



General Assembly

Bill No. 8002

*June Special Session,
2007*

LCO No. **9698**

*09698 _____ *

Referred to Committee on No Committee

Introduced by:

REP. AMANN, 118th Dist.

SEN. WILLIAMS, 29th Dist.

***AN ACT IMPLEMENTING THE PROVISIONS OF THE BUDGET
CONCERNING HUMAN SERVICES AND PUBLIC HEALTH.***

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

1 Section 1. Subsections (a) and (b) of section 17b-321 of the general
2 statutes are repealed and the following is substituted in lieu thereof
3 (*Effective July 1, 2007*):

4 (a) On or before July 1, 2005, and on or before July first biennially
5 thereafter, the Commissioner of Social Services shall determine the
6 amount of the user fee and promptly notify the commissioner and
7 nursing homes of such amount. The user fee shall be (1) the sum of
8 each nursing home's anticipated nursing home net revenue, including,
9 but not limited to, its estimated net revenue from any increases in
10 Medicaid payments, during the twelve-month period ending on June
11 thirtieth of the succeeding calendar year, (2) which sum shall be
12 multiplied by a percentage as determined by the Secretary of the Office
13 of Policy and Management, in consultation with the Commissioner of
14 Social Services, provided before January 1, 2008, such percentage shall

15 not exceed six per cent and on and after January 1, 2008, such
16 percentage shall not exceed five and one-half per cent, and (3) which
17 product shall be divided by the sum of each nursing home's
18 anticipated resident days during the twelve-month period ending on
19 June thirtieth of the succeeding calendar year. The Commissioner of
20 Social Services, in anticipating nursing home net revenue and resident
21 days, shall use the most recently available nursing home net revenue
22 and resident day information. On or before July 1, 2007, the
23 Commissioner of Social Services shall report, in accordance with
24 section 11-4a, to the joint standing committees of the General
25 Assembly having cognizance of matters relating to appropriations and
26 the budgets of state agencies and human services on the detrimental
27 effects, if any, that a biennial determination of the user fee may have
28 on private payors.

29 (b) Upon approval of the waiver of federal requirements for
30 uniform and broad-based user fees in accordance with 42 CFR 433.68
31 pursuant to section 17b-323, the Commissioner of Social Services shall
32 redetermine the amount of the user fee and promptly notify the
33 commissioner and nursing homes of such amount. The user fee shall
34 be (1) the sum of each nursing home's anticipated nursing home net
35 revenue, including, but not limited to, its estimated net revenue from
36 any increases in Medicaid payments, during the twelve-month period
37 ending on June thirtieth of the succeeding calendar year but not
38 including any such anticipated net revenue of any nursing home
39 exempted from such user fee due to waiver of federal requirements
40 pursuant to section 17b-323, (2) which sum shall be multiplied by a
41 percentage as determined by the Secretary of the Office of Policy and
42 Management, in consultation with the Commissioner of Social
43 Services, provided before January 1, 2008, such percentage shall not
44 exceed six per cent and on and after January 1, 2008, such percentage
45 shall not exceed five and one-half per cent, and (3) which product shall
46 be divided by the sum of each nursing home's anticipated resident
47 days, but not including the anticipated resident days of any nursing
48 home exempted from such user fee due to waiver of federal

49 requirements pursuant to section 17b-323. Notwithstanding the
50 provisions of this subsection, the amount of the user fee for each
51 nursing home licensed for more than two hundred thirty beds or
52 owned by a municipality shall be equal to the amount necessary to
53 comply with federal provider tax uniformity waiver requirements as
54 determined by the Commissioner of Social Services. The
55 Commissioner of Social Services may increase retroactively the user fee
56 for nursing homes not licensed for more than two hundred thirty beds
57 and not owned by a municipality to the effective date of waiver of said
58 federal requirements to offset user fee reductions necessary to meet the
59 federal waiver requirements. On or before July 1, 2005, and biennially
60 thereafter, the Commissioner of Social Services shall determine the
61 amount of the user fee in accordance with this subsection. The
62 Commissioner of Social Services, in anticipating nursing home net
63 revenue and resident days, shall use the most recently available
64 nursing home net revenue and resident day information. On or before
65 July 1, 2007, the Commissioner of Social Services shall report, in
66 accordance with section 11-4a, to the joint standing committees of the
67 General Assembly having cognizance of matters relating to
68 appropriations and the budgets of state agencies and human services
69 on the detrimental effects, if any, that a biennial determination of the
70 user fee may have on private payors.

71 Sec. 2. Subsections (a) and (b) of section 17b-104 of the general
72 statutes are repealed and the following is substituted in lieu thereof
73 (*Effective July 1, 2007*):

74 (a) The Commissioner of Social Services shall administer the
75 program of state supplementation to the Supplemental Security
76 Income Program provided for by the Social Security Act and state law.
77 The commissioner may delegate any powers and authority to any
78 deputy, assistant, investigator or supervisor, who shall have, within
79 the scope of the power and authority so delegated, all of the power
80 and authority of the Commissioner of Social Services. [On and after
81 January 1, 1994, the] The commissioner shall establish a standard of

82 need based on the cost of living in this state for the temporary family
83 assistance program and the state-administered general assistance
84 program. The commissioner shall make a reinvestigation, at least every
85 twelve months, of all cases receiving aid from the state, except that
86 such reinvestigation may be conducted every twenty-four months for
87 recipients of assistance to the elderly or disabled with stable
88 circumstances, and shall maintain all case records of the several
89 programs administered by the Department of Social Services so that
90 such records show, at all times, full information with respect to
91 eligibility of the applicant or recipient. In the determination of need
92 under any public assistance program, such income or earnings shall be
93 disregarded as federal law requires, and such income or earnings may
94 be disregarded as federal law permits. The commissioner shall
95 encourage and promulgate such incentive earning programs as are
96 permitted by federal law and regulations.

97 (b) On July 1, [1988] 2007, and annually thereafter, the commissioner
98 shall increase the payment standards over those of the previous fiscal
99 year under the [aid to families with dependent children program,]
100 temporary family assistance program and the state-administered
101 general assistance program by the percentage increase, if any, in the
102 most recent calendar year average in the consumer price index for
103 urban consumers over the average for the previous calendar year,
104 provided the annual increase, if any, shall not exceed five per cent. [,
105 except that the payment standards for the fiscal years ending June 30,
106 1992, June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June 30,
107 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June 30,
108 2002, June 30, 2003, June 30, 2004, June 30, 2005, June 30, 2006, and June
109 30, 2007, shall not be increased. On January 1, 1994, the payment
110 standards shall be equal to the standards of need in effect July 1, 1993.]

111 Sec. 3. Subsection (a) of section 17b-106 of the general statutes is
112 repealed and the following is substituted in lieu thereof (*Effective July*
113 *1, 2007*):

114 (a) On January 1, 2006, and on each January first thereafter, the
115 Commissioner of Social Services shall increase the unearned income
116 disregard for recipients of the state supplement to the federal
117 Supplemental Security Income Program by an amount equal to the
118 federal cost-of-living adjustment, if any, provided to recipients of
119 federal Supplemental Security Income Program benefits for the
120 corresponding calendar year. On July 1, 1989, and annually thereafter,
121 the commissioner shall increase the adult payment standards over
122 those of the previous fiscal year for the state supplement to the federal
123 Supplemental Security Income Program by the percentage increase, if
124 any, in the most recent calendar year average in the consumer price
125 index for urban consumers over the average for the previous calendar
126 year, provided the annual increase, if any, shall not exceed five per
127 cent, except that the adult payment standards for the fiscal years
128 ending June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June
129 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June
130 30, 2002, June 30, 2003, June 30, 2004, June 30, 2005, June 30, 2006, [and]
131 June 30, 2007, June 30, 2008, and June 30, 2009, shall not be increased.
132 Effective October 1, 1991, the coverage of excess utility costs for
133 recipients of the state supplement to the federal Supplemental Security
134 Income Program is eliminated. Notwithstanding the provisions of this
135 section, the commissioner may increase the personal needs allowance
136 component of the adult payment standard as necessary to meet federal
137 maintenance of effort requirements.

138 Sec. 4. Section 17b-265e of the general statutes is repealed and the
139 following is substituted in lieu thereof (*Effective July 1, 2007*):

140 (a) There is established a fund to be known as the "Medicare Part D
141 Supplemental Needs Fund" which shall be an account within the
142 General Fund under the Department of Social Services. [The
143 Commissioner of Social Services shall, within available appropriations,
144 designate moneys to said fund.] Moneys available in said fund shall be
145 utilized by the Department of Social Services to provide [financial]
146 assistance to Medicare Part D beneficiaries who are enrolled in the

147 ConnPACE program or who are full benefit dually eligible Medicare
148 Part D beneficiaries, as defined in section 17b-265d, and [who lack the
149 financial means to obtain medically necessary] whose medical needs
150 require that they obtain nonformulary prescription drugs. A
151 beneficiary requesting such [financial] assistance from the department
152 shall be required to make a satisfactory showing of the medical
153 necessity of obtaining such nonformulary prescription drug to the
154 department. If the department, in consultation with the prescribing
155 physician, determines that the prescription is medically necessary, the
156 department shall cover the cost of the original prescription and any
157 prescribed refills of the original prescription, less any applicable
158 copayments. The department [may] shall require as a condition of
159 receiving such [financial] assistance that a beneficiary establish, to the
160 satisfaction of the department, that the beneficiary has made good faith
161 efforts to: (1) Enroll in a Medicare Part D plan recommended by the
162 commissioner or the commissioner's agent; and (2) utilize the
163 exception process established by the prescription drug plan in which
164 the beneficiary is enrolled. [The department shall expeditiously review
165 all requests for financial assistance pursuant to this section and shall
166 notify the beneficiary as to whether the request for financial assistance
167 has been granted not later than two hours after receiving the request
168 from the beneficiary.] The commissioner shall implement policies and
169 procedures to administer the provisions of this section and to ensure
170 that all requests for, and determinations made concerning [financial]
171 assistance available pursuant to this section are expeditiously
172 processed.

173 (b) Assistance provided in accordance with the provisions of
174 subsection (a) of this section shall be subject to available funds. All
175 expenditures for prescription drugs under subsection (a) of this section
176 shall be charged to the Medicare Part D Supplemental Needs Fund.
177 For each fiscal year, such expenditures shall not exceed the amount
178 appropriated to the Department of Social Services in section 1 of public
179 act 06-186 for the Medicare Part D Supplemental Needs Fund.

180 [(b)] (c) The Department of Social Services shall, in accordance with
181 the provisions of this section, pay claims for prescription drugs for
182 Medicare Part D beneficiaries, who are also either Medicaid or
183 ConnPACE recipients and who are denied coverage by the Medicare
184 Part D plan in which such beneficiary is enrolled because a prescribed
185 drug is not on the formulary utilized by such Medicare Part D plan.
186 Payment shall initially be made by the department for a thirty-day
187 supply, subject to any applicable copayment. The beneficiary shall
188 appoint the commissioner as such beneficiary's representative for the
189 purpose of appealing any denial of Medicare Part D benefits and for
190 any other purpose allowed under said act and deemed necessary by
191 the commissioner.

