state supplement to the federal Supplemental Security Income Program to a level not to exceed that in effect on June 30, 1994. On July 1, 1989, and annually thereafter, the Commissioner of Social Services shall increase the adult payment standards over those of the previous fiscal year for the state supplement to the federal Supplemental Security Income Program by the percentage increase, if any, in the most recent calendar year average in the consumer price index for urban consumers over the average for the previous calendar year, provided the annual increase, if any, shall not exceed five per cent, except that the adult payment standards for the fiscal years ending June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June 30, 2002, June 30, 2003, June 30, 2004, and June 30, 2005, June 30, 2006 and June 30, 2007, shall not be increased. Effective October 1, 1991, the coverage of excess utility costs for recipients of the state supplement to the federal Supplemental Security Income Program is eliminated. Notwithstanding the provisions of this section, the Commissioner of Social Services may increase the personal needs allowance component of the adult payment standard as necessary to meet federal maintenance of effort requirements.

Sec. 39. Subsection (a) of section 17b-802 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) The Commissioner of Social Services shall establish, within available appropriations, and administer a security deposit guarantee program for persons who (1) (A) are recipients of temporary family assistance, aid under the state supplement program, or state-administered general assistance, or (B) have a documented showing of financial need, and (2) (A) are residing in emergency shelters or other emergency housing, cannot remain in permanent housing due to any reason specified in subsection (a) of section 17b-808, or are served a notice to quit in a summary process action instituted pursuant to chapter 832, or (B) have a rental assistance program or federal Section 8 certificate or voucher. Under such program, the Commissioner of Social Services may provide security deposit guarantees for use by such persons in lieu of a security deposit on a rental dwelling unit. Eligible persons may receive a security deposit guarantee in an amount not to exceed the equivalent of two months' rent on such rental unit. No person may apply for and receive a security deposit guarantee more than once in any eighteen-month period without the express authorization of the Commissioner of Social Services, except as provided in subsection (b) of this section. The Commissioner of Social Services may deny eligibility for the security deposit guarantee program to an applicant who has made more than two claims in a five-year period. The Commissioner of Social Services may establish priorities for **[**allocating**]** providing security deposit guarantees **[**between**]** to eligible persons described in subparagraphs (A) and (B) of subdivision (2) of this subsection in order to administer the program within available appropriations.

Sec. 40. Section 17b-261a of the general statutes, as amended by public act 05-209, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any transfer or assignment of assets resulting in the imposition of a penalty period shall be presumed to be made with the intent, on the part of the transferor or the transferee, to enable the transferor to obtain or maintain eligibility for medical assistance. This presumption may be rebutted only by clear and convincing evidence that the transferor's eligibility or potential eligibility for medical assistance was not a basis for the transfer or assignment.

(b) Any transfer or assignment of assets resulting in the establishment or imposition of a penalty period shall create a debt, as defined in section 36a-645, that shall be due and owing by the transferor or transferee to the Department of Social Services in an amount equal to the amount of the medical assistance provided to or on behalf of the transferor on or after the date of the transfer of assets, but said amount shall not exceed the fair market value of the assets at the time of transfer. The Commissioner of Social Services, the Commissioner of Administrative Services and the Attorney General shall have the power or authority to seek administrative, legal or equitable relief as provided by other statutes or by common law.

(c) The Commissioner of Social Services may waive the imposition of a penalty period when the transferor (1) in accordance with the provisions of section 3025.25 of the department's Uniform Policy Manual, suffers from dementia at the time of application for medical assistance and cannot explain transfers that would otherwise result in the imposition of a penalty period; or (2) suffered from dementia at the time of the transfer; or (3) was exploited into making such a transfer due to dementia. Waiver of the imposition of a penalty period does not prohibit the establishment of a debt in accordance with subsection (b) of this section.

[(c)**]** (d) The Commissioner of Social Services, pursuant to section 17b-10, shall implement the policies and procedures necessary to carry out the provisions of this section while in the process of adopting such

policies and procedures in regulation form, provided notice of intent to adopt regulations is published in the Connecticut Law Journal not later than twenty days after implementation. Such policies and procedures shall be valid until the time final regulations are effective.

Sec. 41. Subsection (a) of section 17b-354 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) Except for applications deemed complete as of August 9, 1991, the Department of Social Services shall not accept or approve any requests for additional nursing home beds or modify the capital cost of any prior approval for the period from September 4, 1991, through June 30, 2007, except (1) beds restricted to use by patients with acquired immune deficiency syndrome or traumatic brain injury; (2) beds associated with a continuing care facility which guarantees life care for its residents; (3) Medicaid certified beds to be relocated from one licensed nursing facility to another licensed nursing facility, provided (A) the availability of beds in an area of need will not be adversely affected; (B) no such relocation shall result in an increase in state expenditures; and (C) the relocation results in a reduction in the number of nursing facility beds in the state; **[**and**]** (4) a request for no more than twenty beds submitted by a licensed nursing facility that participates in neither the Medicaid program nor the Medicare program, admits residents and provides health care to said residents without regard to their income or assets and demonstrates its financial ability to provide lifetime nursing home services to such residents without participating in the Medicaid program to the satisfaction of the department, provided the department does not accept or approve more than one request pursuant to this subdivision; and (5) a request for not nor more than twenty beds associated with a free standing facility dedicated to providing hospice care services for terminally ill persons operated by an organization previously authorized by the

Department of Public Health to provide hospice services in accordance with section 19a-122b. Notwithstanding the provisions of this subsection, any provision of the general statutes or any decision of the Office of Health Care Access, (i) the date by which construction shall begin for each nursing home certificate of need in effect August 1, 1991, shall be December 31, 1992, (ii) the date by which a nursing home shall be licensed under each such certificate of need shall be October 1, 1995, and (iii) the imposition of such dates shall not require action by the Commissioner of Social Services. Except as provided in subsection (c) of this section, a nursing home certificate of need in effect August 1, 1991, shall expire if construction has not begun or licensure has not been obtained in compliance with the dates set forth in subparagraphs (i) and (ii) of this subsection.

Sec. 42. (*Effective from passage*) Not later than January 1, 2006, the Commissioner of Social Services shall report to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies on the feasibility and costs of establishing a program to purchase and continue health insurance policies for persons with human immunodeficiency virus or acquired immunodeficiency virus that would operate under the same eligibility criteria utilized to make eligibility determinations for the Connecticut AIDS drug assistance program.

Sec. 43. Section 17a-93 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

As used in sections 17a-90 to 17a-124, inclusive, and 17a-152:

(a) "Child" means any person under eighteen years of age, except as otherwise specified, or any person under twenty-one years of age who is in full-time attendance in a secondary school, a technical school, a college or a state-accredited job training program;

(b) "Parent" means natural or adoptive parent;

(c) "Adoption" means the establishment by court order of the legal relationship of parent and child;

(d) "Guardianship" means guardianship, unless otherwise specified, of the person of a minor and refers to the obligation of care and control, the right to custody and the duty and authority to make major decisions affecting such minor's welfare, including, but not limited to, consent determinations regarding marriage, enlistment in the armed forces and major medical, psychiatric or surgical treatment;

(e) "Termination of parental rights" means the complete severance by court order of the legal relationship, with all its rights and responsibilities, between the child and his parent or parents so that the child is free for adoption except it shall not affect the right of inheritance of such child or the religious affiliation of such child;

(f) "Statutory parent" means the Commissioner of Children and Families or that child-placing agency appointed by the court for the purpose of giving a minor child or minor children in adoption;

(g) "Child-placing agency" means any agency within or without the state of Connecticut licensed or approved by the Commissioner of Children and Families in accordance with sections 17a-149 and 17a-151, and in accordance with such standards which shall be established by regulations of the Department of Children and Families;

(h) "Child care facility" means a congregate residential setting licensed by the Department of Children and Families for the out-of-home placement of children or youth under eighteen years of age, **[**licensed by the Department of Children and Families**]** or any person under twenty-one years of age who is in full-time attendance in a secondary school, a technical school, a college or state accredited job training program and was placed in a congregate residential setting

prior to such person's eighteenth birthday;

(i) "Protective supervision" means a status created by court order following adjudication of neglect whereby a child's place of abode is not changed but assistance directed at correcting the neglect is provided at the request of the court through the Department of Children and Families or such other social agency as the court may specify;

(j) "Receiving home" means a facility operated by the Department of Children and Families to receive and temporarily care for children in the guardianship or care of the commissioner;

(k) "Protective services" means public welfare services provided after complaints of abuse, neglect or abandonment, but in the absence of an adjudication or assumption of jurisdiction by a court;

(l) "Person responsible for the health, welfare or care of a child or youth" means a child's or a youth's parent, guardian or foster parent; an employee of a public or private residential home, agency or institution or other person legally responsible in a residential setting; or any staff person providing out-of-home care, including center-based child day care, family day care or group day care, as defined in section 19a-77;

(m) "Foster family" means a person or persons, licensed or certified by the Department of Children and Families or approved by a licensed child-placing agency, for the care of a child or children in a private home;

(n) "Prospective adoptive family" means a person or persons, licensed by the Department of Children and Families or approved by a licensed child-placing agency, who is awaiting the placement of, or who has a child or children placed in their home for the purposes of adoption;

(o) "Person entrusted with the care of a child or youth" means a person given access to a child or youth by a person responsible for the health, welfare or care of a child or youth for the purpose of providing education, child care, counseling, spiritual guidance, coaching, training, instruction, tutoring or mentoring of such child or youth.

Sec. 44. Subsection (c) of section 17b-93 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(c) No claim shall be made, or lien applied, against any payment made pursuant to chapter 135, any payment made pursuant to section 47-88d or 47-287, <u>any moneys received as a settlement or award in a housing or employment discrimination case,</u> any court-ordered retroactive rent abatement, including any made pursuant to subsection (e) of section 47a-14h, section 47a-4a, 47a-5, or 47a-57, or any security deposit refund pursuant to subsection (d) of section 47a-21 paid to a beneficiary of assistance under the state supplement program, medical assistance program, aid to families with dependent children program, temporary family assistance program or state-administered general assistance program.

Sec. 45. (NEW) (*Effective October 1, 2005*) Any payment received by a complainant under chapter 814c of the general statutes or under any equivalent federal antidiscrimination law, either as a settlement of a claim or as an award made in a judicial or administrative proceeding, shall not be considered as income, resources or assets for the purpose of determining the eligibility of or amount of assistance to be received by such person in the month of receipt or the three months following receipt under the state supplement program, Medicaid or any other medical assistance program, temporary family assistance program, state-administered general assistance program, or the temporary assistance for needy families program. After such time period, any remaining funds shall be subject to state and federal laws governing

such programs, including, but not limited to, provisions concerning individual development accounts, as defined in section 31-51ww.

Sec. 46. (NEW) (*Effective July 1, 2005*) The Commissioner of Social Services shall establish prior authorization procedures under the Medicaid program for home health services, such that prior authorization shall be required for skilled nursing visits that exceed two per week. Unless there are revisions to the prior authorization received during the month, providers shall not be required to submit prior authorization requests more than once a month. The Commissioner of Social Services may contract with an entity for administration of any such aspect of prior authorization or may expand the scope of an existing contract with an entity that performs utilization review services on behalf of the department. The commissioner, pursuant to section 17b-10 of the general statutes, may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 47. Section 78 of public act 05-251 is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) For purposes of this section and section 79 of **[**this act**]** public act 05-251:

(1) "Commissioner" means the Commissioner of Revenue Services;

(2) "Department" means the Department of Revenue Services;

(3) "Nursing home" means any licensed chronic and convalescent nursing home or a rest home with nursing supervision, but does not

include, upon approval of the waiver of federal requirements for uniform and broad-based user fees in accordance with 42 CFR 433.68, pursuant to section 82 of **[**this act**]** public act 05-251, any nursing home that is owned and operated as of May 1, 2005, by the legal entity that is registered as a continuing care facility with the Department of Social Services in accordance with section 17b-521 of the general statutes, regardless of whether such nursing home participates in the Medicaid program and any nursing home licensed after May 1, 2005, that is owned and operated by the legal entity that is registered as a continuing care facility with the Department of Social Services in accordance with section 17b-521 of the general statutes;

(4) "Medicare day" means a day of nursing home care service provided to an individual who is eligible for payment, in full or with a coinsurance requirement, under the federal Medicare program, including fee for service and managed care coverage;

(5) "Resident day" means a day of nursing home care service provided to an individual and includes the day a resident is admitted and any day for which the nursing home is eligible for payment for reserving a resident's bed due to hospitalization or temporary leave and for the date of death. For purposes of this subdivision, a day of nursing home care service shall be the period of time between the census-taking hour in a nursing home on two successive calendar days. "Resident day" does not include a Medicare day or the day a resident is discharged;

(6) "Nursing home net revenue" means amounts billed by a nursing home for all room, board and ancillary services, minus (A) contractual allowances, (B) payer discounts, (C) charity care, and (D) bad debts; and

(7) "Contractual allowances" mean the amount of discounts allowed by a nursing home to certain payers from amounts billed for room,

board and ancillary services.