192 [(c)] (d) Notwithstanding any provision of the general statutes, not
193 later than July 1, 2006, the Commissioner of Social Services shall
194 [contract with an entity specializing in Medicare appeals and
195 reconsideration for the purpose of having such entity exhaust
196 remedies] implement a plan for pursuing payment under Medicare
197 Part D by Part D plans for prescriptions denied as nonformulary
198 drugs, including remedies available through reconsideration by an
199 independent review entity, review by an administrative law judge, the
200 Medicare Appeals Council or Federal District Court. Reimbursement
201 secured [by such entity] from the Medicare Part D plan shall be
202 returned to the Department of Social Services.

203 [(d)] (e) The [entity contracting with the] Department of Social
204 Services, pursuant to subsection [(c)] (d) of this section, [shall submit]
205 may authorize appeals beyond the independent review entity. [only
206 upon authorization from the department.] Upon determination by the
207 department that it is not cost-effective to pursue further appeals, the
208 department shall pay for the denied nonformulary drug for the
209 remainder of the calendar year, provided the beneficiary remains
210 enrolled in the Part D plan that denied coverage. Pending the outcome
211 of the appeals process, the department shall continue to pay claims for
212 the nonformulary drug denied by the Part D plan until the earlier of

213 approval of such drug by the Part D plan or for the remainder of the
214 calendar year.

215 Sec. 5. Section 17b-369 of the general statutes is repealed and the
216 following is substituted in lieu thereof (*Effective July 1, 2007*):

217 The Commissioner of Social Services, pursuant to Section 6071 of
218 the Deficit Reduction Act of 2005, may submit an application to the
219 Secretary of Health and Human Services to establish a Money Follows
220 the Person demonstration project. [In the event the state is selected to
221 participate in the demonstration project and the Department of Social
222 Services elects to participate in such project, such] Such project shall
223 serve not more than [one] seven hundred persons and shall be
224 designed to achieve the objectives set forth in Section 6071(a) of the
225 Deficit Reduction Act of 2005. Services available under the
226 demonstration project shall include, but not be limited to, personal
227 care assistance services. The commissioner may apply for a Medicaid
228 research and demonstration waiver under Section 1115 of the Social
229 Security Act, if such waiver is necessary to implement the
230 demonstration project. The commissioner may, if necessary, modify
231 any existing Medicaid home or community-based waiver if such
232 modification is required to implement the demonstration project.

233 Sec. 6. Section 17b-285 of the general statutes is repealed and the
234 following is substituted in lieu thereof (*Effective July 1, 2007*):

235 [An] Notwithstanding any provision of the general statutes, an
236 institutionalized person or person in need of institutional care who
237 applies for Medicaid [shall] may assign to the Commissioner of Social
238 Services the right of support derived from the assets of the community
239 spouse of such person [, provided the spouse of such person is
240 unwilling or unable to provide the information necessary to determine
241 eligibility for Medicaid] but only if (1) the assets of the institutionalized
242 person or person in need of institutional care do not exceed the
243 Medicaid program asset limit; and (2) the institutionalized person or
244 person in need of institutional care cannot locate the community

245 spouse; or the community spouse is unable to provide information
246 regarding his or her own assets. If such [applicant] assignment is made
247 or if the institutionalized person or person in need of institutional care
248 lacks the ability to execute such an assignment due to physical or
249 mental impairment, the commissioner may [bring a support
250 proceeding against such applicant's spouse without such assignment]
251 seek recovery of any medical assistance paid on behalf of the
252 institutionalized person or person in need of institutional care up to
253 the amount of the community spouse's assets that are in excess of the
254 community spouse protected amount as of the initial month of
255 Medicaid eligibility.

256 Sec. 7. Section 17b-261 of the general statutes, as amended by section
257 3 of public act 07-185, is repealed and the following is substituted in
258 lieu thereof (*Effective July 1, 2007*):

259 (a) Medical assistance shall be provided for any otherwise eligible
260 person whose income, including any available support from legally
261 liable relatives and the income of the person's spouse or dependent
262 child, is not more than one hundred forty-three per cent, pending
263 approval of a federal waiver applied for pursuant to subsection (d) of
264 this section, of the benefit amount paid to a person with no income
265 under the temporary family assistance program in the appropriate
266 region of residence and if such person is an institutionalized
267 individual as defined in Section 1917(c) of the Social Security Act, 42
268 USC 1396p(c), and has not made an assignment or transfer or other
269 disposition of property for less than fair market value for the purpose
270 of establishing eligibility for benefits or assistance under this section.
271 Any such disposition shall be treated in accordance with Section
272 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
273 property made on behalf of an applicant or recipient or the spouse of
274 an applicant or recipient by a guardian, conservator, person
275 authorized to make such disposition pursuant to a power of attorney
276 or other person so authorized by law shall be attributed to such
277 applicant, recipient or spouse. A disposition of property ordered by a

278 court shall be evaluated in accordance with the standards applied to
279 any other such disposition for the purpose of determining eligibility.
280 The commissioner shall establish the standards for eligibility for
281 medical assistance at one hundred forty-three per cent of the benefit
282 amount paid to a family unit of equal size with no income under the
283 temporary family assistance program in the appropriate region of
284 residence. Except as provided in section 17b-277, as amended by this
285 act, the medical assistance program shall provide coverage to persons
286 under the age of nineteen with family income up to one hundred
287 eighty-five per cent of the federal poverty level without an asset limit
288 and to persons under the age of nineteen and their parents and needy
289 caretaker relatives, who qualify for coverage under Section 1931 of the
290 Social Security Act, with family income up to one hundred eighty-five
291 per cent of the federal poverty level without an asset limit. Such levels
292 shall be based on the regional differences in such benefit amount, if
293 applicable, unless such levels based on regional differences are not in
294 conformance with federal law. Any income in excess of the applicable
295 amounts shall be applied as may be required by said federal law, and
296 assistance shall be granted for the balance of the cost of authorized
297 medical assistance. All contracts entered into on and after July 1, 1997,
298 pursuant to this section shall include provisions for collaboration of
299 managed care organizations with the Nurturing Families Network
300 established pursuant to section 17a-56. The Commissioner of Social
301 Services shall provide applicants for assistance under this section, at
302 the time of application, with a written statement advising them of (1)
303 the effect of an assignment or transfer or other disposition of property
304 on eligibility for benefits or assistance, (2) the effect that having income
305 that exceeds the limits prescribed in this subsection will have with
306 respect to program eligibility, [(3) the availability of HUSKY Plan, Part
307 B health insurance benefits for persons who are not eligible for
308 assistance pursuant to this subsection or who are subsequently
309 determined ineligible for assistance pursuant to this subsection,] and
310 [(4)] (3) the availability of, and eligibility for, services provided by the
311 Nurturing Families Network established pursuant to section 17a-56.

312 Persons who are determined ineligible for assistance pursuant to this
313 section shall be provided a written statement notifying such persons of
314 their ineligibility and advising such persons of the availability of
315 HUSKY Plan, Part B health insurance benefits.

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

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

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

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

343 (f) To the extent permitted by federal law, Medicaid eligibility shall
344 be extended for one year to a family that becomes ineligible for
345 medical assistance under Section 1931 of the Social Security Act due to
346 income from employment by one of its members who is a caretaker
347 relative or due to receipt of child support income. A family receiving
348 extended benefits on July 1, 2005, shall receive the balance of such
349 extended benefits, provided no such family shall receive more than
350 twelve additional months of such benefits.

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

365 [(h) The Commissioner of Social Services shall, to the extent
366 permitted by federal law, or, pursuant to an approved waiver of
367 federal law submitted by the commissioner, in accordance with the
368 provisions of section 17b-8, impose the following cost-sharing
369 requirements under the HUSKY Plan, on all parent and needy
370 caretaker relatives with incomes exceeding one hundred per cent of the
371 federal poverty level: (1) A twenty-five-dollar premium per month per
372 parent or needy caretaker relative; and (2) a copayment of one dollar
373 per visit for outpatient medical services delivered by an enrolled
374 Medicaid or HUSKY Plan provider. The commissioner may implement
375 policies and procedures necessary to administer the provisions of this

376 subsection while in the process of adopting such policies and
377 procedures as regulations, provided the commissioner publishes notice
378 of the intent to adopt regulations in the Connecticut Law Journal not
379 later than twenty days after implementation. Policies and procedures
380 implemented pursuant to this subsection shall be valid until the time
381 final regulations are adopted.]

382 [(i)] (h) Medical assistance shall be provided, in accordance with the
383 provisions of subsection (e) of section 17a-6, to any child under the
384 supervision of the Commissioner of Children and Families who is not
385 receiving Medicaid benefits, has not yet qualified for Medicaid benefits
386 or is otherwise ineligible for such benefits because of institutional
387 status. To the extent practicable, the Commissioner of Children and
388 Families shall apply for, or assist such child in qualifying for, the
389 Medicaid program.

390 [(j)] (i) The Commissioner of Social Services shall provide Early and
391 Periodic Screening, Diagnostic and Treatment program services, as
392 required and defined as of December 31, 2005, by 42 USC 1396a(a)(43),
393 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal
394 regulations, to all persons who are under the age of twenty-one and
395 otherwise eligible for medical assistance under this section.

396 Sec. 8. (NEW) (Effective July 1, 2007) (a) The Commissioner of Social
397 Services shall, if required, seek a waiver from federal law for the
398 purpose of enhancing the enrollment of HUSKY Plan, Part A recipients
399 in available employer sponsored private health insurance. Such a
400 waiver shall include, but shall not be limited to, provisions that: (1)
401 Require the enrollment of HUSKY Plan, Part A parents, needy
402 caretaker relatives and dependents in any available employer
403 sponsored health insurance to the maximum extent of available
404 coverage as a condition of eligibility when determined to be cost
405 effective by the Department of Social Services; (2) require a subsidy to
406 be paid directly to the HUSKY Plan, Part A caretaker relative in an
407 amount equal to the premium payment requirements of any available

408 employer sponsored health insurance paid by way of payroll
409 deduction; and (3) assure HUSKY Plan, Part A coverage requirements
410 for medical assistance not covered by any available employment
411 sponsored health insurance.

412 (b) Notwithstanding any provision of the general statutes or any
413 provision established in a contract between an employer and a health
414 insurance carrier, no HUSKY Plan, Part A recipient, required to enroll
415 in available employer sponsored health insurance under this section,
416 shall be prohibited from enrollment in employer sponsored health
417 insurance due to limitations on enrollment of employees in employer
418 sponsored health insurance to open enrollment periods.

419 (c) The Commissioner of Social Services, pursuant to section 17b-10
420 of the general statutes, may implement policies and procedures
421 necessary to administer the provisions of this section while in the
422 process of adopting such policies and procedures as regulation,
423 provided the commissioner prints notice of the intent to adopt the
424 regulation in the Connecticut Law Journal not later than twenty days
425 after the date of implementation. Policies and procedures implemented
426 pursuant to this section shall be valid until the time final regulations
427 are adopted.

428 Sec. 9. Section 17b-277 of the general statutes as amended by section
429 4 of public act 07-185 is repealed and the following is substituted in
430 lieu thereof (*Effective July 1, 2007*):

431 (a) The Commissioner of Social Services shall provide, in accordance
432 with federal law and regulations, medical assistance under the
433 Medicaid program to needy pregnant women whose families have an
434 income not exceeding two hundred fifty per cent of the federal poverty
435 level.

436 (b) The commissioner shall expedite eligibility for appropriate
437 pregnant women applicants for the Medicaid program. The process for
438 making expedited eligibility determinations concerning needy

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

446 (c) On or before September 30, 2007, the Commissioner of Social
447 Services, shall submit a state plan amendment or, if required by the
448 federal government, seek a waiver under federal law to provide health
449 insurance coverage to pregnant women, who do not otherwise have
450 creditable coverage, as defined in 42 USC 300gg(c), and who have
451 income above one hundred eighty-five per cent of the federal poverty
452 level but not in excess of two hundred fifty per cent of the federal
453 poverty level. Following approval of such state plan amendment or
454 approval of such waiver application, the commissioner, on or before
455 January 1, 2008, shall implement the provisions of subsections (a) and
456 (b) of this section.

457 [(c)] (d) Presumptive eligibility for medical assistance shall be
458 implemented for any uninsured newborn child born in a hospital in
459 this state or a border state hospital, provided (1) the parent or
460 caretaker relative of such child resides in this state, and (2) the parent
461 or caretaker relative of such child authorizes enrollment in the
462 program.

463 [(d)] (e) The commissioner shall submit biannual reports to the
464 council, established pursuant to section 17b-28, on the department's
465 compliance with the administrative processing requirements set forth
466 in subsection (b) of this section.

467 Sec. 10. Section 13 of public act 07-185 is repealed and the following
468 is substituted in lieu thereof (*Effective July 1, 2007*):

469 (a) The Commissioner of Social Services, in consultation with the

470 Commissioner of Public Health, shall develop and within available
471 appropriations implement a plan for a system of preventive health
472 services for children under the HUSKY Plan, Part A and Part B. The
473 goal of the system shall be to improve health outcomes for all children
474 enrolled in the HUSKY Plan and to reduce racial and ethnic health
475 disparities among children. Such system shall ensure that services
476 under the federal Early and Periodic Screening, Diagnosis and
477 Treatment program are provided to children enrolled in the HUSKY
478 Plan, Part A.

479 (b) The plan shall:

480 (1) Establish a coordinated system for preventive health services for
481 HUSKY Plan, Part A and Part B beneficiaries including, but not limited
482 to, services under the federal Early and Periodic Screening, Diagnosis
483 and Treatment program, [vision care] ophthalmologic and optometric
484 services, oral health care, care coordination, chronic disease
485 management and periodicity schedules based on standards specified
486 by the American Academy of Pediatrics;

487 (2) Require the Department of Social Services to track
488 [electronically] the utilization of services in the system of preventive
489 health services by HUSKY Plan, Part A and Part B beneficiaries to
490 ensure that such beneficiaries receive all the services available under
491 the system and to track the health outcomes of children; and

492 (3) Include payment methodologies to create financial incentives
493 and rewards for health care providers who participate and provide
494 services in the system, such as case management fees, pay for
495 performance, and payment for technical support and data entry
496 associated with patient registries.

497 (c) The Commissioner of Social Services shall develop the plan for a
498 system of preventive health services not later than January 1, 2008, and
499 implement the plan not later than July 1, 2008.

500 (d) Not later than July 1, 2009, the Commissioner of Social Services
501 shall report, in accordance with the provisions of section 11-4a of the
502 general statutes, to the joint standing committees of the General
503 Assembly having cognizance of matters relating to human services,
504 insurance and public health on [the implementation of] the plan for a
505 system of preventive health services. The report shall include
506 information on health outcomes, quality of care and methodologies
507 utilized in the plan to improve the quality of care and health outcomes
508 for children.

509 Sec. 11. Subdivision (4) of subsection (f) of section 17b-340 of the
510 general statutes is repealed and the following is substituted in lieu
511 thereof (*Effective July 1, 2007*):

512 (4) For the fiscal year ending June 30, 1992, (A) no facility shall
513 receive a rate that is less than the rate it received for the rate year
514 ending June 30, 1991; (B) no facility whose rate, if determined pursuant
515 to this subsection, would exceed one hundred twenty per cent of the
516 state-wide median rate, as determined pursuant to this subsection,
517 shall receive a rate which is five and one-half per cent more than the
518 rate it received for the rate year ending June 30, 1991; and (C) no
519 facility whose rate, if determined pursuant to this subsection, would be
520 less than one hundred twenty per cent of the state-wide median rate,
521 as determined pursuant to this subsection, shall receive a rate which is
522 six and one-half per cent more than the rate it received for the rate year
523 ending June 30, 1991. For the fiscal year ending June 30, 1993, no
524 facility shall receive a rate that is less than the rate it received for the
525 rate year ending June 30, 1992, or six per cent more than the rate it
526 received for the rate year ending June 30, 1992. For the fiscal year
527 ending June 30, 1994, no facility shall receive a rate that is less than the
528 rate it received for the rate year ending June 30, 1993, or six per cent
529 more than the rate it received for the rate year ending June 30, 1993.
530 For the fiscal year ending June 30, 1995, no facility shall receive a rate
531 that is more than five per cent less than the rate it received for the rate
532 year ending June 30, 1994, or six per cent more than the rate it received

533 for the rate year ending June 30, 1994. For the fiscal years ending June
534 30, 1996, and June 30, 1997, no facility shall receive a rate that is more
535 than three per cent more than the rate it received for the prior rate
536 year. For the fiscal year ending June 30, 1998, a facility shall receive a
537 rate increase that is not more than two per cent more than the rate that
538 the facility received in the prior year. For the fiscal year ending June
539 30, 1999, a facility shall receive a rate increase that is not more than
540 three per cent more than the rate that the facility received in the prior
541 year and that is not less than one per cent more than the rate that the
542 facility received in the prior year, exclusive of rate increases associated
543 with a wage, benefit and staffing enhancement rate adjustment added
544 for the period from April 1, 1999, to June 30, 1999, inclusive. For the
545 fiscal year ending June 30, 2000, each facility, except a facility with an
546 interim rate or replaced interim rate for the fiscal year ending June 30,
547 1999, and a facility having a certificate of need or other agreement
548 specifying rate adjustments for the fiscal year ending June 30, 2000,
549 shall receive a rate increase equal to one per cent applied to the rate the
550 facility received for the fiscal year ending June 30, 1999, exclusive of
551 the facility's wage, benefit and staffing enhancement rate adjustment.
552 For the fiscal year ending June 30, 2000, no facility with an interim rate,
553 replaced interim rate or scheduled rate adjustment specified in a
554 certificate of need or other agreement for the fiscal year ending June
555 30, 2000, shall receive a rate increase that is more than one per cent
556 more than the rate the facility received in the fiscal year ending June
557 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a
558 facility with an interim rate or replaced interim rate for the fiscal year
559 ending June 30, 2000, and a facility having a certificate of need or other
560 agreement specifying rate adjustments for the fiscal year ending June
561 30, 2001, shall receive a rate increase equal to two per cent applied to
562 the rate the facility received for the fiscal year ending June 30, 2000,
563 subject to verification of wage enhancement adjustments pursuant to
564 subdivision (15) of this subsection. For the fiscal year ending June 30,
565 2001, no facility with an interim rate, replaced interim rate or
566 scheduled rate adjustment specified in a certificate of need or other

567 agreement for the fiscal year ending June 30, 2001, shall receive a rate
568 increase that is more than two per cent more than the rate the facility
569 received for the fiscal year ending June 30, 2000. For the fiscal year
570 ending June 30, 2002, each facility shall receive a rate that is two and
571 one-half per cent more than the rate the facility received in the prior
572 fiscal year. For the fiscal year ending June 30, 2003, each facility shall
573 receive a rate that is two per cent more than the rate the facility
574 received in the prior fiscal year, except that such increase shall be
575 effective January 1, 2003, and such facility rate in effect for the fiscal
576 year ending June 30, 2002, shall be paid for services provided until
577 December 31, 2002, except any facility that would have been issued a
578 lower rate effective July 1, 2002, than for the fiscal year ending June 30,
579 2002, due to interim rate status or agreement with the department shall
580 be issued such lower rate effective July 1, 2002, and have such rate
581 increased two per cent effective June 1, 2003. For the fiscal year ending
582 June 30, 2004, rates in effect for the period ending June 30, 2003, shall
583 remain in effect, except any facility that would have been issued a
584 lower rate effective July 1, 2003, than for the fiscal year ending June 30,
585 2003, due to interim rate status or agreement with the department shall
586 be issued such lower rate effective July 1, 2003. For the fiscal year
587 ending June 30, 2005, rates in effect for the period ending June 30, 2004,
588 shall remain in effect until December 31, 2004, except any facility that
589 would have been issued a lower rate effective July 1, 2004, than for the
590 fiscal year ending June 30, 2004, due to interim rate status or
591 agreement with the department shall be issued such lower rate
592 effective July 1, 2004. Effective January 1, 2005, each facility shall
593 receive a rate that is one per cent greater than the rate in effect
594 December 31, 2004. Effective upon receipt of all the necessary federal
595 approvals to secure federal financial participation matching funds
596 associated with the rate increase provided in this subdivision, but in
597 no event earlier than July 1, 2005, and provided the user fee imposed
598 under section 17b-320 is required to be collected, for the fiscal year
599 ending June 30, 2006, the department shall compute the rate for each
600 facility based upon its 2003 cost report filing or [] a subsequent cost

601 year filing for facilities having an interim rate for the period ending
602 June 30, 2005, as provided under section 17-311-55 of the regulations of
603 Connecticut state agencies. For each facility not having an interim rate
604 for the period ending June 30, 2005, the rate for the period ending June
605 30, 2006, shall be determined beginning with the higher of the
606 computed rate based upon its 2003 cost report filing or the rate in
607 effect for the period ending June 30, 2005. Such rate shall then be
608 increased by eleven dollars and eighty cents per day except that in no
609 event shall the rate for the period ending June 30, 2006, be thirty-two
610 dollars more than the rate in effect for the period ending June 30, 2005,
611 and for any facility with a rate below one hundred ninety-five dollars
612 per day for the period ending June 30, 2005, such rate for the period
613 ending June 30, 2006, shall not be greater than two hundred seventeen
614 dollars and forty-three cents per day and for any facility with a rate
615 equal to or greater than one hundred ninety-five dollars per day for
616 the period ending June 30, 2005, such rate for the period ending June
617 30, 2006, shall not exceed the rate in effect for the period ending June
618 30, 2005, increased by eleven and one-half per cent. For each facility
619 with an interim rate for the period ending June 30, 2005, the interim
620 replacement rate for the period ending June 30, 2006, shall not exceed
621 the rate in effect for the period ending June 30, 2005, increased by
622 eleven dollars and eighty cents per day plus the per day cost of the
623 user fee payments made pursuant to section 17b-320 divided by
624 annual resident service days, except for any facility with an interim
625 rate below one hundred ninety-five dollars per day for the period
626 ending June 30, 2005, the interim replacement rate for the period
627 ending June 30, 2006, shall not be greater than two hundred seventeen
628 dollars and forty-three cents per day and for any facility with an
629 interim rate equal to or greater than one hundred ninety-five dollars
630 per day for the period ending June 30, 2005, the interim replacement
631 rate for the period ending June 30, 2006, shall not exceed the rate in
632 effect for the period ending June 30, 2005, increased by eleven and one-
633 half per cent. Such July 1, 2005, rate adjustments shall remain in effect
634 unless (i) the federal financial participation matching funds associated