(b) (1) (A) For each calendar quarter commencing on or after July 1, 2005, there is hereby imposed a resident day user fee on each nursing home in this state, which fee shall be the product of the nursing home's total resident days during the calendar quarter multiplied by the user fee, as determined by the Commissioner of Social Services pursuant to subsection (a) of section 79 of **[**this act**]** public act 05-251.

(B) Commencing with the calendar quarter in which approval of the waiver of federal requirements for uniform and broad-based user fees in accordance with 42 CFR 433.68 pursuant to section **[**80 of this act**]** 82 of public act 05-251 is granted, the resident day user fee shall be the product of the nursing home's total resident days during the calendar quarter multiplied by the user fee, as redetermined by the Commissioner of Social Service pursuant to subsection (b) of section 79 of **[**this act**]** public act 05-251.

(2) Each nursing home shall, on or before the last day of January, April, July, and October of each year, render to the commissioner a return, on forms prescribed or furnished by the commissioner, stating the nursing home's total resident days during the calendar quarter ending on the last day of the preceding month and stating such other information as the commissioner deems necessary for the proper administration of this section. The resident day user fee imposed under this section shall be due and payable on the due date of such return. Each nursing home shall be required to file such return electronically with the department and to make such payment by electronic funds transfer in the manner provided by chapter 228g of the general statutes, irrespective of whether the nursing home would have otherwise been required to file such return electronically or to make such payment by electronic funds transfer under the provisions of said chapter 228g.

(c) Whenever such resident day user fee is not paid when due, a penalty of ten per cent of the amount due or fifty dollars, whichever is greater, shall be imposed, and interest at the rate of one per cent per month or fraction thereof shall accrue on such user fee from the due date of such user fee until the date of payment.

(d) The commissioner shall notify the Commissioner of Social Services of any amount delinquent under **[**this act**]** public act 05-251 and, upon receipt of such notice, the Commissioner of Social Services shall deduct and withhold such amount from amounts otherwise payable by the Department of Social Services to the delinquent nursing home.

(e) The provisions of section 12-548, sections 12-550 to 12-554, inclusive, and section 12-555a of the general statutes shall apply to the provisions of this section in the same manner and with the same force and effect as if the language of said sections had been incorporated in full into this section and had expressly referred to the user fee imposed under this section, except to the extent that any provision is inconsistent with a provision in this section. For purposes of section 12-39g of the general statutes, the resident day user fee shall be treated as a tax.

(f) The commissioner may enter into an agreement with the Commissioner of Social Services delegating to the Commissioner of Social Services the authority to examine the records and returns of any nursing home subject to the resident day user fee imposed under this section and to determine whether such user fee has been underpaid or overpaid. If such authority is so delegated, examinations of such records and returns by the Department of Social Services and determinations by said department that such user fee has been underpaid or overpaid, shall have the same effect as similar examinations or determinations made by the Department of Revenue Services.

(g) (1) The commissioner shall not collect the resident day user fee pursuant to this section until the Commissioner of Social Services informs the commissioner that all the necessary federal approvals are in effect to secure federal financial participation matching funds associated with the rate increases as described in section 81 of **[**this act**]** public act 05-251.

(2) The commissioner shall cease to collect the resident day user fee pursuant to this section if the Commissioner of Social Services informs the commissioner that the federal approvals described in subdivision (1) of this subsection are withheld or withdrawn.

Sec. 48. Section 79 of public act 05-251 is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) On or before July 1, 2005, and on or before July **[**1**]** first of each succeeding calendar year, the Commissioner of Social Services shall determine the amount of the user fee and promptly notify the commissioner and nursing homes of such amount. The user fee shall be the (1) the sum of each nursing home's anticipated nursing home net revenue, including but not limited to its estimated net revenue from any increases in Medicaid payments, during the twelve-month period ending on June **[**30**]** thirtieth of the succeeding calendar year, (2) which sum shall be multiplied by six per cent, and (3) which product shall be divided by the sum of each nursing home's anticipated resident days during the twelve-month period ending on June **[**30**]** thirtieth of the succeeding calendar year. The Commissioner of Social Services, in anticipating nursing home net revenue and resident days, shall use the most recently available nursing home net revenue and resident day information.

(b) Upon approval of the waiver of federal requirements for uniform and broad-based user fees in accordance with 42 CFR 433.68 pursuant to section **[**81 of this act**]** 82 of public act 05-251, the

Commissioner of Social Services shall redetermine the amount of the user fee and promptly notify the commissioner and nursing homes of such amount. The user fee shall be the (1) the sum of each nursing home's anticipated nursing home net revenue, including but not limited to its estimated net revenue from any increases in Medicaid payments, during the twelve-month period ending on June **[**30**]** thirtieth of the succeeding calendar year but not including any such anticipated net revenue of any nursing home exempted from such user fee due to waiver of federal requirements pursuant to section **[**4 of this act**]** 82 of public act 05-251, (2) which sum shall be multiplied by six per cent, and (3) which product shall be divided by the sum of each nursing home's anticipated resident days, but not including the anticipated resident days of any nursing home exempted from such user fee due to waiver of federal requirements pursuant to section **[**81 of this act**]** 82 of public act 05-251. Notwithstanding the provisions of this subsection, the amount of the user fee for each nursing home licensed for more than two hundred thirty beds or owned by a municipality shall be equal to the amount necessary to comply with federal provider tax uniformity waiver requirements as determined by the Commissioner of Social Services. The Commissioner of Social Services may increase retroactively the user fee for nursing homes not licensed for more than two hundred thirty beds and not owned by a municipality to the effective date of waiver of said federal requirements to offset user fee reductions necessary to meet the federal waiver requirements. Thereafter, on or before July **[**1**]** first of each succeeding calendar year, the Commissioner of Social Services shall determine the amount of the user fee in accordance with this subsection. The Commissioner of Social Services, in anticipating nursing home net revenue and resident days, shall use the most recently available nursing home net revenue and resident day information.

(c) (1) Following a redetermination of the resident day user fee by

the Commissioner of Social Services pursuant to subsection (b) of this section, the Commissioner of Social Services shall notify the commissioner of the identity of (A) any nursing home subsequently exempted from the resident day user fee due to the waiver of federal requirements pursuant to section **[**81 of this act**]** 82 of public act 05-251 and the effective date of such waiver, (B) any nursing home licensed for more than two hundred thirty beds or owned by a municipality and the effective date of any change in its user fee, and (C) any nursing home for which the user fee is retroactively increased pursuant to subsection (b) of this section and the effective date of such increase. The Commissioner of Social Services shall provide notice of any such retroactive user fee increase to each nursing home so affected.

(2) Upon being notified by the Commissioner of Social Services, the commissioner shall refund or credit to any nursing home subsequently exempted from the resident day user fee due to the waiver of federal requirements pursuant to section **[**81 of this act**]** 82 of public act 05-251 any resident day user fee collected from such home. No interest shall be payable on the amount of such refund or credit. Any such nursing home shall refund any fees paid by or on behalf of any resident to the party making such payment.

(3) Upon being notified by the Commissioner of Social Services, the commissioner shall refund or credit to any nursing home licensed for more than two hundred thirty beds or owned by a municipality any resident day user fee collected from such home in excess of the resident day user fee that would have been payable had the user fee, as redetermined by the Commissioner of Social Services, been used in calculating the nursing home's resident day user fee. No interest shall be payable on the amount of such refund or credit.

(4) Upon being notified by the Commissioner of Social Services, the commissioner shall notify any nursing home for which the user fee is retroactively increased pursuant to subsection (b) of this section of the

additional amount of resident day user fee due and owing from such nursing home. Such a notice of additional amount due and owing to the commissioner shall not be treated as a notice of deficiency assessment by the commissioner nor shall the nursing home have, based on such notice of additional amount due, any right of protest or appeal to the commissioner as in the case of such a deficiency assessment. No interest shall be payable on such additional amount to the extent such additional amount is paid on or before the last day of the month next succeeding the month during which the Commissioner of Social Services provided notice of such retroactive user fee increase to such nursing home.

Sec. 49. Subdivision (4) of subsection (f) of section 17b-340 of the general statutes, as amended by section 81 of public act 05-251, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(4) For the fiscal year ending June 30, 1992, (A) no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1991; (B) no facility whose rate, if determined pursuant to this subsection, would exceed one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is five and one-half per cent more than the rate it received for the rate year ending June 30, 1991; and (C) no facility whose rate, if determined pursuant to this subsection, would be less than one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is six and one-half per cent more than the rate it received for the rate year ending June 30, 1991. For the fiscal year ending June 30, 1993, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1992, or six per cent more than the rate it received for the rate year ending June 30, 1992. For the fiscal year ending June 30, 1994, no facility shall receive a rate that is less than the

rate it received for the rate year ending June 30, 1993, or six per cent more than the rate it received for the rate year ending June 30, 1993. For the fiscal year ending June 30, 1995, no facility shall receive a rate that is more than five per cent less than the rate it received for the rate year ending June 30, 1994, or six per cent more than the rate it received for the rate year ending June 30, 1994. For the fiscal years ending June 30, 1996, and June 30, 1997, no facility shall receive a rate that is more than three per cent more than the rate it received for the prior rate year. For the fiscal year ending June 30, 1998, a facility shall receive a rate increase that is not more than two per cent more than the rate that the facility received in the prior year. For the fiscal year ending June 30, 1999, a facility shall receive a rate increase that is not more than three per cent more than the rate that the facility received in the prior year and that is not less than one per cent more than the rate that the facility received in the prior year, exclusive of rate increases associated with a wage, benefit and staffing enhancement rate adjustment added for the period from April 1, 1999, to June 30, 1999, inclusive. For the fiscal year ending June 30, 2000, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 1999, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2000, shall receive a rate increase equal to one per cent applied to the rate the facility received for the fiscal year ending June 30, 1999, exclusive of the facility's wage, benefit and staffing enhancement rate adjustment. For the fiscal year ending June 30, 2000, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2000, shall receive a rate increase that is more than one per cent more than the rate the facility received in the fiscal year ending June 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 2000, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June

30, 2001, shall receive a rate increase equal to two per cent applied to the rate the facility received for the fiscal year ending June 30, 2000, subject to verification of wage enhancement adjustments pursuant to subdivision (15) of this subsection. For the fiscal year ending June 30, 2001, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2001, shall receive a rate increase that is more than two per cent more than the rate the facility received for the fiscal year ending June 30, 2000. For the fiscal year ending June 30, 2002, each facility shall receive a rate that is two and one-half per cent more than the rate the facility received in the prior fiscal year. For the fiscal year ending June 30, 2003, each facility shall receive a rate that is two per cent more than the rate the facility received in the prior fiscal year, except that such increase shall be effective January 1, 2003, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until December 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate increased two per cent effective June 1, 2003. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until December 31, 2004, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective January 1, 2005, each facility shall receive a rate that is one per cent greater than the rate in effect