635 with the rate increase are no longer available; or (ii) the user fee
636 created pursuant to section 17b-320 is not in effect. For the fiscal year
637 ending June 30, 2007, each facility shall receive a rate that is three per
638 cent greater than the rate in effect for the period ending June 30, 2006,
639 except any facility that would have been issued a lower rate effective
640 July 1, 2006, than for the rate period ending June 30, 2006, due to
641 interim rate status or agreement with the department, shall be issued
642 such lower rate effective July 1, 2006. For the fiscal year ending June
643 30, 2008, each facility shall receive a rate that is two and nine-tenths
644 per cent greater than the rate in effect for the period ending June 30,
645 2007, except any facility that would have been issued a lower rate
646 effective July 1, 2007, than for the rate period ending June 30, 2007, due
647 to interim rate status or agreement with the department, shall be
648 issued such lower rate effective July 1, 2007. For the fiscal year ending
649 June 30, 2009, rates in effect for the period ending June 30, 2008, shall
650 remain in effect until June 30, 2009, except any facility that would have
651 been issued a lower rate for the fiscal year ending June 30, 2009, due to
652 interim rate status or agreement with the department shall be issued
653 such lower rate. The Commissioner of Social Services shall add fair
654 rent increases to any other rate increases established pursuant to this
655 subdivision for a facility which has undergone a material change in
656 circumstances related to fair rent. Interim rates may take into account
657 reasonable costs incurred by a facility, including wages and benefits.

658 Sec. 12. Subsection (g) of section 17b-340 of the general statutes is
659 repealed and the following is substituted in lieu thereof (*Effective July*
660 *1, 2007*):

661 (g) For the fiscal year ending June 30, 1993, any intermediate care
662 facility for the mentally retarded with an operating cost component of
663 its rate in excess of one hundred forty per cent of the median of
664 operating cost components of rates in effect January 1, 1992, shall not
665 receive an operating cost component increase. For the fiscal year
666 ending June 30, 1993, any intermediate care facility for the mentally
667 retarded with an operating cost component of its rate that is less than

668 one hundred forty per cent of the median of operating cost
669 components of rates in effect January 1, 1992, shall have an allowance
670 for real wage growth equal to thirty per cent of the increase
671 determined in accordance with subsection (q) of section 17-311-52 of
672 the regulations of Connecticut state agencies, provided such operating
673 cost component shall not exceed one hundred forty per cent of the
674 median of operating cost components in effect January 1, 1992. Any
675 facility with real property other than land placed in service prior to
676 October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a
677 rate of return on real property equal to the average of the rates of
678 return applied to real property other than land placed in service for the
679 five years preceding October 1, 1993. For the fiscal year ending June 30,
680 1996, and any succeeding fiscal year, the rate of return on real property
681 for property items shall be revised every five years. The commissioner
682 shall, upon submission of a request, allow actual debt service,
683 comprised of principal and interest, in excess of property costs allowed
684 pursuant to section 17-311-52 of the regulations of Connecticut state
685 agencies, provided such debt service terms and amounts are
686 reasonable in relation to the useful life and the base value of the
687 property. For the fiscal year ending June 30, 1995, and any succeeding
688 fiscal year, the inflation adjustment made in accordance with
689 subsection (p) of section 17-311-52 of the regulations of Connecticut
690 state agencies shall not be applied to real property costs. For the fiscal
691 year ending June 30, 1996, and any succeeding fiscal year, the
692 allowance for real wage growth, as determined in accordance with
693 subsection (q) of section 17-311-52 of the regulations of Connecticut
694 state agencies, shall not be applied. For the fiscal year ending June 30,
695 1996, and any succeeding fiscal year, no rate shall exceed three
696 hundred seventy-five dollars per day unless the commissioner, in
697 consultation with the Commissioner of Mental Retardation,
698 determines after a review of program and management costs, that a
699 rate in excess of this amount is necessary for care and treatment of
700 facility residents. For the fiscal year ending June 30, 2002, rate period,
701 the Commissioner of Social Services shall increase the inflation

702 adjustment for rates made in accordance with subsection (p) of section
703 17-311-52 of the regulations of Connecticut state agencies to update
704 allowable fiscal year 2000 costs to include a three and one-half per cent
705 inflation factor. For the fiscal year ending June 30, 2003, rate period, the
706 commissioner shall increase the inflation adjustment for rates made in
707 accordance with subsection (p) of section 17-311-52 of the regulations
708 of Connecticut state agencies to update allowable fiscal year 2001 costs
709 to include a one and one-half per cent inflation factor, except that such
710 increase shall be effective November 1, 2002, and such facility rate in
711 effect for the fiscal year ending June 30, 2002, shall be paid for services
712 provided until October 31, 2002, except any facility that would have
713 been issued a lower rate effective July 1, 2002, than for the fiscal year
714 ending June 30, 2002, due to interim rate status or agreement with the
715 department shall be issued such lower rate effective July 1, 2002, and
716 have such rate updated effective November 1, 2002, in accordance with
717 applicable statutes and regulations. For the fiscal year ending June 30,
718 2004, rates in effect for the period ending June 30, 2003, shall remain in
719 effect, except any facility that would have been issued a lower rate
720 effective July 1, 2003, than for the fiscal year ending June 30, 2003, due
721 to interim rate status or agreement with the department shall be issued
722 such lower rate effective July 1, 2003. For the fiscal year ending June
723 30, 2005, rates in effect for the period ending June 30, 2004, shall
724 remain in effect until September 30, 2004. Effective October 1, 2004,
725 each facility shall receive a rate that is five per cent greater than the
726 rate in effect September 30, 2004. Effective upon receipt of all the
727 necessary federal approvals to secure federal financial participation
728 matching funds associated with the rate increase provided in
729 subdivision (4) of subsection (f) of this section, but in no event earlier
730 than October 1, 2005, and provided the user fee imposed under section
731 17b-320 is required to be collected, each facility shall receive a rate that
732 is four per cent more than the rate the facility received in the prior
733 fiscal year, except any facility that would have been issued a lower rate
734 effective October 1, 2005, than for the fiscal year ending June 30, 2005,
735 due to interim rate status or agreement with the department, shall be

736 issued such lower rate effective October 1, 2005. Such rate increase
737 shall remain in effect unless: (A) The federal financial participation
738 matching funds associated with the rate increase are no longer
739 available; or (B) the user fee created pursuant to section 17b-320 is not
740 in effect. For the fiscal year ending June 30, 2007, rates in effect for the
741 period ending June 30, 2006, shall remain in effect until September 30,
742 2006, except any facility that would have been issued a lower rate
743 effective July 1, 2006, than for the fiscal year ending June 30, 2006, due
744 to interim rate status or agreement with the department, shall be
745 issued such lower rate effective July 1, 2006. Effective October 1, 2006,
746 no facility shall receive a rate that is more than three per cent greater
747 than the rate in effect for the facility on September 30, 2006, except [for]
748 any facility that would have been issued a lower rate effective October
749 1, 2006, due to interim rate status or agreement with the department,
750 shall be issued such lower rate effective October 1, 2006. For the fiscal
751 year ending June 30, 2008, each facility shall receive a rate that is two
752 and nine-tenths per cent greater than the rate in effect for the period
753 ending June 30, 2007, except any facility that would have been issued a
754 lower rate effective July 1, 2007, than for the rate period ending June
755 30, 2007, due to interim rate status, or agreement with the department,
756 shall be issued such lower rate effective July 1, 2007. For the fiscal year
757 ending June 30, 2009, rates in effect for the period ending June 30, 2008,
758 shall remain in effect until June 30, 2009, except any facility that would
759 have been issued a lower rate for the fiscal year ending June 30, 2009,
760 due to interim rate status or agreement with the department, shall be
761 issued such lower rate.

762 Sec. 13. Subsection (a) of section 17b-244 of the general statutes is
763 repealed and the following is substituted in lieu thereof (*Effective July*
764 *1, 2007*):

765 (a) The room and board component of the rates to be paid by the
766 state to private facilities and facilities operated by regional education
767 service centers which are licensed to provide residential care pursuant
768 to section 17a-227, but not certified to participate in the Title XIX

769 Medicaid program as intermediate care facilities for persons with
770 mental retardation, shall be determined annually by the Commissioner
771 of Social Services, except that rates effective April 30, 1989, shall
772 remain in effect through October 31, 1989. Any facility with real
773 property other than land placed in service prior to July 1, 1991, shall,
774 for the fiscal year ending June 30, 1995, receive a rate of return on real
775 property equal to the average of the rates of return applied to real
776 property other than land placed in service for the five years preceding
777 July 1, 1993. For the fiscal year ending June 30, 1996, and any
778 succeeding fiscal year, the rate of return on real property for property
779 items shall be revised every five years. The commissioner shall, upon
780 submission of a request by such facility, allow actual debt service,
781 comprised of principal and interest, on the loan or loans in lieu of
782 property costs allowed pursuant to section 17-313b-5 of the regulations
783 of Connecticut state agencies, whether actual debt service is higher or
784 lower than such allowed property costs, provided such debt service
785 terms and amounts are reasonable in relation to the useful life and the
786 base value of the property. In the case of facilities financed through the
787 Connecticut Housing Finance Authority, the commissioner shall allow
788 actual debt service, comprised of principal, interest and a reasonable
789 repair and replacement reserve on the loan or loans in lieu of property
790 costs allowed pursuant to section 17-313b-5 of the regulations of
791 Connecticut state agencies, whether actual debt service is higher or
792 lower than such allowed property costs, provided such debt service
793 terms and amounts are determined by the commissioner at the time
794 the loan is entered into to be reasonable in relation to the useful life
795 and base value of the property. The commissioner may allow fees
796 associated with mortgage refinancing provided such refinancing will
797 result in state reimbursement savings, after comparing costs over the
798 terms of the existing proposed loans. For the fiscal year ending June 30,
799 1992, the inflation factor used to determine rates shall be one-half of
800 the gross national product percentage increase for the period between
801 the midpoint of the cost year through the midpoint of the rate year. For
802 fiscal year ending June 30, 1993, the inflation factor used to determine

803 rates shall be two-thirds of the gross national product percentage
804 increase from the midpoint of the cost year to the midpoint of the rate
805 year. For the fiscal years ending June 30, 1996, and June 30, 1997, no
806 inflation factor shall be applied in determining rates. The
807 Commissioner of Social Services shall prescribe uniform forms on
808 which such facilities shall report their costs. Such rates shall be
809 determined on the basis of a reasonable payment for necessary
810 services. Any increase in grants, gifts, fund-raising or endowment
811 income used for the payment of operating costs by a private facility in
812 the fiscal year ending June 30, 1992, shall be excluded by the
813 commissioner from the income of the facility in determining the rates
814 to be paid to the facility for the fiscal year ending June 30, 1993,
815 provided any operating costs funded by such increase shall not
816 obligate the state to increase expenditures in subsequent fiscal years.
817 Nothing contained in this section shall authorize a payment by the
818 state to any such facility in excess of the charges made by the facility
819 for comparable services to the general public. The service component
820 of the rates to be paid by the state to private facilities and facilities
821 operated by regional education service centers which are licensed to
822 provide residential care pursuant to section 17a-227, but not certified
823 to participate in the Title XIX Medicaid programs as intermediate care
824 facilities for persons with mental retardation, shall be determined
825 annually by the Commissioner of Mental Retardation in accordance
826 with section 17b-244a. For the fiscal year ending June 30, 2008, no
827 facility shall receive a rate that is more than two per cent greater than
828 the rate in effect for the facility on June 30, 2007, except any facility that
829 would have been issued a lower rate effective July 1, 2007, due to
830 interim rate status or agreement with the department, shall be issued
831 such lower rate effective July 1, 2007. For the fiscal year ending June
832 30, 2009, no facility shall receive a rate that is more than two per cent
833 greater than the rate in effect for the facility on June 30, 2008, except
834 any facility that would have been issued a lower rate effective July 1,
835 2008, due to interim rate status or agreement with the department,
836 shall be issued such lower rate effective July 1, 2008.

837 Sec. 14. Section 17b-192 of the general statutes as amended by
838 section 2 of public act 07-185 is repealed and the following is
839 substituted in lieu thereof (*Effective July 1, 2007*):

840 (a) The Commissioner of Social Services shall implement a state
841 medical assistance component of the state-administered general
842 assistance program for persons ineligible for Medicaid. Eligibility
843 criteria concerning income shall be the same as the medically needy
844 component of the Medicaid program, except that earned monthly
845 gross income of up to one hundred fifty dollars shall be disregarded.
846 Unearned income shall not be disregarded. No person who has family
847 assets exceeding one thousand dollars shall be eligible. No person shall
848 be eligible for assistance under this section if such person made,
849 during the three months prior to the month of application, an
850 assignment or transfer or other disposition of property for less than
851 fair market value. The number of months of ineligibility due to such
852 disposition shall be determined by dividing the fair market value of
853 such property, less any consideration received in exchange for its
854 disposition, by five hundred dollars. Such period of ineligibility shall
855 commence in the month in which the person is otherwise eligible for
856 benefits. Any assignment, transfer or other disposition of property, on
857 the part of the transferor, shall be presumed to have been made for the
858 purpose of establishing eligibility for benefits or services unless such
859 person provides convincing evidence to establish that the transaction
860 was exclusively for some other purpose.

861 (b) Each person eligible for state-administered general assistance
862 shall be entitled to receive medical care through a federally qualified
863 health center or other primary care provider as determined by the
864 commissioner. The Commissioner of Social Services shall determine
865 appropriate service areas and shall, in the commissioner's discretion,
866 contract with community health centers, other similar clinics, and
867 other primary care providers, if necessary, to assure access to primary
868 care services for recipients who live farther than a reasonable distance
869 from a federally qualified health center. The commissioner shall assign

870 and enroll eligible persons in federally qualified health centers and
871 with any other providers contracted for the program because of access
872 needs. Each person eligible for state-administered general assistance
873 shall be entitled to receive hospital services. Medical services under the
874 program shall be limited to the services provided by a federally
875 qualified health center, hospital, or other provider contracted for the
876 program at the commissioner's discretion because of access needs. The
877 commissioner shall ensure that ancillary services and specialty services
878 are provided by a federally qualified health center, hospital, or other
879 providers contracted for the program at the commissioner's discretion.
880 Ancillary services include, but are not limited to, radiology, laboratory,
881 and other diagnostic services not available from a recipient's assigned
882 primary-care provider, and durable medical equipment. Specialty
883 services are services provided by a physician with a specialty that are
884 not included in ancillary services. [In no event shall ancillary]
885 Ancillary or specialty services provided under the program shall not
886 exceed such services provided under the state-administered general
887 assistance program on July 1, 2003, except for nonemergency medical
888 transportation and vision care services which may be provided for a
889 limited duration. Notwithstanding any provision of this subsection,
890 the commissioner may, when determined cost effective, provide or
891 require a contractor to provide home health services or skilled nursing
892 facility coverage for state-administered general assistance recipients
893 being discharged from a chronic disease hospital.

894 (c) Pharmacy services shall be provided to recipients of state-
895 administered general assistance through the federally qualified health
896 center to which they are assigned or through a pharmacy with which
897 the health center contracts. Recipients who are assigned to a
898 community health center or similar clinic or primary care provider
899 other than a federally qualified health center or to a federally qualified
900 health center that does not have a contract for pharmacy services shall
901 receive pharmacy services at pharmacies designated by the
902 commissioner. The Commissioner of Social Services or the managed
903 care organization or other entity performing administrative functions

904 for the program as permitted in subsection (d) of this section, shall
905 require prior authorization for coverage of drugs for the treatment of
906 erectile dysfunction. The commissioner or the managed care
907 organization or other entity performing administrative functions for
908 the program may limit or exclude coverage for drugs for the treatment
909 of erectile dysfunction for persons who have been convicted of a sexual
910 offense who are required to register with the Commissioner of Public
911 Safety pursuant to chapter 969.

912 (d) The Commissioner of Social Services shall contract with
913 federally qualified health centers or other primary care providers as
914 necessary to provide medical services to eligible state-administered
915 general assistance recipients pursuant to this section. The
916 commissioner shall, within available appropriations, make payments
917 to such centers based on their pro rata share of the cost of services
918 provided or the number of clients served, or both. The Commissioner
919 of Social Services shall, within available appropriations, make
920 payments to other providers based on a methodology determined by
921 the commissioner. The Commissioner of Social Services may reimburse
922 for extraordinary medical services, provided such services are
923 documented to the satisfaction of the commissioner. For purposes of
924 this section, the commissioner may contract with a managed care
925 organization or other entity to perform administrative functions,
926 including a grievance process for recipients to access review of a denial
927 of coverage for a specific medical service, and to operate the program
928 in whole or in part. Provisions of a contract for medical services
929 entered into by the commissioner pursuant to this section shall
930 supersede any inconsistent provision in the regulations of Connecticut
931 state agencies. A recipient who has exhausted the grievance process
932 established through such contract and wishes to seek further review of
933 the denial of coverage for a specific medical service may request a
934 hearing in accordance with the provisions of section 17b-60.

935 (e) Each federally qualified health center participating in the
936 program shall enroll in the federal Office of Pharmacy Affairs Section

937 340B drug discount program established pursuant to 42 USC 256b to
938 provide pharmacy services to recipients at Federal Supply Schedule
939 costs. Each such health center may establish an on-site pharmacy or
940 contract with a commercial pharmacy to provide such pharmacy
941 services.

942 (f) The Commissioner of Social Services shall, within available
943 appropriations, make payments to hospitals for inpatient services
944 based on their pro rata share of the cost of services provided or the
945 number of clients served, or both. The Commissioner of Social Services
946 shall, within available appropriations, make payments for any
947 ancillary or specialty services provided to state-administered general
948 assistance recipients under this section based on a methodology
949 determined by the commissioner.

950 (g) On or before January 1, 2008, the Commissioner of Social
951 Services shall seek a waiver of federal law for the purpose of extending
952 health insurance coverage under Medicaid to persons with income not
953 in excess of one hundred per cent of the federal poverty level who
954 otherwise qualify for medical assistance under the state-administered
955 general assistance program. The provisions of section 17b-8 shall apply
956 to this section.

957 (h) The commissioner, pursuant to section 17b-10, may implement
958 policies and procedures to administer the provisions of this section
959 while in the process of adopting such policies and procedures as
960 regulation, provided the commissioner prints notice of the intent to
961 adopt the regulation in the Connecticut Law Journal not later than
962 twenty days after the date of implementation. Such policy shall be
963 valid until the time final regulations are adopted.

964 Sec. 15. Section 17b-733 of the general statutes is repealed and the
965 following is substituted in lieu thereof (*Effective July 1, 2007*):

966 The Department of Social Services shall be the lead agency for child
967 day care services in Connecticut. The department shall: (1) Identify,

968 annually, existing child day care services and maintain an inventory of
969 all available services; (2) provide technical assistance to corporations
970 and private agencies in the development and expansion of child day
971 care services for families at all income levels, including families of their
972 employees and clients; (3) study and identify funding sources available
973 for child day care including federal funds and tax benefits; (4) study
974 the cost and availability of liability insurance for child day care
975 providers; (5) provide, in conjunction with the Departments of
976 Education and Higher Education, ongoing training for child day care
977 providers including preparing videotaped workshops and distributing
978 them to cable stations for broadcast on public access stations, and seek
979 private donations to fund such training; (6) encourage child day care
980 services to obtain accreditation; (7) develop a range of financing
981 options for child care services, including the use of a tax-exempt bond
982 program, a loan guarantee program and establishing a direct revolving
983 loan program; (8) promote the colocation of child day care and school
984 readiness programs pursuant to section 4b-31; (9) establish a
985 performance-based evaluation system; (10) develop for
986 recommendation to the Governor and the General Assembly measures
987 to provide incentives for the private sector to develop and support
988 expanded child day care services; (11) provide, within available funds
989 and in conjunction with the temporary family assistance program as
990 defined in section 17b-680, child day care to public assistance
991 recipients; (12) develop and implement, with the assistance of the
992 Child Day Care Council and the Departments of Public Health, Social
993 Services, Education, Higher Education, Children and Families,
994 Economic and Community Development and Consumer Protection, a
995 state-wide coordinated child day care and early childhood education
996 training system (A) for child day care centers, group day care homes
997 and family day care homes that provide child day care services, and
998 (B) that makes available to such providers and their staff, within
999 available appropriations, scholarship assistance, career counseling and
1000 training, advancement in career ladders, as defined in section 4-124bb,
1001 through seamless articulation of levels of training, program

1002 accreditation support and other initiatives recommended by the
1003 Departments of Social Services, Education and Higher Education; (13)
1004 plan and implement a unit cost reimbursement system for state-
1005 funded child day care services such that, on and after January 1, 2008,
1006 any increase in reimbursement shall be based on a requirement that
1007 such centers meet the staff qualifications, as defined in subsection (b)
1008 of section 10-16p; (14) develop, within available funds, initiatives to
1009 increase compensation paid to child day care providers for educational
1010 opportunities, including, but not limited to, (A) incentives for
1011 educational advancement paid to persons employed by child day care
1012 centers receiving state or federal funds, and (B) support for the
1013 establishment and implementation by the Labor Commissioner of
1014 apprenticeship programs for child day care workers pursuant to
1015 sections 31-22m to 31-22q, inclusive, which programs shall be jointly
1016 administered by labor and management trustees; (15) evaluate the
1017 effectiveness of any initiatives developed pursuant to subdivision (14)
1018 of this section in improving staff retention rates and the quality of
1019 education and care provided to children; and (16) report annually to
1020 the Governor and the General Assembly on the status of child day care
1021 in Connecticut. Such report shall include (A) an itemization of the
1022 allocation of state and federal funds for child care programs; (B) the
1023 number of children served under each program so funded; (C) the
1024 number and type of such programs, providers and support personnel;
1025 (D) state activities to encourage partnership between the public and
1026 private sectors; (E) average payments issued by the state for both part-
1027 time and full-time child care; (F) range of family income and
1028 percentages served within each range by such programs; and (G) age
1029 range of children served.