December 31, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in this subdivision, but in no event earlier than July 1, 2005, and provided the user fee imposed under section 78 of **[**this act**]** public act 05-251 is required to be collected, for the fiscal year ending June 30, 2006, the department shall compute the rate for each facility based upon its 2003 cost report filing or, a subsequent cost year filing for facilities having an interim rate for the period ending June 30, 2005 as provided under Section 17-311-55 of the Regulations of Connecticut State Agencies. For each facility not having an interim rate for the period ending June 30, 2005, the rate for the period ending June 30, 2006 shall be determined beginning with the higher of the computed rate based upon its 2003 cost report filing or the rate in effect for the period ending June 30, 2005. Such rate shall then be increased by $11.80 per day except that in no event shall the rate for the period ending June 30, 2006 be $32.00 more than the rate in effect for the period ending June 30, 2005 and for any facility with a rate below $195.00 per day for the period ending June 30, 2005 such rate for the period ending June 30, 2006 shall not be greater than $217.43 per day and for any facility with a rate equal to or greater than $195.00 per day for the period ending June 30, 2005 such rate for the period ending June 30, 2006 shall not exceed the rate in effect for the period ending June 30, 2005 increased by eleven and one-half per cent. For each facility with an interim rate for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006 shall not exceed the rate in effect for the period ending June 30, 2005 increased by $11.80 per day plus the per day cost of the user fee payments made pursuant to **[**Section**]** section 78 of **[**this act**]** public act 05-251 divided by annual resident service days, except for any facility with an interim rate below $195.00 per day for the period ending June 30, 2005 the interim replacement rate for the period ending June 30, 2006 shall not be greater than $217.43 per day and for any facility with an interim rate equal to or greater than $195.00 per day for the period

ending June 30, 2005 the interim replacement rate for the period ending June 30, 2006 shall not exceed the rate in effect for the period ending June 30, 2005 increased by eleven and one-half per cent. Such July 1, 2005, rate adjustments shall remain in effect unless (i) the federal financial participation matching funds associated with the rate increase are no longer available; or (ii) the user fee created pursuant to section 78 of public act 05-251 is not in effect. For fiscal year ending June 30, 2007, all facility rates in effect for the period ending June 30, 2006, shall remain in effect, except for any facility that would been issued a lower rate effective July 1, 2006, than for the rate period ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. The Commissioner of Social Services shall add fair rent increases to any other rate increases established pursuant to this subdivision for a facility which has undergone a material change in circumstances related to fair rent. Interim rates may take into account reasonable costs incurred by a facility, including wages and benefits.

Sec. 50. Section 82 of public act 05-251 is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

Not later than fifteen days after approval of the Medicaid state plan amendment required to implement section 81 of **[**this act**]** public act 05-251, the Commissioner of Social Services shall seek approval from the Centers for Medicare and Medicaid Services for, and shall file a provider user fee uniformity waiver request regarding, the user fee set forth in **[**this act**]** public act 05-251. The request for approval shall include a request for a waiver of federal requirements for uniform and broad-based user fees in accordance with 42 CFR 433.68, to (1) exempt from the user fee prescribed by section 78 of **[**this act**]** public act 05-251 any **[**nursing facility owned by an entity that provides continuing care in exchange for a transfer of assets or an entrance fee in addition to or in lieu of periodic payments, regardless of whether such nursing

facility participates in the Medicaid program**]** nursing home that is owned and operated as of May 1, 2005, by the legal entity that is registered as a continuing care facility with the Department of Social Services, in accordance with section 17b-521, regardless of whether such nursing home participants in the Medicaid program and any nursing home licensed after May 1, 2005, that is owned and operated by the legal entity that is registered as a continuing care facility with the Department of Social Services in accordance with section 17b-521; and (2) impose a user fee in an amount less than the fee determined pursuant to section 78 of **[**this act**]** public act 05-251 as necessary to meet the requirements of 42 CFR 433.68(e)(2) on (A) nursing homes owned by a municipality and (B) nursing homes licensed for more than 230 beds. Notwithstanding any section of the general statutes, the provisions of section 17b-8 of the general statutes shall not apply to the waiver sought pursuant to this section.

Sec. 51. Subdivision (1) of subsection (h) of section 17b-340 of the general statutes, as amended by section 84 of public act 05-251, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(h) (1) For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate in excess of one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate that is less than one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to sixty-five per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred thirty per cent of the

median of operating cost components in effect January 1, 1992. Beginning with the fiscal year ending June 30, 1993, for the purpose of determining allowable fair rent, a residential care home with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Beginning with the fiscal year ending June 30, 1997, a residential care home with allowable fair rent less than three dollars and ten cents per day shall be reimbursed as having allowable fair rent equal to three dollars and ten cents per day. Property additions placed in service during the cost year ending September 30, 1996, or any succeeding cost year shall receive a fair rent allowance for such additions as an addition to three dollars and ten cents per day if the fair rent for the facility for property placed in service prior to September 30, 1995, is less than or equal to three dollars and ten cents per day. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. Beginning with the fiscal year ending June 30, 1997, minimum allowable patient days for rate computation purposes for a residential care home with twenty-five beds or less shall be eighty-five per cent of licensed capacity. Beginning with the fiscal year ending June 30, 2002, for the purposes of determining the allowable salary of an administrator of a residential care home with sixty beds or less the department shall revise the allowable base salary to thirty-seven thousand dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies. The rates for the fiscal year ending June 30, 2002, shall be based upon the increased allowable salary of an administrator,

regardless of whether such amount was expended in the 2000 cost report period upon which the rates are based. Beginning with the fiscal year ending June 30, 2000, the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall be increased by two per cent, and beginning with the fiscal year ending June 30, 2002, the inflation adjustment for rates made in accordance with subsection (c) of said section shall be increased by one per cent. Beginning with the fiscal year ending June 30, 1999, for the purpose of determining the allowable salary of a related party, the department shall revise the maximum salary to twenty-seven thousand eight hundred fifty-six dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies and beginning with the fiscal year ending June 30, 2001, such allowable salary shall be computed on an hourly basis and the maximum number of hours allowed for a related party other than the proprietor shall be increased from forty hours to forty-eight hours per work week. For the fiscal year ending June 30, 2005, each facility shall receive a rate that is two and one-quarter per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, as amended by this act, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 78 of **[**this act**]** public act 05-251 is required to be collected, each facility shall receive a rate that is **[**four per cent more than the rate the facility received in the prior fiscal year**]** determined in accordance with applicable law and subject to appropriations, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June

30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (A) The federal financial participation matching funds associated with the rate increase are no longer available; or (B) the user fee created pursuant to section 78 of **[**this act**]** public act 05-251 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006.

Sec. 52. Section 85 of public act 05-251 is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

For the fiscal year ending June 30, 2006, any nursing home that receives a net gain in revenue **[**shall apply at least eighty five per cent of such net gain to increased employee wage rates and benefits and additional direct and indirect component staffing. Such net gain**]** shall not be applied to wage and salary increases provided to the administrator, assistant administrator, owners or related party employees. For the purposes of this section, "net gain in revenue" means the difference between the rate in effect June 30, 2005, and the rate in effect on July 1, 2005, multiplied by the number of resident days eligible for state payment for the period between July 1, 2005, and June 30, 2006, less **[**state revenue taxes**]** resident day user fees accrued for the period between July 1, 2005, and June 30, 2006. The Commissioner of Social Services **[**shall**]** may compare expenditures for wages, **[**benefits and staffing**]** and salary increases provided to administrators, assistant administrators, owners or related party employees for the fiscal year ending June 30, 2006, **[**exclusive of administrator, assistant administrator, owners or related party employee expenditures,**]** to such expenditures in the year ending June 30, 2005, to verify **[**whether

a facility has applied at least eighty five per cent of its net gain to specified wage, benefit and staffing enhancements**]** compliance with this section. In the event that the commissioner determines that a facility did **[**not**]** apply **[**at least eighty five per cent of its net gain to such specified enhancements**]** its net gain in revenue to wage and salary increases for administrators, assistant administrators, owners or related party employees, the commissioner shall recover such amounts from the facility through rate adjustments or other means. The commissioner may require facilities to file cost reporting forms, in addition to the annual cost report, as may be necessary, to verify the appropriate application of any net gain.

Sec. 53. (NEW) (*Effective January 1, 2007*) (a) There is established a Department on Aging which shall be under the direction and supervision of the Commissioner on Aging who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, of the general statutes with the powers and duties prescribed in said sections. The commissioner shall be knowledgeable and experienced with respect to the conditions and needs of elderly persons and shall serve on a full-time basis.

(b) The Commissioner on Aging shall administer all laws under the jurisdiction of the Department on Aging and shall employ the most efficient and practical means for the provision of care and protection of elderly persons. The commissioner shall have the power and duty to do the following: (1) Administer, coordinate and direct the operation of the department; (2) adopt and enforce regulations, in accordance with chapter 54 of the general statutes, as necessary to implement the purposes of the department as established by statute; (3) establish rules for the internal operation and administration of the department; (4) establish and develop programs and administer services to achieve the purposes of the department; (5) contract for facilities, services and programs to implement the purposes of the department; (6) act as

advocate for necessary additional comprehensive and coordinated programs for elderly persons; (7) assist and advise all appropriate state, federal, local and area planning agencies for elderly persons in the performance of their functions and duties pursuant to federal law and regulation; (8) plan services and programs for elderly persons; (9) coordinate outreach activities by public and private agencies serving elderly persons; and (10) consult and cooperate with area and private planning agencies.

(c) The functions, powers, duties and personnel of the Division of Elderly Services of the Department of Social Services, or any subsequent division or portion of a division with similar functions, powers, personnel and duties, shall be transferred to the Department on Aging pursuant to the provisions of sections 4-38d, 4-38e and 4-39 of the general statutes.

(d) Any order or regulation of the Department of Social Services or the Commission on Aging that is in force on January 1, 2007, shall continue in force and effect as an order or regulation until amended, repealed or superseded pursuant to law.

Sec. 54. (*Effective July 1, 2005*) (a) There is established a task force to study the reestablishment of the Department on Aging pursuant to this act. The task force shall study the provisions of this act and shall make recommendations on revisions to the general statutes and other changes necessary or advisable to implement the provisions of this act.

(b) The task force shall consist of the following members:

(1) One appointed by the speaker of the House of Representatives;

(2) One appointed by the president pro tempore of the Senate;

(3) One appointed by the majority leader of the House of Representatives;

(4) One appointed by the majority leader of the Senate;

(5) One appointed by the minority leader of the House of Representatives;

(6) One appointed by the minority leader of the Senate;

(7) The chairpersons, vice chairpersons and ranking members of the select committee of the General Assembly having cognizance of matters relating to aging;

(8) Two appointed by the Governor;

(9) The Secretary of the Office of Policy and Management, or the secretary's designee; and

(10) The Commissioners of Social Services, Public Health, Mental Health and Addiction Services and Transportation and the Chief State's Attorney, or their designees.

(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to the task force shall be made no later than thirty days after the effective date of this section. If an appointment is not made by the expiration of said thirty-day period, the chairpersons, vice-chairpersons and ranking members of the select committee of the General Assembly having cognizance of matters relating to aging may make the appointment. Any vacancy shall be filled by the appointing authority.

(e) The speaker of the House of Representatives and the president pro tempore of the Senate shall jointly with the Governor select the chairpersons of the task force, from among the members of the task force. Such chairpersons shall schedule the first meeting of the task

force, which shall be held no later than sixty days after the effective date of this section.

(f) The administrative staff of the select committee of the General Assembly having cognizance of matters relating to aging shall serve as administrative staff of the task force.

(g) Not later than February 15, 2006, the task force shall submit a report on its findings and recommendations to the select committee of the General Assembly having cognizance of matters relating to aging, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2007, whichever is earlier.