1030 Sec. 16. (NEW) (*Effective July 1, 2007*) Notwithstanding any
1031 provision of the general statutes, not later than November 1, 2007, the
1032 Department of Social Services shall develop a plan to implement a
1033 pilot program for the delivery of health care services through a system
1034 of primary care case management to not less than one thousand
1035 individuals who are otherwise eligible to receive HUSKY Plan, Part A

1036 benefits. Such plan shall be submitted to the joint standing committees
1037 of the General Assembly having cognizance of matters relating to
1038 human services and appropriations and the budgets of state agencies.
1039 Not later than thirty days after the date of receipt of such plan, said
1040 joint standing committees of the General Assembly shall hold a joint
1041 public hearing to review such plan. Said joint standing committees of
1042 the General Assembly may advise the commissioner of their approval
1043 or denial or modifications, if any, of the plan. Primary care providers
1044 participating in the primary care case management system shall
1045 provide program beneficiaries with primary care medical services and
1046 arrange for specialty care as needed. For purposes of this section,
1047 "primary care case management" means a system of care in which the
1048 health care services for program beneficiaries are coordinated by a
1049 primary care provider chosen by or assigned to the beneficiary. The
1050 Commissioner of Social Services shall begin enrollment for the primary
1051 care case management system not later than April 1, 2008.

1052 Sec. 17. Section 17b-292 of the general statutes as amended by
1053 section 6 of public act 07-185 is repealed and the following is
1054 substituted in lieu thereof (*Effective July 1, 2007*):

1055 (a) A child who resides in a household with a family income which
1056 exceeds one hundred eighty-five per cent of the federal poverty level
1057 and does not exceed [four] three hundred per cent of the federal
1058 poverty level may be eligible for subsidized benefits under the HUSKY
1059 Plan, Part B.

1060 (b) A child who resides in a household with a family income over
1061 [four] three hundred per cent of the federal poverty level may be
1062 eligible for unsubsidized benefits under the HUSKY Plan, Part B.

1063 (c) Whenever a court or family support magistrate orders a
1064 noncustodial parent to provide health insurance for a child, such
1065 parent may provide for coverage under the HUSKY Plan, Part B.

1066 (d) To the extent allowed under federal law, the commissioner shall

1077 not pay for services or durable medical equipment under the HUSKY
1078 Plan, Part B if the enrollee has other insurance coverage for the services
1079 or such equipment.

1070 (e) A newborn child who otherwise meets the eligibility criteria for
1071 the HUSKY Plan, Part B shall be eligible for benefits retroactive to his
1072 or her date of birth, provided an application is filed on behalf of the
1073 child not later than thirty days after such date. Any uninsured child
1074 born in a hospital in this state or in a border state hospital shall be
1075 enrolled on an expedited basis in the HUSKY Plan, Part B, provided (1)
1076 the parent or caretaker relative of such child resides in this state, and
1077 (2) the parent or caretaker relative of such child authorizes enrollment
1078 in the program. The commissioner shall pay any premium cost such
1079 family would otherwise incur for the first [two] four months of
1080 coverage to the managed care organization selected by the parent or
1081 caretaker relative to provide coverage for such child.

1082 (f) The commissioner shall implement presumptive eligibility for
1083 children applying for Medicaid. Such presumptive eligibility
1084 determinations shall be in accordance with applicable federal law and
1085 regulations. The commissioner shall adopt regulations, in accordance
1086 with chapter 54, to establish standards and procedures for the
1087 designation of organizations as qualified entities to grant presumptive
1088 eligibility. Qualified entities shall ensure that, at the time a
1089 presumptive eligibility determination is made, a completed application
1090 for Medicaid is submitted to the department for a full eligibility
1091 determination. In establishing such standards and procedures, the
1092 commissioner shall ensure the representation of state-wide and local
1093 organizations that provide services to children of all ages in each
1094 region of the state.

1095 (g) The commissioner shall [enter into a contract with an entity to
1096 be] provide for a single point of entry servicer for applicants and
1097 enrollees under the HUSKY Plan, Part A and Part B. The
1098 commissioner, in consultation with the servicer, shall establish a

1099 centralized unit to be responsible for processing all applications for
1100 assistance under the HUSKY Plan, Part A and Part B. The department,
1101 through its [contract with the] servicer, shall ensure that a child who is
1102 determined to be eligible for benefits under the HUSKY Plan, Part A,
1103 or the HUSKY Plan, Part B has uninterrupted health insurance
1104 coverage for as long as the parent or guardian elects to enroll or re-
1105 enroll such child in the HUSKY Plan, Part A or Part B. The
1106 commissioner, in consultation with the servicer, and in accordance
1107 with the provisions of section 17b-297, as amended by this act, shall
1108 jointly market both Part A and Part B together as the HUSKY Plan and
1109 shall develop and implement public information and outreach
1110 activities with community programs. Such servicer shall electronically
1111 transmit data with respect to enrollment and disenrollment in the
1112 HUSKY Plan, Part A and Part B to the commissioner.

1113 (h) Upon the expiration of any contractual provisions entered into
1114 pursuant to subsection (g) of this section, the commissioner shall
1115 develop a new contract for single point of entry services and managed
1116 care enrollment brokerage services. The commissioner may enter into
1117 one or more contractual arrangements for such services for a contract
1118 period not to exceed seven years. Such contracts shall include
1119 performance measures, including, but not limited to, specified time
1120 limits for the processing of applications, parameters setting forth the
1121 requirements for a completed and reviewable application and the
1122 percentage of applications forwarded to the department in a complete
1123 and timely fashion. Such contracts shall also include a process for
1124 identifying and correcting noncompliance with established
1125 performance measures, including sanctions applicable for instances of
1126 continued noncompliance with performance measures.

1127 (i) The single point of entry servicer shall send all applications and
1128 supporting documents to the commissioner for determination of
1129 eligibility. The servicer shall enroll eligible beneficiaries in the
1130 applicant's choice of managed care plan. Upon enrollment in a
1131 managed care plan, an eligible HUSKY Plan Part A or Part B

1132 beneficiary shall remain enrolled in such managed care plan for twelve
1133 months from the date of such enrollment unless (1) an eligible
1134 beneficiary demonstrates good cause to the satisfaction of the
1135 commissioner of the need to enroll in a different managed care plan, or
1136 (2) the beneficiary no longer meets program eligibility requirements.

1137 (j) Not later than ten months after the determination of eligibility for
1138 benefits under the HUSKY Plan, Part A and Part B and annually
1139 thereafter, the commissioner or the servicer, as the case may be, shall
1140 [determine if the child continues to be eligible for the plan. The
1141 commissioner or the servicer shall,] within existing budgetary
1142 resources, mail or, upon request of a participant, electronically
1143 transmit an application form to each participant in the plan for the
1144 purposes of obtaining information to make a determination on
1145 continued eligibility beyond the twelve months of initial eligibility. To
1146 the extent permitted by federal law, in determining eligibility for
1147 benefits under the HUSKY Plan, Part A or Part B with respect to family
1148 income, the commissioner or the servicer shall rely upon information
1149 provided in such form by the participant unless the commissioner or
1150 the servicer has reason to believe that such information is inaccurate or
1151 incomplete. The Department of Social Services shall annually review a
1152 random sample of cases to confirm that, based on the statistical
1153 sample, relying on such information is not resulting in ineligible clients
1154 receiving benefits under HUSKY Plan Part A or Part B. The
1155 determination of eligibility shall be coordinated with health plan open
1156 enrollment periods.

1157 (k) The commissioner shall implement the HUSKY Plan, Part B
1158 while in the process of adopting necessary policies and procedures in
1159 regulation form in accordance with the provisions of section 17b-10.

1160 (l) The commissioner shall adopt regulations, in accordance with
1161 chapter 54, to establish residency requirements and income eligibility
1162 for participation in the HUSKY Plan, Part B and procedures for a
1163 simplified mail-in application process. Notwithstanding the provisions

1164 of section 17b-257b, such regulations shall provide that any child
1165 adopted from another country by an individual who is a citizen of the
1166 United States and a resident of this state shall be eligible for benefits
1167 under the HUSKY Plan, Part B upon arrival in this state.

1168 Sec. 18. Subsection (a) of section 17b-137 of the general statutes is
1169 repealed and the following is substituted in lieu thereof (*Effective July*
1170 *1, 2007*):

1171 (a) (1) (A) Any person who has in his possession or control any
1172 property of any person applying for or presently or formerly receiving
1173 aid or care or child support enforcement services, as defined in
1174 subdivision (2) of subsection (b) of section 46b-231, from the state or
1175 who is indebted to such applicant or recipient or has knowledge of any
1176 insurance, including health insurance or property currently or
1177 formerly belonging to him, or information pertaining to eligibility for
1178 such aid or care or services, and any officer who has control of the
1179 books and accounts of any corporation which has possession or control
1180 of any property belonging to any person applying for or receiving such
1181 aid or care or services or who is indebted to him, or has knowledge of
1182 any insurance, including health insurance or any person having in his
1183 employ any such person, shall, upon presentation by the
1184 Commissioner of Social Services, or the Commissioner of
1185 Administrative Services, or the Commissioner of Public Safety, or a
1186 support enforcement officer of the Superior Court, or any person
1187 deputized by any of them, of a certificate, signed by him, stating that
1188 such applicant, recipient or employee has applied for or is receiving or
1189 has received such aid or care or services from the state, make full
1190 disclosure to said commissioner, such officer or such deputy of any
1191 such property, insurance, wages, indebtedness or information.
1192 Notwithstanding the provisions of this subparagraph, any health
1193 insurer, including a self-insured plan, group health plan, as defined in
1194 Section 607(1) of the Employee Retirement Income Security Act of
1195 1974, service benefit plan, managed care organization, health care
1196 center, pharmacy benefit manager, dental benefit manager or other

1197 party that is, by statute, contract or agreement, legally responsible for
1198 payment of a claim for a health care item or service, which may or may
1199 not be financially at risk for the cost of a health care item or service,
1200 shall, upon request of the Commissioner of Social Services, or the
1201 commissioner's designee, provide any and all information in a manner
1202 and format prescribed by the commissioner, or the commissioner's
1203 designee, to identify, determine or establish third-party coverage,
1204 including, all information necessary to determine during what period a
1205 person, his or her spouse or his or her dependents may be, or may
1206 have been, covered by a health insurer and the nature of the coverage
1207 that is or was provided by the health insurer, including the name,
1208 address and identifying number of the plan. Such information shall
1209 also be provided by such health insurer to all third-party
1210 administrators, pharmacy benefit managers, dental benefit managers
1211 or other entities with which the health insurer has an arrangement to
1212 adjudicate claims for a health care item or service.