Sec. 55. (*Effective from passage*) During the fiscal year ending June 30, 2006, the Commissioner of Social Services shall, within existing budgetary resources, in an amount not to exceed one hundred thousand dollars, provide grants not to exceed twenty-five thousand dollars for each grant, to four municipalities with populations of twenty-five thousand or more, or to a nonprofit organization located within any such municipality. Such grants shall be used by such municipality or nonprofit organization to develop and plan financially self-sustaining community-based regional transportation systems that, through a combination of private donations and user fees, provide transportation services on behalf of elderly persons. Prior to the disbursement of any grant made pursuant to this section, a municipality selected to receive such grant shall demonstrate to the satisfaction of the commissioner, that such municipality has secured additional private funds, in an amount of not less than twenty-five thousand dollars that shall be used to develop and plan financially self-sustaining community-based regional transportation systems. Any municipality selected to receive a grant pursuant to this section shall, to the extent practicable, model such community-based regional transportation system on the ITNAmerica model and shall work

cooperatively with the regional planning agency of which the municipality is a member in planning and developing such community-based regional transportation system.

Sec. 56. Section 8-3e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) No zoning regulation shall treat the following in a manner different from any single family residence: (1) Any community residence **[**which**]** that houses six or fewer mentally retarded persons and necessary staff persons and **[**which**]** that is licensed under the provisions of section 17a-227, **[**or**]** (2) any child-care residential facility **[**which**]** that houses six or fewer children with mental or physical disabilities and necessary staff persons and **[**which**]** that is licensed under sections 17a-145 to 17a-151, inclusive, or (3) any community residence that houses six or fewer persons receiving mental health or addiction services and necessary staff persons paid for or provided by the Department of Mental Health and Addiction Services and that has been issued a license by the Department of Public Health under the provisions of section 19a-491, if a license is required.

(b) Any resident of a municipality in which such a community residence or child-care residential facility is located may, with the approval of the legislative body of such municipality, petition (1) the Commissioner of Mental Retardation to revoke the license of such community residence on the grounds that such community residence is not in compliance with the provisions of any statute or regulation concerning the operation of such residences, **[**or**]** (2) the Commissioner of Children and Families to revoke the license of such child-care residential facility on the grounds that such child-care residential facility is not in compliance with the provision of any general statute or regulation concerning the operation of such child-care residential facility, or (3) the Commissioner of Mental Health and Addiction Services to withdraw funding from such community residence on the

grounds that such community residence is not in compliance with the provisions of any general statute or regulation adopted thereunder concerning the operation of a community residence.

Sec. 57. (NEW) (*Effective July 1, 2005*) (a) There is established a board of directors to advise the Department of Public Health on the operations of the critical access hospital. The board shall consist of the following members: The Commissioners of Public Health, Emergency Management and Homeland Security, Public Safety and Social Services, or their designees, the Secretary of the Office of Policy and Management, or the secretary's designee, the Adjutant General, or the Adjutant General's designee, one representative of a hospital in this state with more than five hundred licensed beds and one representative of a hospital in this state with five hundred or fewer licensed beds, both appointed by the Commissioner of Public Health. The Commissioner of Public Health shall be the chairperson of the board. The board shall adopt bylaws and shall meet at such times as specified in such bylaws and at such other times as the Commissioner of Public Health deems necessary.

(b) The board shall advise the department on matters, including, but not limited to: Operating policies and procedures; facility deployment and operation; appropriate utilization of the facility; clinical programs and delivery of patient health care services; hospital staffing patterns and staff-to-patient ratios; human resources policies; standards and accreditation guidelines; credentialing of clinical and support staff; patient admission, transfer and discharge policies and procedures; quality assurance and performance improvement; patient rates and billing and reimbursement mechanisms; staff education and training requirements and alternative facility uses.

Sec. 58. Subsection (a) of section 19a-638 of the general statutes, as amended by section 1 of public act 05-93, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) Except as provided in sections 19a-639a to 19a-639c, inclusive, and section 59 of this act:

(1) Each health care facility or institution, that intends to (A) transfer all or part of its ownership or control, (B) change the governing powers of the board of a parent company or an affiliate, whatever its designation, or (C) change or transfer the powers or control of a governing or controlling body of an affiliate, shall submit to the office, prior to the proposed date of such transfer or change, a request for permission to undertake such transfer or change.

(2) Each health care facility or institution or state health care facility or institution, including any inpatient rehabilitation facility, which intends to introduce any additional function or service into its program of health care shall submit to the office, prior to the proposed date of the institution of such function or service, a request for permission to undertake such function or service.

(3) Each health care facility or institution or state health care facility or institution which intends to terminate a health service offered by such facility or institution or reduce substantially its total bed capacity, shall submit to the office, prior to the proposed date of such termination or decrease, a request to undertake such termination or decrease.

(4) Except as provided in sections 19a-639a to 19a-639c, inclusive, each applicant, prior to submitting a certificate of need application under this section, section 19a-639 or under both sections, shall submit a request, in writing, for application forms and instructions to the office. The request shall be known as a letter of intent. A letter of intent shall include: (A) The name of the applicant or applicants; (B) a statement indicating whether the application is for (i) a new, replacement or additional facility, service or function, (ii) the expansion or relocation of an existing facility, service or function, (iii) a

change in ownership or control, (iv) a termination of a service or a reduction in total bed capacity and the bed type, (v) any new or additional beds and their type, (vi) a capital expenditure over one million dollars, (vii) the purchase, lease or donation acceptance of major medical equipment costing over four hundred thousand dollars, (viii) a CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment, a linear accelerator or other similar equipment utilizing technology that is new or being introduced into the state, or (ix) any combination thereof; (C) the estimated capital cost, value or expenditure; (D) the town where the project is or will be located; and (E) a brief description of the proposed project. The office shall provide public notice of any complete letter of intent submitted under this section, section 19a-639, or both, by publication in a newspaper having a substantial circulation in the area served or to be served by the applicant. Such notice shall be submitted for publication not later than fifteen business days after a determination that a letter of intent is complete. No certificate of need application will be considered submitted to the office unless a current letter of intent, specific to the proposal and in compliance with this subsection, has been on file with the office at least sixty days. A current letter of intent is a letter of intent that has been on file at the office up to and including one hundred twenty days, except that an applicant may request a one-time extension of a letter of intent of up to an additional thirty days for a maximum total of up to one hundred fifty days if, prior to the expiration of the current letter of intent, the office receives a written request to so extend the letter of intent's current status. The extension request shall fully explain why an extension is requested. The office shall accept or reject the extension request not later than five business days from the date it receives such request and shall so notify the applicant.

Sec. 59. (NEW) (*Effective July 1, 2005*) Any additional critical access hospital beds and related equipment obtained for the purpose of

enhancing the state's bed surge capacity or providing isolation care under the state's public health preparedness planning and response activities shall be exempt from the provisions of subdivision (2) of subsection (a) of section 19a-638 of the general statutes, as amended by this act.

Sec. 60. Section 19a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

As used in this chapter and sections 57, 59 and 64 to 67, inclusive, of this act:

(a) "Institution" means a hospital, residential care home, health care facility for the handicapped, nursing home, rest home, home health care agency, homemaker-home health aide agency, mental health facility, substance abuse treatment facility, outpatient surgical facility, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency, except facilities for the care or treatment of mentally ill persons or persons with substance abuse problems; and a residential facility for the mentally retarded licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for the mentally retarded;

(b) "Hospital" means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals;

(c) "Residential care home", "nursing home" or "rest home" means an establishment which furnishes, in single or multiple facilities, food and

shelter to two or more persons unrelated to the proprietor and, in addition, provides services which meet a need beyond the basic provisions of food, shelter and laundry;

(d) "Home health care agency" means a public or private organization, or a subdivision thereof, engaged in providing professional nursing services and the following services, available twenty-four hours per day, in the patient's home or a substantially equivalent environment: Homemaker-home health aide services as defined in this section, physical therapy, speech therapy, occupational therapy or medical social services. The agency shall provide professional nursing services and at least one additional service directly and all others directly or through contract. An agency shall be available to enroll new patients seven days a week, twenty-four hours per day;

(e) "Homemaker-home health aide agency" means a public or private organization, except a home health care agency, which provides in the patient's home or a substantially equivalent environment supportive services which may include, but are not limited to, assistance with personal hygiene, dressing, feeding and incidental household tasks essential to achieving adequate household and family management. Such supportive services shall be provided under the supervision of a registered nurse and, if such nurse determines appropriate, shall be provided by a social worker, physical therapist, speech therapist or occupational therapist. Such supervision may be provided directly or through contract;

(f) "Homemaker-home health aide services" as defined in this section shall not include services provided to assist individuals with activities of daily living when such individuals have a disease or condition that is chronic and stable as determined by a physician licensed in the state of Connecticut;

(g) "Mental health facility" means any facility for the care or treatment of mentally ill or emotionally disturbed adults, or any mental health outpatient treatment facility that provides treatment to persons sixteen years of age or older who are receiving services from the Department of Mental Health and Addiction Services, but does not include family care homes for the mentally ill;

(h) "Alcohol or drug treatment facility" means any facility for the care or treatment of persons suffering from alcoholism or other drug addiction;

(i) "Person" means any individual, firm, partnership, corporation, limited liability company or association;

(j) "Commissioner" means the Commissioner of Public Health;

(k) "Home health agency" means an agency licensed as a home health care agency or a homemaker-home health aide agency; **[**and**]**

(l) "Assisted living services agency" means an institution that provides, among other things, nursing services and assistance with activities of daily living to a population that is chronic and stable; and

(m) "Critical access hospital" means a facility used intermittently, deployed at the discretion of the Governor, or the Governor's designee, for the purpose of training or in the event of a public health or other emergency for isolation care purposes or triage and treatment during a mass casualty event.

Sec. 61. Section 19a-630 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

As used in this chapter:

(1) "Health care facility or institution" means any facility or institution engaged primarily in providing services for the prevention,

diagnosis or treatment of human health conditions, including, but not limited to: Outpatient clinics; outpatient surgical facilities; imaging centers; home health agencies, critical access hospital as defined in section 19a-490, as amended by this act; clinical laboratory or central service facilities serving one or more health care facilities, practitioners or institutions; hospitals; nursing homes; rest homes; nonprofit health centers; diagnostic and treatment facilities; rehabilitation facilities; and mental health facilities. "Health care facility or institution" includes any parent company, subsidiary, affiliate or joint venture, or any combination thereof, of any such facility or institution, but does not include any health care facility operated by a nonprofit educational institution solely for the students, faculty and staff of such institution and their dependents, or any Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(2) "State health care facility or institution" means a hospital or other such facility or institution operated by the state providing services which are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC Section 301 et seq., as amended.

(3) "Office" means the Office of Health Care Access.

(4) "Commissioner" means the Commissioner of Health Care Access.

(5) "Person" has the meaning assigned to it in section 4-166.

Sec. 62. (NEW) (*Effective July 1, 2005*) There is established a critical access hospital account which shall be a separate, nonlapsing account within the General Fund. Moneys in the account shall be used by the Department of Social Services to fund the operations of the critical access hospital in the event of an activation. The account shall contain all moneys required by law to be deposited in the account.

Sec. 63. (*Effective July 1, 2005*) (a) The sum of one dollar is

appropriated to the Department of Social Services, from the General Fund, for the fiscal year ending June 30, 2006, for deposit in the account established pursuant to section 62 of this act.

(b) The sum of one dollar is appropriated to the Department of Social Services, from the General Fund, for the fiscal year ending June 30, 2007, for deposit in the account established pursuant to section 62 of this act.

Sec. 64. (NEW) (*Effective July 1, 2005*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1) to (13), inclusive, of section 38a-469 of the general statutes, delivered, issued for delivery, renewed, amended or continued in the state on or after July 1, 2005, shall provide benefits for isolation care and emergency services provided by the state's critical access hospital. Such benefits shall be subject to any policy provisions which apply to other services covered by such policy. The rates paid by individual health insurance policies pursuant to this section shall be equal to the rates paid under the Medicaid program, as determined by the Department of Social Services.

Sec. 65. (NEW) (*Effective July 1, 2005*) Each group health insurance policy providing coverage of the type specified in subdivisions (1) to (13), inclusive, of section 38a-469 of the general statutes, delivered, issued for delivery, renewed, amended or continued in the state on or after July 1, 2005, shall provide benefits for isolation care and emergency services provided by the state's critical access hospital. Such benefits shall be subject to any policy provisions which apply to other services covered by such policy. The rates paid by group health insurance policies pursuant to this section shall be equal to the rates paid under the Medicaid program, as determined by the Department of Social Services.

Sec. 66. (NEW) (*Effective July 1, 2005*) The Commissioner of Social

Services shall provide coverage for isolation care and emergency services provided by the state's critical access hospital to persons participating in the Husky Plan Part A and Part B and fee for services Medicaid programs under chapter 319v of the general statutes.

Sec. 67. (NEW) (*Effective July 1, 2005*) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54 of the general statutes, to implement critical access hospital policies and procedures for isolation care and emergency services.

Sec. 68. (*Effective from passage*) (a) The Commissioner of Public Health, in conjunction with the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health, shall convene a working group to study whether the state should contract for the development of a program or enter into an existing program, that allows Connecticut residents to purchase prescription drugs through pharmacies located in Canada or other countries. The working group shall include, but not be limited to, the Commissioner of Public health, or the commissioner's designee, the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health, or their designees, the Attorney General or the Attorney General's designee, a representative of the Office of Policy and Management and any other person the Commissioner of Public Health and the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health deem necessary.

(b) The study shall include (1) an evaluation of any new or existing prescription drug program that would allow Connecticut residents to purchase prescription drugs through pharmacies located in Canada or other countries (A) for the purpose of assessing whether the program would meet all of the current levels of safety and quality assurance afforded Connecticut residents with respect to the purchase of prescription drugs and whether the program would provide

Connecticut residents who enroll in the program access to more affordable prescription drugs, and (B) to assess whether Connecticut residents would be required to compromise any legal rights as a condition of participating in the program, and (2) an examination of, and recommendations about, the parameters of a request for proposal to solicit the implementation of such prescription drug program in Connecticut.

(c) The Commissioner of Public Health may enter into contracts with consultants to assist in the completion of the study authorized by this section.

(d) Not later than January 1, 2006, the Commissioner of Public Health shall submit, in accordance with the provisions of section 11-4a of the general statutes, a report of the working group's findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies.

Sec. 69. (NEW) (*Effective October 1, 2005*) As used in sections 69 to 71, inclusive, of this act and subsection (c) of section 19a-14 of the general statutes, as amended by this act:

(1) "Commissioner" means the Commissioner of Public Health.

(2) "Department" means the Department of Public Health.

(3) "Extracorporeal circulation" means the diversion of a patient's blood through a heart-lung machine or a similar device that assumes the functions of the patient's heart, lungs, kidney, liver or other organs.

(4) "Perfusion" means the functions necessary for the support, treatment, measurement or supplementation of the cardiovascular, circulatory or respiratory system or other organs, or a combination of such activities, and to ensure the safe management of physiologic

functions by monitoring and analyzing the parameters of the systems under an order and under the supervision of a licensed physician, including, but not limited to:

(A) The use of extracorporeal circulation, long-term cardiopulmonary support techniques including extracorporeal carbon-dioxide removal and extracorporeal membrane oxygenation and associated therapeutic and diagnostic technologies;

(B) Counterpulsation, ventricular assistance, autotransfusion, blood conservation techniques, myocardial and organ preservation, extracorporeal life support and isolated limb perfusion;

(C) The use of techniques involving blood management, advanced life support and other related functions; and

(D) In the performance of the following activities:

(i) The administration of pharmacological and therapeutic agents, or blood products or anesthetic agents through the extracorporeal circuit or through an intravenous line as ordered by a physician;

(ii) The performance and use of anticoagulation monitoring and analysis; physiologic monitoring and analysis; blood gas and chemistry monitoring and analysis; hematologic monitoring and analysis; hypothermia; hyperthermia; hemoconcentration and hemodilution; or modified extracorporeal circulatory hemodialysis; or

(iii) The observation of signs and symptoms related to perfusion services, the determination of whether the signs and symptoms exhibit abnormal characteristics, and the implementation of appropriate reporting, perfusion protocols, or changes in or the initiation of emergency procedures.

(5) "Perfusionist" means a person who is licensed to practice

perfusion pursuant to the provisions of sections 48 to 50, inclusive, of this act.

(6) "Direct supervision" means a supervising physician is physically present in the location where the perfusionist trainee is performing routine perfusion functions.

Sec. 70. (NEW) (*Effective October 1, 2005*) (a) No person shall practice perfusion in this state unless the person holds a valid license from the department to practice perfusion in this state. No person shall use the title "perfusionist" or make use of any title, words, letters or abbreviations that may reasonably be confused with licensure as a perfusionist unless such person holds a valid license from the department to practice perfusion in this state.

(b) Each person seeking licensure to practice perfusion in this state shall make application on forms prescribed by the department, pay an application fee of two hundred fifty dollars and present to the department satisfactory evidence that such person (1) successfully completed a perfusion education program with standards established by the Accreditation Committee for Perfusion Education and approved by the Commission on Accreditation of Allied Health Education Programs; (2) completed a minimum of fifty cases after graduating from a perfusion education program accredited or approved pursuant to subdivision (1) of this subsection; and (3) after completing the requirements set forth in subdivision (2) of this subsection, successfully completed the certification examination offered by the American Board of Cardiovascular Perfusion, or its successor. The commissioner shall grant a license as a perfusionist to any applicant who meets the requirements of this subsection.

(c) From the period beginning October 1, 2005, and ending December 31, 2006, an applicant for licensure as a perfusionist may, in lieu of the requirements set forth in subsection (b) of this section,

submit to the department satisfactory evidence that the applicant has (1) actively engaged in the practice of perfusion in this state since October 1, 2005, or earlier, and (2) been operating a cardiopulmonary bypass system during cardiac surgical procedures in a licensed health care facility as part of the applicant's primary job duties since October 1, 2005. The commissioner shall grant a license as a perfusionist to any applicant who meets the requirements of this subsection.

(d) Nothing in this section shall be construed to apply to the activities and services of a person who (1) has successfully completed a perfusion education program that meets the criteria of subdivision (1) of subsection (b) of this section from gaining experience in the practice of perfusion, provided such activities (A) are necessary to satisfy the requirements of subdivision (2) of said subsection (b), (B) are performed under direct supervision, and (C) such person is designated as an intern or trainee or other such title indicating the training status appropriate to such person's level of training, or (2) is enrolled in an accredited perfusion education program and performing such work as is incidental to the course of study.

(e) The provisions of this section do not apply to any practicing physician or surgeon licensed under chapter 370 of the general statutes.

(f) No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint in this or any other state or territory.

(g) Licenses shall be renewed annually in accordance with the provisions of section 19a-88 of the general statutes, as amended by this act, for a fee of two hundred fifty dollars.

Sec. 71. (NEW) (*Effective October 1, 2005*) The Commissioner of

Public Health may take any disciplinary action set forth in section 19a-17 of the general statutes, against a perfusionist for any of the following reasons: (1) Failure to conform to the accepted standards of the profession; (2) conviction of a felony; (3) fraud or deceit in obtaining or seeking reinstatement of a license to practice perfusion; (4) fraud or deceit in the practice of the profession; (5) negligent, incompetent or wrongful conduct in professional activities; (6) physical, mental or emotional illness or disorder resulting in an inability to conform to the accepted standards of the profession; (7) alcohol or substance abuse; (8) wilful falsification of entries in any hospital, patient or other record pertaining to the profession; or (9) violation of any provision of sections 69 to 71, inclusive, of this act. The commissioner may order a license holder to submit to a reasonable physical or mental examination if the physical or mental capacity of the license holder to practice safely is the subject of an investigation. The commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to said section 19a-17. The commissioner shall give notice and an opportunity to be heard on any contemplated action under said section 19a-17.

Sec. 72. Subsection (c) of section 19a-14 of the general statutes, as amended by section 2 of public act 05-66, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(c) No board shall exist for the following professions that are licensed or otherwise regulated by the Department of Public Health:

(1) Speech pathologist and audiologist;

(2) Hearing instrument specialist;

(3) Nursing home administrator;

(4) Sanitarian;

(5) Subsurface sewage system installer or cleaner;

(6) Marital and family therapist;

(7) Nurse-midwife;

(8) Licensed clinical social worker;

(9) Respiratory care practitioner;

(10) Asbestos contractor and asbestos consultant;

(11) Massage therapist;

(12) Registered nurse's aide;

(13) Radiographer;

(14) Dental hygienist;

(15) Dietitian-Nutritionist;

(16) Asbestos abatement worker;

(17) Asbestos abatement site supervisor;

(18) Licensed or certified alcohol and drug counselor;

(19) Professional counselor;

(20) Acupuncturist;

(21) Occupational therapist and occupational therapist assistant;

(22) Lead abatement contractor, lead consultant contractor, lead consultant, lead abatement supervisor, lead abatement worker, inspector and planner-project designer;

(23) Emergency medical technician, emergency medical technician-

intermediate, medical response technician and emergency medical services instructor;

(24) Paramedic; **[**and**]**

(25) Dialysis patient care technician; and

(26) Perfusionist.

The department shall assume all powers and duties normally vested with a board in administering regulatory jurisdiction over such professions. The uniform provisions of this chapter and chapters 368v, 369 to 381a, inclusive, 383 to 388, inclusive, 393a, 395, 398, 399, 400a and 400c, including, but not limited to, standards for entry and renewal; grounds for professional discipline; receiving and processing complaints; and disciplinary sanctions, shall apply, except as otherwise provided by law, to the professions listed in this subsection.

Sec. 73. Subsection (c) of section 19a-14 of the general statutes, as amended by section 8 of public act 00-226 and section 3 of public act 05-66, is repealed and the following is substituted in lieu thereof (*Effective on and after the later of October 1, 2000, or the date notice is published by the Commissioner of Public Health in the Connecticut Law Journal indicating that the licensing of athletic trainers and physical therapist assistants is being implemented by the commissioner*):

(c) No board shall exist for the following professions that are licensed or otherwise regulated by the Department of Public Health:

(1) Speech pathologist and audiologist;

(2) Hearing instrument specialist;

(3) Nursing home administrator;

(4) Sanitarian;

(5) Subsurface sewage system installer or cleaner;

(6) Marital and family therapist;

(7) Nurse-midwife;

(8) Licensed clinical social worker;

(9) Respiratory care practitioner;

(10) Asbestos contractor and asbestos consultant;

(11) Massage therapist;

(12) Registered nurse's aide;

(13) Radiographer;

(14) Dental hygienist;

(15) Dietitian-Nutritionist;

(16) Asbestos abatement worker;

(17) Asbestos abatement site supervisor;

(18) Licensed or certified alcohol and drug counselor;

(19) Professional counselor;

(20) Acupuncturist;

(21) Occupational therapist and occupational therapist assistant;

(22) Lead abatement contractor, lead consultant contractor, lead consultant, lead abatement supervisor, lead abatement worker, inspector and planner-project designer;

(23) Emergency medical technician, emergency medical technician-

intermediate, medical response technician and emergency medical services instructor;

(24) Paramedic;

(25) Athletic trainer; **[**and**]**

(26) Dialysis patient care technician; and

(27) Perfusionist.

The department shall assume all powers and duties normally vested with a board in administering regulatory jurisdiction over such professions. The uniform provisions of this chapter and chapters 368v, 369 to 381a, inclusive, 383 to 388, inclusive, 393a, 395, 398, 399, 400a and 400c, including, but not limited to, standards for entry and renewal; grounds for professional discipline; receiving and processing complaints; and disciplinary sanctions, shall apply, except as otherwise provided by law, to the professions listed in this subsection.

Sec. 74. Subsection (e) of section 19a-88 of the general statutes is amended by adding subdivision (5) as follows (*Effective October 1, 2005*):

(NEW) (5) Each person holding a license issued pursuant to section 70 of this act shall, annually, during the month of such person's birth, apply for renewal of such license to the Department of Public Health, upon payment of a fee of two hundred fifty dollars, giving such person's name in full, such person's residence and business address and such other information as the department requests.