1213 (B) At the request of the Commissioner of Social Services, [insurance
1214 companies licensed to do business in Connecticut] any health insurer,
1215 including a self-insured plan, group health plan, as defined in Section
1216 607(1) of the Employee Retirement Income Security Act of 1974, service
1217 benefit plan, managed care organization, health care center, pharmacy
1218 benefit manager, dental benefit manager or other party that is, by
1219 statute, contract or agreement, legally responsible for payment of a
1220 claim for a health care item or service, which may or may not be
1221 financially at risk for the cost of a health care item or service, shall be
1222 required, [when compatible data elements are available,] to conduct, or
1223 to allow the commissioner, or the commissioner's designee, to conduct
1224 automated data matches to identify insurance coverage for recipients
1225 and the parents of recipients who are minors. Upon completion of such
1226 matches the commissioner shall reimburse such companies for the
1227 reasonable documented costs of conducting the matches.

1228 (2) (A) Such disclosure may be obtained in like manner of the
1229 property, wages or indebtedness of any person who is either: (i) Liable

1230 for the support of any such applicant or recipient, including the
1231 parents of any child receiving aid or services through the Department
1232 of Children and Families, or one adjudged or acknowledged to be the
1233 father of an illegitimate child; or (ii) the subject of an investigation in a
1234 IV-D support case, as defined in subdivision (13) of subsection (b) of
1235 section 46b-231. Any company or officer who has control of the books
1236 and accounts of any corporation shall make full disclosure to the IV-D
1237 agency, as defined in subdivision (12) of subsection (b) of section 46b-
1238 231, or to the support enforcement officer of the Superior Court of any
1239 such property, wages or indebtedness in all support cases, including
1240 IV-D support cases, as defined in subdivision (13) of subsection (b) of
1241 section 46b-231.

1242 (B) The Commissioner of Social Services, the Commissioner of
1243 Administrative Services, the Commissioner of Public Safety or a
1244 support enforcement officer of the Superior Court, or any person
1245 deputized by any of them, may compel, by subpoena, the attendance
1246 and testimony under oath of any person who refuses to disclose in
1247 accordance with the provisions of this section, or of any person who is
1248 either: (i) Liable for the support of any such applicant or recipient; or
1249 (ii) the subject of an investigation in a IV-D support case, as defined in
1250 subdivision (13) of subsection (b) of section 46b-231, who refuses to
1251 disclose his own financial circumstances, and may so compel the
1252 production of books and papers pertaining to such information.

1253 (C) The Commissioner of Social Services may subpoena the financial
1254 records of any financial institution concerning property of any person
1255 applying for or presently or formerly receiving aid or care from the
1256 state or who is indebted to such applicant or recipient. The
1257 Commissioner of Social Services may subpoena such records of any
1258 parent or parents of any child applying for or presently or formerly
1259 receiving assistance under the aid to families with dependent children
1260 program, the temporary family assistance program or the state-
1261 administered general assistance program.

1262 (D) The commissioner, or a support enforcement officer of the
1263 Superior Court, or the person deputized by the commissioner or officer
1264 shall set a time and place for any examination under this subdivision,
1265 and any person summoned who, without reasonable excuse, fails to
1266 appear and testify or to produce such books and papers shall be fined
1267 fifty dollars for each such offense.

1268 Sec. 19. (NEW) (*Effective July 1, 2007*) Any health insurer, including a
1269 self-insured plan, group health plan, as defined in Section 607(1) of the
1270 Employee Retirement Income Security Act of 1974, service benefit
1271 plan, managed care organization, health care center, pharmacy benefit
1272 manager, dental benefit manager or other party that is, by statute,
1273 contract or agreement, legally responsible for payment of a claim for a
1274 health care item or service, and which may or may not be financially at
1275 risk for the cost of a health care item or service, shall, as a condition of
1276 doing business in the state, be required to: (1) Provide, with respect to
1277 an individual who is eligible for, or is provided, medical assistance
1278 under the Medicaid state plan, to all third-party administrators,
1279 pharmacy benefit managers, dental benefit managers or other entities
1280 with which the health insurer has a contract or arrangement to
1281 adjudicate claims for a health care item or service, and to the
1282 Commissioner of Social Services, or the commissioner's designee, any
1283 and all information in a manner and format prescribed by the
1284 commissioner, or commissioner's designee, necessary to determine
1285 when the individual, his or her spouse or the individual's dependents
1286 may be or have been covered by a health insurer and the nature of the
1287 coverage that is or was provided by such health insurer including the
1288 name, address and identifying number of the plan; (2) accept the state's
1289 right of recovery and the assignment to the state of any right of an
1290 individual or other entity to payment from the health insurer for an
1291 item or service for which payment has been made under the Medicaid
1292 state plan; (3) respond to any inquiry by the commissioner, or the
1293 commissioner's designee, regarding a claim for payment for any health
1294 care item or service that is submitted not later than three years after the
1295 date of the provision of the item or service; and (4) agree not to deny a

1296 claim submitted by the state solely on the basis of the date of
1297 submission of the claim, the type or format of the claim form or a
1298 failure to present proper documentation at the point-of-sale that is the
1299 basis of the claim, if (A) the claim is submitted by the state or its agent
1300 within the three-year period beginning on the date on which the item
1301 or service was furnished; and (B) any legal action by the state to
1302 enforce its rights with respect to such claim is commenced within six
1303 years of the state's submission of such claim.

1304 Sec. 20. Section 17b-265 of the general statutes is repealed and the
1305 following is substituted in lieu thereof (*Effective July 1, 2007*):

1306 (a) In accordance with 42 USC 1396k, the Department of Social
1307 Services shall be subrogated to any right of recovery or
1308 indemnification [which] that an applicant or recipient of medical
1309 assistance or any legally liable relative of such applicant or recipient
1310 has against [a private] an insurer or other legally liable third party [, as
1311 defined in 42 CFR 433.136,] including, but not limited to, a self-insured
1312 plan, group health plan, as defined in Section 607(1) of the Employee
1313 Retirement Income Security Act of 1974, service benefit plan, managed
1314 care organization, health care center, pharmacy benefit manager,
1315 dental benefit manager or other party that is, by statute, contract or
1316 agreement, legally responsible for payment of a claim for a health care
1317 item or service, for the cost of all health care items or services
1318 furnished to the applicant or recipient, including, but not limited to,
1319 hospitalization, pharmaceutical services, physician services, nursing
1320 services, behavioral health services, long-term care services and other
1321 medical services, not to exceed the amount expended by the
1322 department for such care and treatment of the applicant or recipient. In
1323 the case of such a recipient who is an enrollee in a managed care
1324 organization under a Medicaid managed care contract with the state or
1325 a legally liable relative of such an enrollee, the department shall be
1326 subrogated to any right of recovery or indemnification which the
1327 enrollee or legally liable relative has against such a private insurer or
1328 other third party for the medical costs incurred by the managed care

1329 organization on behalf of an enrollee.

1330 (b) An applicant or recipient or legally liable relative, by the act of
1331 the applicant or recipient receiving medical assistance, shall be deemed
1332 to have made a subrogation assignment and an assignment of claim for
1333 benefits to the department. The department shall inform an applicant
1334 of such assignments at the time of application. Any entitlements from a
1335 contractual agreement with an applicant or recipient, legally liable
1336 relative or a state or federal program for such medical services, not to
1337 exceed the amount expended by the department, shall be so assigned.
1338 Such entitlements shall be directly reimbursable to the department by
1339 third party payors. The Department of Social Services may assign its
1340 right to subrogation or its entitlement to benefits to a designee or a
1341 health care provider participating in the Medicaid program and
1342 providing services to an applicant or recipient, in order to assist the
1343 provider in obtaining payment for such services. [A] In accordance
1344 with subsection (b) of section 38a-472, a provider that has received an
1345 assignment from the department shall notify the [private] recipient's
1346 health insurer or other legally liable third party including, but not
1347 limited to, a self-insured plan, group health plan, as defined in Section
1348 607(1) of the Employee Retirement Income Security Act of 1974, service
1349 benefit plan, managed care organization, health care center, pharmacy
1350 benefit manager, dental benefit manager or other party that is, by
1351 statute, contract or agreement, legally responsible for payment of a
1352 claim for a health care item or service, of the assignment upon
1353 rendition of services to the applicant or recipient. Failure to so notify
1354 the [private] health insurer or other legally liable third party shall
1355 render the provider ineligible for payment from the department. The
1356 provider shall notify the department of any request by the applicant or
1357 recipient or legally liable relative or representative of such applicant or
1358 recipient for billing information. This subsection shall not be construed
1359 to affect the right of an applicant or recipient to maintain an
1360 independent cause of action against such third party tortfeasor.

1361 (c) Claims for recovery or indemnification submitted by the

1362 department, or the department's designee, shall not be denied solely
1363 on the basis of the date of the submission of the claim, the type or
1364 format of the claim or the failure to present proper documentation at
1365 the point-of-service that is the basis of the claim, if (1) the claim is
1366 submitted by the state within the three-year period beginning on the
1367 date on which the item or service was furnished; and (2) any action by
1368 the state to enforce its rights with respect to such claim is commenced
1369 within six years of the state's submission of the claim.

1370 [(b)] (d) When a recipient of medical assistance has personal health
1371 insurance in force covering care or other benefits provided under such
1372 program, payment or part-payment of the premium for such insurance
1373 may be made when deemed appropriate by the Commissioner of
1374 Social Services. Effective January 1, 1992, the commissioner shall limit
1375 reimbursement to medical assistance providers, except those providers
1376 whose rates are established by the Commissioner of Public Health
1377 pursuant to chapter 368d, for coinsurance and deductible payments
1378 under Title XVIII of the Social Security Act to assure that the combined
1379 Medicare and Medicaid payment to the provider shall not exceed the
1380 maximum allowable under the Medicaid program fee schedules.

1381 [(c)] (e) Notwithstanding the provisions of subsection (c) of section
1382 38a-553, no [(1) individual or group accident, health or accident and
1383 health policy or medical expense policy or medical service plan
1384 contract, delivered, issued for delivery or renewed in this state on or
1385 after July 1, 1984, or (2) self-insured or self-funded plan subject to the
1386 provisions of the Employee Retirement Income Security Act of 1974]
1387 self-insured plan, group health plan, as defined in Section 607(1) of the
1388 Employee Retirement Income Security Act of 1974, service benefit
1389 plan, managed care plan, or any plan offered or administered by a
1390 health care center, pharmacy benefit manager, dental benefit manager
1391 or other party that is, by statute, contract or agreement, legally
1392 responsible for payment of a claim for a health care item or service,
1393 shall contain any provision [which] that has the effect of denying or
1394 limiting enrollment benefits or excluding coverage because services are

1395 rendered to an insured or beneficiary who is eligible for or who
1396 received medical assistance under this chapter. No insurer, as defined
1397 in section 38a-497a, shall impose requirements on the state Medicaid
1398 agency, which has been assigned the rights of an individual eligible for
1399 Medicaid and covered for health benefits from an insurer, that differ
1400 from requirements applicable to an agent or assignee of another
1401 individual so covered.

1402 [(d)] (f) The Commissioner of Social Services shall not pay for any
1403 services provided under this chapter if the individual eligible for
1404 medical assistance has coverage for the services under an accident or
1405 health insurance policy.