Sec. 75. Subsection (e) of section 19a-88 of the general statutes, as amended by section 9 of public act 00-226, is amended by adding subdivision (5) as follows (*Effective on and after the later of October 1, 2000, or the date notice is published by the Commissioner of Public Health in*

the Connecticut Law Journal indicating that the licensing of athletic trainers and physical therapist assistants is being implemented by the commissioner):

(NEW) (5) Each person holding a license issued pursuant to section 70 of this act shall, annually, during the month of such person's birth, apply for renewal of such license to the Department of Public Health, upon payment of a fee of two hundred fifty dollars, giving such person's name in full, such person's residence and business address and such other information as the department requests.

Sec. 76. Section 20-9 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(a) No person shall, for compensation, gain or reward, received or expected, diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease, actual or imaginary, of another person, nor practice surgery, until he has obtained such a license as provided in section 20-10, and then only in the kind or branch of practice stated in such license.

(b) The provisions of this chapter shall not apply to:

(1) Dentists while practicing dentistry only;

(2) Any person in the employ of the United States government while acting in the scope of his employment;

(3) Any person who furnishes medical or surgical assistance in cases of sudden emergency;

(4) Any person residing out of this state who is employed to come into this state to render temporary assistance to or consult with any physician or surgeon who has been licensed in conformity with the provisions of this chapter;

(5) Any physician or surgeon residing out of this state who holds a

current license in good standing in another state and who is employed to come into this state to treat, operate or prescribe for any injury, deformity, ailment or disease from which the person who employed such physician, or the person on behalf of whom such physician is employed, is suffering at the time when such nonresident physician or surgeon is so employed, provided such physician or surgeon may practice in this state without a Connecticut license for a period not to exceed thirty consecutive days;

(6) Any person rendering service as (A) an advanced practice registered nurse if such service is rendered in collaboration with a licensed physician, or (B) an advanced practice registered nurse maintaining classification from the American Association of Nurse Anesthetists if such service is under the direction of a licensed physician;

(7) Any nurse-midwife practicing nurse-midwifery in accordance with the provisions of chapter 377;

(8) Any podiatrist licensed in accordance with the provisions of chapter 375;

(9) Any Christian Science practitioner who does not use or prescribe in his practice any drugs, poisons, medicines, chemicals, nostrums or surgery;

(10) Any person licensed to practice any of the healing arts named in section 20-1, who does not use or prescribe in his practice any drugs, medicines, poisons, chemicals, nostrums or surgery;

(11) Any graduate of any school or institution giving instruction in the healing arts who has been issued a permit in accordance with subsection (a) of section 20-11a and who is serving as an intern, resident or medical officer candidate in a hospital;

(12) Any student participating in a clinical clerkship program who has the qualifications specified in subsection (b) of section 20-11a;

(13) Any person, otherwise qualified to practice medicine in this state except that he is a graduate of a medical school located outside of the United States or the Dominion of Canada which school is recognized by the American Medical Association or the World Health Organization, to whom the Connecticut Medical Examining Board, subject to such regulations as the Commissioner of Public Health, with advice and assistance from the board, prescribes, has issued a permit to serve as an intern or resident in a hospital in this state for the purpose of extending his education;

(14) Any person rendering service as a physician assistant licensed pursuant to section 20-12b, a registered nurse, a licensed practical nurse or a paramedic, as defined in subdivision (15) of section 19a-175, acting within the scope of regulations adopted pursuant to section 19a-179, if such service is rendered under the supervision, control and responsibility of a licensed physician;

(15) Any student enrolled in an accredited physician assistant program or paramedic program approved in accordance with regulations adopted pursuant to section 19a-179, who is performing such work as is incidental to his course of study;

(16) Any person who, on June 1, 1993, has worked continuously in this state since 1979 performing diagnostic radiology services and who, as of October 31, 1997, continued to render such services under the supervision, control and responsibility of a licensed physician solely within the setting where such person was employed on June 1, 1993;

(17) Any person performing athletic training as described in section 19a-16a;

(18) When deemed by the Connecticut Medical Examining Board to

be in the public's interest, based on such considerations as academic attainments, specialty board certification and years of experience, to a foreign physician or surgeon whose professional activities shall be confined within the confines of a recognized medical school; **[**or**]**

(19) Any technician engaging in tattooing in accordance with the provisions of section 19a-92a and any regulations adopted thereunder; or

(20) Any person practicing perfusion, as defined in section 69 of this act.

(c) This section shall not authorize anyone to practice optometry, as defined in chapter 380, or to practice dentistry, as defined in chapter 379, or dental hygiene, as defined in chapter 379a.

(d) The provisions of subsection (a) of this section shall apply to any individual whose practice of medicine includes any ongoing, regular or contractual arrangement whereby, regardless of residency in this or any other state, he provides, through electronic communications or interstate commerce, diagnostic or treatment services, including primary diagnosis of pathology specimens, slides or images, to any person located in this state. In the case of electronic transmissions of radiographic images, licensure shall be required for an out-of-state physician who provides, through an ongoing, regular or contractual arrangement, official written reports of diagnostic evaluations of such images to physicians or patients in this state. The provisions of subsection (a) of this section shall not apply to a nonresident physician who, while located outside this state, consults (A) on an irregular basis with a physician licensed by section 20-10 who is located in this state or (B) with a medical school within this state for educational or medical training purposes. Notwithstanding the provisions of this subsection, the provisions of subsection (a) of this section shall not apply to any individual who regularly provides the types of services

described in this subsection pursuant to any agreement or arrangement with a short-term acute care general hospital, licensed by the Department of Public Health, provided such agreement or arrangement was entered into prior to February 1, 1996, and is in effect as of October 1, 1996.

(e) On and after October 1, 1999, any person licensed as an osteopathic physician or osteopath pursuant to chapter 371 shall be deemed licensed as a physician and surgeon pursuant to this chapter.

Sec. 77. Section 20-9 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective on and after the later of October 1, 2000, or the date notice is published by the Commissioner of Public Health in the Connecticut Law Journal indicating that the licensing of athletic trainers and physical therapist assistants is being implemented by the commissioner*):

(a) No person shall, for compensation, gain or reward, received or expected, diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease, actual or imaginary, of another person, nor practice surgery, until he has obtained such a license as provided in section 20-10, and then only in the kind or branch of practice stated in such license.

(b) The provisions of this chapter shall not apply to:

(1) Dentists while practicing dentistry only;

(2) Any person in the employ of the United States government while acting in the scope of his employment;

(3) Any person who furnishes medical or surgical assistance in cases of sudden emergency;

(4) Any person residing out of this state who is employed to come

into this state to render temporary assistance to or consult with any physician or surgeon who has been licensed in conformity with the provisions of this chapter;

(5) Any physician or surgeon residing out of this state who holds a current license in good standing in another state and who is employed to come into this state to treat, operate or prescribe for any injury, deformity, ailment or disease from which the person who employed such physician, or the person on behalf of whom such physician is employed, is suffering at the time when such nonresident physician or surgeon is so employed, provided such physician or surgeon may practice in this state without a Connecticut license for a period not to exceed thirty consecutive days;

(6) Any person rendering service as (A) an advanced practice registered nurse if such service is rendered in collaboration with a licensed physician, or (B) an advanced practice registered nurse maintaining classification from the American Association of Nurse Anesthetists if such service is under the direction of a licensed physician;

(7) Any nurse-midwife practicing nurse-midwifery in accordance with the provisions of chapter 377;

(8) Any podiatrist licensed in accordance with the provisions of chapter 375;

(9) Any Christian Science practitioner who does not use or prescribe in his practice any drugs, poisons, medicines, chemicals, nostrums or surgery;

(10) Any person licensed to practice any of the healing arts named in section 20-1, who does not use or prescribe in his practice any drugs, medicines, poisons, chemicals, nostrums or surgery;

(11) Any graduate of any school or institution giving instruction in the healing arts who has been issued a permit in accordance with subsection (a) of section 20-11a and who is serving as an intern, resident or medical officer candidate in a hospital;

(12) Any student participating in a clinical clerkship program who has the qualifications specified in subsection (b) of section 20-11a;

(13) Any person, otherwise qualified to practice medicine in this state except that he is a graduate of a medical school located outside of the United States or the Dominion of Canada which school is recognized by the American Medical Association or the World Health Organization, to whom the Connecticut Medical Examining Board, subject to such regulations as the Commissioner of Public Health, with advice and assistance from the board, prescribes, has issued a permit to serve as an intern or resident in a hospital in this state for the purpose of extending his education;

(14) Any person rendering service as a physician assistant licensed pursuant to section 20-12b, a registered nurse, a licensed practical nurse or a paramedic, as defined in subdivision (15) of section 19a-175, acting within the scope of regulations adopted pursuant to section 19a-179, if such service is rendered under the supervision, control and responsibility of a licensed physician;

(15) Any student enrolled in an accredited physician assistant program or paramedic program approved in accordance with regulations adopted pursuant to section 19a-179, who is performing such work as is incidental to his course of study;

(16) Any person who, on June 1, 1993, has worked continuously in this state since 1979 performing diagnostic radiology services and who, as of October 31, 1997, continued to render such services under the supervision, control and responsibility of a licensed physician solely

within the setting where such person was employed on June 1, 1993;

(17) Any person practicing athletic training, as defined in section 20-65f;

(18) When deemed by the Connecticut Medical Examining Board to be in the public's interest, based on such considerations as academic attainments, specialty board certification and years of experience, to a foreign physician or surgeon whose professional activities shall be confined within the confines of a recognized medical school; **[**or**]**

(19) Any technician engaging in tattooing in accordance with the provisions of section 19a-92a and any regulations adopted thereunder; or

(20) Any person practicing perfusion, as defined in section 69 of this act.

(c) This section shall not authorize anyone to practice optometry, as defined in chapter 380, or to practice dentistry, as defined in chapter 379, or dental hygiene, as defined in chapter 379a.

(d) The provisions of subsection (a) of this section shall apply to any individual whose practice of medicine includes any ongoing, regular or contractual arrangement whereby, regardless of residency in this or any other state, he provides, through electronic communications or interstate commerce, diagnostic or treatment services, including primary diagnosis of pathology specimens, slides or images, to any person located in this state. In the case of electronic transmissions of radiographic images, licensure shall be required for an out-of-state physician who provides, through an ongoing, regular or contractual arrangement, official written reports of diagnostic evaluations of such images to physicians or patients in this state. The provisions of subsection (a) of this section shall not apply to a nonresident physician who, while located outside this state, consults (A) on an irregular basis

with a physician licensed by section 20-10 who is located in this state or (B) with a medical school within this state for educational or medical training purposes. Notwithstanding the provisions of this subsection, the provisions of subsection (a) of this section shall not apply to any individual who regularly provides the types of services described in this subsection pursuant to any agreement or arrangement with a short-term acute care general hospital, licensed by the Department of Public Health, provided such agreement or arrangement was entered into prior to February 1, 1996, and is in effect as of October 1, 1996.

(e) On and after October 1, 1999, any person licensed as an osteopathic physician or osteopath pursuant to chapter 371 shall be deemed licensed as a physician and surgeon pursuant to this chapter.

Sec. 78. Subsection (b) of section 17a-450 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(b) For the purposes of chapter 50, the Department of Mental Health and Addiction Services **[**shall be a single budgeted agency. It shall consist of two divisions, the Division of Mental Health Services and the Division of Substance Abuse Services, that**]** shall be organized to promote comprehensive, client-based services in the areas of mental health treatment and substance abuse treatment and to ensure the programmatic integrity and clinical identity of services in each area. The department shall perform the functions of: Centralized administration, planning and program development; prevention and treatment programs and facilities, both inpatient and outpatient, for persons with psychiatric disabilities or persons with substance abuse disabilities, or both; community mental health centers and community or regional programs and facilities providing services for persons with psychiatric disabilities or persons with substance abuse disabilities, or both; training and education; and research and evaluation of programs

and facilities providing services for persons with psychiatric disabilities or persons with substance abuse disabilities, or both. The department shall include, but not be limited to, the following divisions and facilities or their successor facilities: The office of the Commissioner of Mental Health and Addiction Services; Capitol Region Mental Health Center; Connecticut Valley Hospital, including the Acute Care Division of Connecticut Valley Hospital; the Connecticut Mental Health Center; the Whiting Forensic Division; Ribicoff Research Center; **[**Cedarcrest Hospital;**]** the Southwest Connecticut Mental Health System, including the Franklin S. DuBois Center and the Greater Bridgeport Community Mental Health Center; the Southeastern Mental Health Authority; River Valley Services; the Western Connecticut Mental Health Network; and any other state-operated facility for the treatment of persons with psychiatric disabilities or persons with substance abuse disabilities, or both, but shall not include those portions of such facilities transferred to the Department of Children and Families for the purpose of consolidation of children's services.

Sec. 79. Subsection (c) of section 17a-458 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(c) "State-operated facilities" means those hospitals or other facilities providing treatment for persons with psychiatric disabilities or for persons with substance abuse disabilities, or both, which are operated in whole or in part by the Department of Mental Health and Addiction Services. Such facilities include, but are not limited to, Capitol Region Mental Health Center, Connecticut Valley Hospital, including the Acute Care Division of Connecticut Valley Hospital, Norwich Hospital, Fairfield Hills Hospital, the Connecticut Mental Health Center, the Franklin S. DuBois Center, **[**Cedarcrest Regional Hospital,**]** the Greater Bridgeport Community Mental Health Center **[**, Blue Hills

Hospital, Berkshire Woods Treatment Center, Eugene Boneski Treatment Center,**]** and Dutcher Treatment Center. **[**, but shall not include those portions of such facilities transferred to the Department of Children and Families for the purpose of consolidation of children's services.**]**

Sec. 80. (NEW) (*Effective July 1, 2005*) If the term "Acute Care Division" is used or referred to in any public or special act of 2005 or 2006 or in any section of the general statutes that is amended in 2005 or 2006, it shall be deemed to mean or refer to the Acute Care Division of Connecticut Valley Hospital.

Sec. 81. (NEW) (*Effective July 1, 2005*) Regardless of any consolidation of operational functions at Connecticut Valley Hospital and Cedarcrest Hospital, the campuses of Connecticut Valley Hospital and Cedarcrest Hospital shall constitute separate hospitals for purposes of section 17a-511 of the general statutes, and each such hospital shall designate an administrator who is authorized to render final decisions resolving patient complaints and grievances.

Sec. 82. Section 19a-405 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

The Chief Medical Examiner, with the approval of the commission, shall appoint a deputy who shall perform all the duties of the Chief Medical Examiner in case of his sickness or absence and such associate medical examiners, assistant medical examiners, pathologists, toxicologists, laboratory technicians and other professional staff as the commission may specify. The commission in advance of appointments shall specify the qualifications required for each position in terms of education, experience and other relevant considerations. The commission shall fix the annual salary of the Deputy Chief Medical Examiner and shall submit recommendations concerning salaries and compensation of **[**such**]** other professional staff to the Commissioner of

Administrative Services. The Chief Medical Examiner, the Deputy Chief Medical Examiner, associate medical examiners, and assistant medical examiners shall take the oath provided by law for public officers. Other staff members as determined by the commission shall be appointed by the Chief Medical Examiner, subject to the provisions of chapter 67 and the rules of the commission not inconsistent therewith.

Sec. 83. (NEW) (*Effective July 1, 2005*) On or before July 1, 2006, the Commissioner of Mental Health and Addiction Services shall initiate the development, implementation, promotion and maintenance of a single resource web site to provide timely access to mental health care information and assistance for children, adolescents and adults. The resource web site shall include, but not be limited to: (1) Directory information on available federal, state, regional and community assistance, programs, services and providers; (2) current mental health diagnoses and treatment options; (3) links to national and state advocacy organizations, including legal assistance; (4) summary information on federal and state mental health law, including private insurance coverage; and (5) an optional, secure personal folder for web site users to manage information concerning their individual mental health care and assistance.

Sec. 84. (NEW) (*Effective from passage*) (a) On or before December 31, 2006, the Commissioner of Social Services, in consultation with the Commissioner of Mental Health and Addiction Services and the Community Mental Health Strategy Board, established under section 17a-485b of the general statutes, shall take such action as is necessary to amend the Medicaid state plan to include assertive community treatment teams and community support services within the definition of optional adult rehabilitation services. Such community treatment teams shall provide intensive, integrated, multidisciplinary services to adults with severe psychiatric disabilities, including, but not limited to,

persons who are homeless, persons diverted or discharged from in-patient programs or nursing homes and persons diverted or released from correctional facilities, or who are at risk of incarceration, and such teams shall provide intensive community care management through case managers, nurses and physicians and shall include, but not be limited to, vocational, peer and substance abuse specialists. The Commissioner of Social Services shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, for purposes of establishing the services specified in this subsection. The Commissioner of Social Services may implement policies and procedures for purposes of establishing such services while in the process of adopting such policies or procedures in regulation form, provided notice of intention to adopt the regulations is printed in the Connecticut Law Journal no later than twenty days after implementation and any such policies and procedures shall be valid until the time the regulations are effective.

(b) For purposes of this section, the Commissioner of Social Services shall enter into a memorandum of understanding with the Department of Mental Health and Addiction Services that delegates responsibility to the Commissioner of Mental Health and Addiction Services for the clinical management of adult rehabilitation services provided to adults eighteen years of age or older who are otherwise receiving mental health services from said department. For purposes of this section, the term "clinical management" describes the process of evaluating and determining the appropriateness of the utilization of behavioral health services, providing assistance to clinicians or beneficiaries to ensure appropriate use of resources and may include, but is not limited to, authorization, concurrent and retrospective review, discharge review, quality management, provider certification and provider performance enhancement. The Commissioner of Social Services and the Commissioner of Mental Health and Addiction Services shall jointly develop clinical management policies and procedures for purposes of

this section. The Commissioner of Social Services may implement policies and procedures necessary to carry out the purposes of this section, including any necessary changes to existing behavioral health policies and procedures concerning utilization management, while in the process of adopting such policies and procedures in regulation form, in accordance with the provisions of chapter 54 of the general statutes, provided the commissioner publishes notice of intention to adopt the regulations in the Connecticut Law Journal not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the earlier of the time such regulations are effective, or December 1, 2006.

Sec. 85. (NEW) (*Effective from passage*) On or before July 1, 2005, the Commissioner of Social Services and the Commissioner of Mental Health and Addiction Services shall jointly convene a task force to develop and report to the Governor and General Assembly on or before January 1, 2006, in accordance with the provisions of section 11-4a of the general statutes, on a feasibility plan to obtain a waiver from federal law and establish a Medicaid-financed home and community-based pilot program to provide community-based services and, if necessary, housing assistance, to adults with severe and persistent psychiatric disabilities being discharged or diverted from nursing home residential care. The task force shall consist of (1) the Commissioner of Social Services, or a designee; (2) the Commissioner of Mental Health and Addiction Services, or a designee; (3) the Secretary of the Office of Policy and Management, or a designee; (4) the cochairs and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services; and (5) three members designated by the Community Mental Health Strategy Board, established under section 17a-485b of the general statutes.

Sec. 86. (NEW) (*Effective from passage*) On or before January 1, 2006, the Commissioner of Mental Health and Addiction Services shall, within available appropriations, expand young adult services to cover additional catchment areas in the state and shall identify additional services not being provided to young adults with psychiatric disabilities. On or before January 1, 2007, the Commissioner of Mental Health and Addiction Services shall report, in accordance with the provisions of section 11-4a of the general statutes, on the need for such expanded services and identify additional services needed to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services.

Sec. 87. (*Effective July 1, 2005*) The Commissioner of Children and Families, in consultation with the Commissioner of Mental Health and Addiction Services and the Community Mental Health Strategy Board, established under section 17a-485b of the general statutes, shall, within available appropriations, maintain the availability of flexible emergency funding for children with psychiatric disabilities who are not under the supervision of the Department of Children and Families.

Sec. 88. (NEW) (*Effective July 1, 2005*) The Commissioner of Mental Health and Addiction Services shall, within available appropriations, provide additional supported or supervised housing for adults with severe and persistent psychiatric disabilities.

Sec. 89. Section 38a-1041 of the general statutes is amended by adding subsection (e) as follows (*Effective from passage*):

(NEW) (e) On or before October 1, 2005, the Managed Care Ombudsman, in consultation with the Community Mental Health Strategy Board, established under section 17a-485b of the general statutes, shall establish a process to provide ongoing communication among mental health care providers, patients, state-wide and regional business organizations, managed care companies and other health

insurers to assure: (1) Best practices in mental health treatment and recovery; (2) compliance with the provisions of sections 38a-476a, 38a-476b, 38a-488a and 38a-489 of the general statutes; and (3) the relative costs and benefits of providing effective mental health care coverage to employees and their families. On or before January 1, 2006, and annually thereafter, the Managed Care Ombudsman shall report, in accordance with the provisions of section 11-4a of the general statutes, on the implementation of this subsection to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance.

Sec. 90. (*Effective from passage*) The Commissioner of Social Services, in consultation with the Commissioner of Mental Health and Addiction Services and the Secretary of the Office of Policy and Management, shall determine and report to the Governor and the General Assembly on or before January 1, 2006, in accordance with the provisions of section 11-4a of the general statutes, the feasibility of implementing enhanced care clinics for adults, including hospital-based clinics, and establishing a schedule of Medicaid reimbursement for such clinics on or before July 1, 2006.

Sec. 91. (*Effective from passage*) (a) The Commissioner of the Office of Health Care Access shall establish a committee to examine whether licensed hospital psychiatric inpatient bed capacity for children in this state is sufficient and what steps, if any, are necessary to expand such capacity. The committee shall make specific recommendations concerning the expansion of licensed hospital psychiatric inpatient bed capacity for children in mental health region five, established pursuant to section 17a-478 of the general statutes.

(b) The committee shall consist of the following members:

(1) The Commissioners of Social Services and Children and Families, or the commissioners' designees;

(2) The state Child Advocate, or the Child Advocate's designee; and

(3) Representatives of private children's hospitals and mental health advocacy groups for children.

(c) Not later than January 1, 2006, the Commissioner of the Office of Health Care Access shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, on the committee's findings and recommendations to the General Assembly.

Sec. 92. (NEW) (*Effective July 1, 2005*) (a) The Commissioners of Social Services and Children and Families shall develop and implement an integrated behavioral health service system for HUSKY Part A and HUSKY Part B members, children enrolled in the voluntary services program operated by the Department of Children and Families and may, at the discretion of the Commissioners of Children and Families and Social Services, include other children, adolescents and families served by the Department of Children and Families, which shall be known as the Behavioral Health Partnership. The Behavioral Health Partnership shall seek to increase access to quality behavioral health services through: (1) Expansion of individualized, family-centered, community-based services; (2) maximization of federal revenue to fund behavioral health services; (3) reduction in the unnecessary use of institutional and residential services for children; (4) capture and investment of enhanced federal revenue and savings derived from reduced residential services and increased community-based services; (5) improved administrative oversight and efficiencies; and (6) monitoring of individual outcomes, provider performance, taking into consideration the acuity of the patients served by each provider, and overall program performance.

(b) The Behavioral Health Partnership shall operate in accordance with the financial requirements specified in this subsection. Prior to the conversion of any grant funded services to a rate-based, fee-for-service

payment system, the Department of Social Services and the Department of Children and Families shall submit documentation verifying that the proposed rates seek to cover the reasonable cost of providing services to the Behavioral Health Partnership Oversight Council, established pursuant to section 95 of this act.

Sec. 93. (NEW) (*Effective July 1, 2005*) (a) The Commissioner of Children and Families and the Commissioner of Social Services shall each designate a director for the Behavioral Health Partnership. Each director shall coordinate the responsibilities of his or her department, within the statutory authority of each department, for the planning, development, administration and evaluation of the activities specified under subsection (a) of section 92 of this act to increase access to quality behavioral health services.

(b) The departments shall direct the activities of the administrative services organization, retained in accordance with section 17a-22f of the general statutes, as amended by this act, under terms established in a memorandum of understanding, in the development of a community system of care to:

(1) Alleviate hospital emergency department overcrowding;

(2) Reduce unnecessary admissions and lengths of stay in hospitals and residential treatment settings; and

(3) Increase availability of outpatient services.

Sec. 94. Section 17a-22f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Social Services may, with regard to the provision of behavioral health services provided pursuant to a state plan under Title XIX or Title XXI of the Social Security Act: (1) Contract with an administrative services organization to provide clinical

management, provider network development and other administrative services; and (2) delegate responsibility to the Department of Children and Families for the clinical management portion of **[**an**]** such administrative contract. **[**pertaining to children under eighteen years of age or individuals who are otherwise receiving behavioral health services from said department.**]**

(b) For purposes of this section, the term "clinical management" describes the process of evaluating and determining the appropriateness of the utilization of behavioral health services, providing assistance to clinicians or beneficiaries to ensure appropriate use of resources and may include, but is not limited to, authorization, concurrent and retrospective review, discharge review, quality management, provider certification and provider performance enhancement. The Commissioners of Social Services and Children and Families shall jointly develop clinical management policies and procedures. The Department of Social Services may implement policies and procedures necessary to carry out the purposes of this section, including any necessary changes to existing behavioral health policies and procedures concerning utilization management, while in the process of adopting such policies and procedures in regulation form, provided the commissioner publishes notice of intention to adopt the regulations in the Connecticut Law Journal within twenty days of implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the earlier of (1) the time such regulations are effective, or (2) **[**December 1, 2003**]** December 31, 2006.

Sec. 95. (NEW) (*Effective from passage*) (a) There is established a Behavioral Health Partnership Oversight Council which shall advise the Commissioners of Children and Families and Social Services on the planning and implementation of the Behavioral Health Partnership.

(b) The council shall consist of the following members:

(1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, appropriations and budgets of state agencies, or their designees;

(2) A member of the Community Mental Health Strategy Board, established pursuant to section 17a-485b of the general statutes, as selected by said board;

(3) The Commissioner of Mental Health and Addiction Services, or said commissioner's designee;

(4) Sixteen members appointed by the chairpersons of the advisory council on Medicaid managed care, established pursuant to section 17b-28 of the general statutes;

(A) Two of whom are representatives of general or specialty psychiatric hospitals;

(B) One of whom is an adult with a psychiatric disability;

(C) One of whom is an advocate for adults with psychiatric disabilities;

(D) Two of whom are parents of children who have a behavioral health disorder or have received child protection or juvenile justice services from the Department of Children and Families;

(E) One of whom has expertise in health policy and evaluation;

(F) One of whom is an advocate for children with behavioral health disorders;

(G) One of whom is a primary care provider serving HUSKY children;

(H) One of whom is a child psychiatrist serving HUSKY children;

(I) One of whom is either an adult with a substance use disorder or an advocate for adults with substance use disorders;

(J) One of whom is a representative of school-based health clinics;

(K) One of whom is a provider of community-based behavioral health services for adults;

(L) One of whom is a provider of residential treatment for children;

(M) One of whom is a provider of community-based services for children with behavioral health problems; and

(N) One of whom is a member of the advisory council on Medicaid managed care;

(5) Four nonvoting ex-officio members, one each appointed by the Commissioners of Social Services, Children and Families and Mental Health and Addiction Services to represent his or her department and one appointed by the Secretary of the Office of Policy and Management to represent said department; and

(6) One representative from the administrative services organization and from each Medicaid managed care organization, to be nonvoting ex-officio members.

(c) All appointments to the council shall be made no later than July 1, 2005. Any vacancy shall be filled by the appointing authority.

(d) The chairpersons of the advisory council on Medicaid managed care shall select the chairpersons of the Behavioral Health Partnership Oversight Council from among the members of such oversight council. Such chairpersons shall convene the first meeting of the council, which shall be held not later than August 1, 2005. The council shall meet at

least monthly thereafter.

(e) The Joint Committee on Legislative Management shall provide administrative support to the chairpersons and assistance in convening the council's meetings.

(f) The council shall make specific recommendations on matters related to the planning and implementation of the Behavioral Health Partnership which shall include, but not be limited to: (1) Review of any contract entered into by the Departments of Children and Families and Social Services with an administrative services organization, to assure that the administrative services organization's decisions are based solely on clinical management criteria developed by the clinical management committee established in section 96 of this act; (2) review of behavioral health services pursuant to Title XIX and Title XXI of the Social Security Act to assure that federal revenue is being maximized; and (3) review of periodic reports on the program activities, finances and outcomes, including reports from the director of the Behavioral Health Partnership on achievement of service delivery system goals, pursuant to section 93 of this act. The council may conduct or cause to be conducted an external, independent evaluation of the Behavioral Health Partnership.

(g) On or before March 1, 2006, and annually thereafter, the council shall submit a report to the Governor and, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations and budgets of state agencies, on the council's activities and progress.

Sec. 96. (NEW) (*Effective July 1, 2005*) There is established a clinical management committee to develop clinical management guidelines to be used for the Behavioral Health Partnership. The committee shall consist of two members selected by the Commissioner of Children and

Families, two members selected by the Commissioner of Social Services, one member selected by the Commissioner of Mental Health and Addiction Services and two members selected by the Behavioral Health Partnership Oversight Council, established pursuant to section 95 of this act. Members of the committee shall have requisite expertise or experience in behavioral health services.

Sec. 97. (NEW) (*Effective July 1, 2005*) The Departments of Children and Families and Social Services shall develop consumer grievance procedures and shall submit such procedures to the Behavioral Health Partnership Oversight Council for review and comment. The Departments of Children and Families and Social Services shall establish time frames for appealing decisions made by the administrative services organization, including an expedited review in emergency situations. Any procedure for appeals shall require that an appeal be heard not later than thirty days after such appeal is filed and shall be decided not later than forty-five days after such appeal is filed.

Sec. 98. (NEW) (*Effective July 1, 2005*) On or before October 1, 2006, and annually thereafter, the Commissioners of Children and Families and Social Services shall conduct an evaluation of the Behavioral Health Partnership and shall report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, public health and human services on the provision of behavioral health services under the Behavioral Health Partnership, including information on the status of the administrative services organization implementation, the status of the collaboration among the Departments of Children and Families and Social Services, the services provided, the number of persons served, program outcomes and spending by child and adult populations.

Sec. 99. (NEW) (*Effective July 1, 2005*) The Department of Children and Families shall monitor the implementation of the Behavioral

Health Partnership and shall report annually to the joint standing committees of the General Assembly have cognizance of matters relating to human services, public health and appropriations and the budgets of state agencies as to any estimated cost savings, if any, resulting from implementation of the Behavioral Health Partnership.

Sec. 100. (NEW) (*Effective July 1, 2005*) (a) The Departments of Children and Families and Social Services may establish provider specific inpatient, partial hospitalization, intensive outpatient and other intensive service rates. Within available appropriations, the initial rates shall not be less than each provider's blend of rates from the HUSKY Plans in effect on July 1, 2005, unless the date of implementation of the Behavioral Health Partnership is later than January 1, 2006. If such implementation date is later then January 1, 2006, such initial rates, within available appropriations, shall not be less than each provider's blend of rates in effect sixty days prior to the implementation date of the Behavioral Health Partnership. Within available appropriations, the departments may provide grant payments, where necessary, to address provider financial impacts. The departments may establish uniform outpatient rates allowing a differential for child and adult services. In no event shall such rate increases exceed rates paid through Medicare for such services. The Behavioral Health Partnership Oversight Council shall review any such rate methodology as provided for in subsection (b) of this section. Notwithstanding the provisions of sections 17b-239 and 17b-241 of the general statutes, rates for behavioral health services shall be established in accordance with this section.

(b) All proposals for initial rates, reductions to existing rates and changes in rate methodology within the Behavioral Health Partnership shall be submitted to the Behavioral Health Partnership Oversight Council for review. If the council does not recommend acceptance, it may forward its recommendation to the joint standing committees of

the General Assembly having cognizance of matters relating to public health, human services and appropriations and budgets of state agencies. The committees shall hold a joint public hearing on the subject of the proposed rates, to receive the partnership's rationale for making such a rate change. Not later than ninety days after submission by the departments, the committees of cognizance shall make recommendations to the departments regarding the proposed rates. The departments shall make every effort to incorporate recommendations of both the council and the committees of cognizance when setting rates.

Sec. 101. (NEW) (*Effective from passage*) (a) The Departments of Children and Families and Social Services shall enter a joint contract with an administrative services organization to perform eligibility verification, utilization management, intensive care management, quality management, coordination of medical and behavioral health services, provider network development and management, recipient and provider services and reporting. The contract shall provide for the organization to commence such activities on or after October 1, 2005.

(b) Claims under the Behavioral Health Partnership shall be paid by the Department of Social Services' Medicaid management information systems vendor, except that the Department of Children and Families may, at its discretion, continue to use existing claims payment systems.

(c) The administrative services organization shall authorize services, based solely on guidelines established by the clinical management committee, established pursuant to section 96 of this act. The administrative services organization may make exceptions to the guidelines when requested by a member, or the member's legal guardian or service provider, and determined by the administrative services organization to be in the best interest of the member. Decisions regarding the interpretation of such guidelines shall be made by the Departments of Children and Families and Social

Services. No administrative services organization shall have any financial incentive to approve, deny or reduce services. The administrative services organization shall ensure that service providers and persons seeking services have timely access to program information and timely responses to inquiries, including inquiries concerning the clinical guidelines for services.

(d) The administrative services organization shall provide or arrange for on-site assistance to facilitate the appropriate placement, as soon as practicable, of children with behavioral health diagnoses who the administrative services organization knows to have been in an emergency department for over forty-eight hours. The administrative services organization shall provide or arrange for on-site assistance to arrange for the discharge or appropriate placement, as soon as practicable, for children the administrative services organization knows to have remained in an inpatient hospital unit for more than five days longer than is medically necessary, as agreed by the administrative services organization and the hospital.

(e) The Departments of Children and Families and Social Services shall develop, in consultation with the Behavioral Health Partnership, a comprehensive plan for monitoring the performance of the administrative services organization which shall include data on service authorizations, individual outcomes, appeals, outreach and accessibility, comments from program participants compiled from written surveys and face-to-face interviews.

(f) The Behavioral Health Partnership shall establish policies to coordinate benefits received under the partnership with those received through Medicaid managed care organizations for persons covered by both a Medicaid managed care organization and the Behavioral Health Partnership. Such policies shall specify a coordinated delivery of both physical and behavioral health care. The policies shall be submitted to the Behavioral Health Partnership Oversight Council for review and

comment.

Sec. 102. (NEW) (*Effective July 1, 2005*) The Commissioner of Children and Families shall have the authority to certify providers of behavioral health Medicaid early periodic screening, detection and treatment and rehabilitation services for HUSKY Plan Part A for the purpose of coverage of Medicaid early periodic screening, detection and treatment or optional rehabilitation services. The Commissioner of Children and Families may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, for purposes of certification of such providers. The commissioner may implement policies and procedures for purposes of such certification while in the process of adopting such policies or procedures in regulation form, provided notice of intention to adopt the regulations is printed in the Connecticut Law Journal not later than twenty days after implementation and any such policies and procedures shall be valid until the time the regulations are effective.

Sec. 103. (*Effective July 1, 2005*) The sum of $150,000 shall be transferred from the appropriation to the Department of Social Services, for Medicaid, for the fiscal year ending June 30, 2006, and the fiscal year ending June 30, 2007, to the Department of Mental Health and Addiction Services, for the Governor's Partnership to Protect Connecticut's Workforce.

Sec. 104. Sections 17a-22e, 17b-274b and 17b-362 of the general statutes are repealed. (*Effective July 1, 2005*)

Approved July 13, 2005