1406 Sec. 21. (NEW) (*Effective from passage*) No pharmacy shall claim
1407 payment from the Department of Social Services under a medical
1408 assistance program administered by the department or the Medicare
1409 Part D Supplemental Needs Fund, established pursuant to section 17b-
1410 265e of the general statutes, for prescription drugs dispensed to
1411 individuals who have other prescription drug insurance coverage
1412 unless such coverage has been exhausted and the individual is
1413 otherwise eligible for such a medical assistance program or assistance
1414 from the Medicare Part D Supplemental Needs Fund. The department
1415 shall recoup from the submitting pharmacy any claims submitted to
1416 and paid by the department when other insurance coverage is
1417 available. The department shall investigate a pharmacy that
1418 consistently submits ineligible claims for payment to determine
1419 whether the pharmacy is in violation of its medical assistance provider
1420 agreement or is committing fraud or abuse in the program and based
1421 on the findings of such investigation, may take action against such
1422 pharmacy, in accordance with state and federal law.

1423 Sec. 22. Subdivision (11) of subsection (f) of section 17b-340 of the
1424 general statutes is repealed and the following is substituted in lieu
1425 thereof (*Effective July 1, 2007*):

1426 (11) For the fiscal [year] years ending June 30, 1992, [and any

1427 succeeding fiscal year] through June 30, 2007, one-half of the initial
1428 amount payable in June by the state to a facility pursuant to this
1429 subsection shall be paid to the facility in June and the balance of such
1430 amount shall be paid in July.

1431 Sec. 23. (NEW) (*Effective July 1, 2008*) (a) There is established the
1432 Charter Oak Health Plan for the purpose of providing access to health
1433 insurance coverage for state residents who have been uninsured for at
1434 least six months and who are ineligible for other publicly funded
1435 health insurance plans. The Commissioner of Social Services may enter
1436 into contracts for the provision of comprehensive health care for such
1437 uninsured state residents. The commissioner shall conduct outreach to
1438 facilitate enrollment in the plan.

1439 (b) The commissioner shall impose cost-sharing requirements in
1440 connection with services provided under the Charter Oak Health Plan.
1441 Such requirements may include, but not be limited to: (1) A monthly
1442 premium; (2) an annual deductible not to exceed one thousand dollars;
1443 (3) a coinsurance payment not to exceed twenty per cent after the
1444 deductible amount is met; (4) tiered copayments for prescription drugs
1445 determined by whether the drug is generic or brand name, formulary
1446 or nonformulary and whether purchased through mail order; (5) no fee
1447 for emergency visits to hospital emergency rooms; (6) a copayment not
1448 to exceed one hundred fifty dollars for nonemergency visits to hospital
1449 emergency rooms; and (7) a lifetime benefit not to exceed one million
1450 dollars.

1451 (c) The Commissioner of Social Services shall provide premium
1452 assistance to eligible state residents whose gross annual income does
1453 not exceed three hundred per cent of the federal poverty level. Such
1454 premium assistance shall be limited to: (1) One hundred seventy-five
1455 dollars per month for individuals whose gross annual income is below
1456 one hundred fifty per cent of the federal poverty level; (2) one hundred
1457 fifty dollars per month for individuals whose gross annual income is at
1458 or above one hundred fifty per cent of the federal poverty level but not

1459 more than one hundred eighty-five per cent of the federal poverty
1460 level; (3) seventy-five dollars per month for individuals whose gross
1461 annual income is above one hundred eighty-five per cent of the federal
1462 poverty level but not more than two hundred thirty-five per cent of the
1463 federal poverty level; and (4) fifty dollars per month for individuals
1464 whose gross annual income is above two hundred thirty-five per cent
1465 of the federal poverty level but not more than three hundred per cent
1466 of the federal poverty level. Individuals insured under the Charter Oak
1467 Health Plan shall pay their share of payment for coverage in the plan
1468 directly to the insurer.

1469 (d) The Commissioner of Social Services shall determine minimum
1470 requirements on the amount, duration and scope of benefits under the
1471 Charter Oak Health Plan, except that there shall be no preexisting
1472 condition exclusion. Each participating insurer shall provide an
1473 internal grievance process by which an insured may request and be
1474 provided a review of a denial of coverage under the plan.

1475 (e) The Commissioner of Social Services may contract with the
1476 following entities for the purposes of this section: (1) A health care
1477 center subject to the provisions of chapter 698a of the general statutes;
1478 (2) a consortium of federally qualified health centers and other
1479 community-based providers of health services which are funded by
1480 the state; or (3) other consortia of providers of health care services
1481 established for the purposes of this section. Providers of
1482 comprehensive health care services as described in subdivisions (2)
1483 and (3) of this subsection shall not be subject to the provisions of
1484 chapter 698a of the general statutes. Any such provider shall be
1485 certified by the commissioner to participate in the Charter Oak Health
1486 Plan in accordance with criteria established by the commissioner,
1487 including, but not limited to, minimum reserve fund requirements.

1488 (f) The Commissioner of Social Services shall seek proposals from
1489 entities described in subsection (e) of this section based on the cost
1490 sharing and benefits described in subsections (b) and (c) of this section.

1491 The commissioner may approve an alternative plan in order to make
1492 coverage options available to those eligible to be insured under the
1493 plan.

1494 (g) The Commissioner of Social Services, pursuant to section 17b-10
1495 of the general statutes, may implement policies and procedures to
1496 administer the provisions of this section while in the process of
1497 adopting such policies and procedures as regulation, provided the
1498 commissioner prints notice of the intent to adopt the regulation in the
1499 Connecticut Law Journal not later than twenty days after the date of
1500 implementation. Such policies shall be valid until the time final
1501 regulations are adopted and may include: (1) Exceptions to the
1502 requirement that a resident be uninsured for at least six months to be
1503 eligible for the Charter Oak Health Plan; and (2) requirements for open
1504 enrollment and limitations on the ability of enrollees to change plans
1505 between such open enrollment periods.

1506 Sec. 24. (NEW) (*Effective July 1, 2007*) Each local or regional board of
1507 education shall require each pupil enrolled in the schools under its
1508 jurisdiction to annually report whether the pupil has health insurance.
1509 The Commissioner of Social Services, or the commissioner's designee,
1510 shall provide information to each local or regional board of education
1511 on state-sponsored health insurance programs for children, including
1512 application assistance for such programs. Each local or regional board
1513 of education shall provide such information to the pupil's parent or
1514 guardian.

1515 Sec. 25. Section 17a-317 of the general statutes is repealed and the
1516 following is substituted in lieu thereof (*Effective from passage*):

1517 (a) [There is] Effective July 1, 2008, there shall be established a
1518 Department on Aging which shall be under the direction and
1519 supervision of the Commissioner on Aging who shall be appointed by
1520 the Governor in accordance with the provisions of sections 4-5 to 4-8,
1521 inclusive, with the powers and duties prescribed in said sections. The
1522 commissioner shall be knowledgeable and experienced with respect to

1523 the conditions and needs of elderly persons and shall serve on a full-
1524 time basis.

1525 (b) The Commissioner on Aging shall administer all laws under the
1526 jurisdiction of the Department on Aging and shall employ the most
1527 efficient and practical means for the provision of care and protection of
1528 elderly persons. The commissioner shall have the power and duty to
1529 do the following: (1) Administer, coordinate and direct the operation
1530 of the department; (2) adopt and enforce regulations, in accordance
1531 with chapter 54, as necessary to implement the purposes of the
1532 department as established by statute; (3) establish rules for the internal
1533 operation and administration of the department; (4) establish and
1534 develop programs and administer services to achieve the purposes of
1535 the department; (5) contract for facilities, services and programs to
1536 implement the purposes of the department; (6) act as advocate for
1537 necessary additional comprehensive and coordinated programs for
1538 elderly persons; (7) assist and advise all appropriate state, federal, local
1539 and area planning agencies for elderly persons in the performance of
1540 their functions and duties pursuant to federal law and regulation; (8)
1541 plan services and programs for elderly persons; (9) coordinate
1542 outreach activities by public and private agencies serving elderly
1543 persons; and (10) consult and cooperate with area and private
1544 planning agencies.

1545 (c) The functions, powers, duties and personnel of the Division of
1546 Elderly Services of the Department of Social Services, or any
1547 subsequent division or portion of a division with similar functions,
1548 powers, personnel and duties, shall be transferred to the Department
1549 on Aging pursuant to the provisions of sections 4-38d, 4-38e and 4-39.

1550 (d) Any order or regulation of the Department of Social Services or
1551 the Commission on Aging that is in force on [January 1, 2007] July 1,
1552 2008, shall continue in force and effect as an order or regulation until
1553 amended, repealed or superseded pursuant to law.

1554 Sec. 26. Section 17b-790a of the general statutes is repealed and the

1555 following is substituted in lieu thereof (*Effective July 1, 2007*):

1556 (a) The Commissioner of Social Services, within available
1557 appropriations, shall establish a food assistance program for
1558 individuals entering the United States prior to April 1, 1998, whose
1559 immigrant status meets the eligibility requirements of the federal Food
1560 Stamp Act of 1977, as amended, but who are no longer eligible for food
1561 stamps solely due to their immigrant status under Public Law 104-193.
1562 Individuals who enter the United States after April 1, 1998, must have
1563 resided in the state for six months prior to becoming eligible for the
1564 state program. The commissioner may administer such program in
1565 accordance with the provisions of the federal food stamp program,
1566 except those pertaining to the determination of immigrant status under
1567 Public Law 104-193.

1568 [(b) The amount of the initial assistance provided to individuals
1569 under this section shall be determined at the commissioner's
1570 discretion, based on one of the following methodologies: (1) A
1571 calculated benefit amount for each case; (2) a basic benefit amount for
1572 all cases; or (3) a continuation of the benefit amount previously
1573 received under the federal Food Stamp Act of 1977, as amended, prior
1574 to discontinuance. Individuals may be eligible for retroactive
1575 payments back to April 1, 1998.]

1576 [(c) Not later than April 1, 1999, the] (b) The commissioner shall
1577 provide assistance to an individual under this section in an amount
1578 equal to seventy-five per cent of the amount the individual would be
1579 eligible to receive under the federal Food Stamp Act of 1977, as
1580 amended.

1581 [(d)] (c) The commissioner shall terminate assistance under this
1582 section to any individual whose federal food stamp benefits have been
1583 restored.

1584 [(e)] (d) The commissioner shall implement the policies and
1585 procedures necessary to carry out the provisions of this section while

1586 in the process of adopting such policies and procedures in regulation
1587 form, provided notice of intent to adopt the regulations is published in
1588 the Connecticut Law Journal within twenty days after implementation.
1589 Such policies and procedures shall be valid until the time final
1590 regulations are effective.

1591 Sec. 27. Section 17b-239 of the general statutes is repealed and the
1592 following is substituted in lieu thereof (*Effective July 1, 2007*):

1593 (a) The rate to be paid by the state to hospitals receiving
1594 appropriations granted by the General Assembly and to freestanding
1595 chronic disease hospitals, providing services to persons aided or cared
1596 for by the state for routine services furnished to state patients, shall be
1597 based upon reasonable cost to such hospital, or the charge to the
1598 general public for ward services or the lowest charge for semiprivate
1599 services if the hospital has no ward facilities, imposed by such
1600 hospital, whichever is lowest, except to the extent, if any, that the
1601 commissioner determines that a greater amount is appropriate in the
1602 case of hospitals serving a disproportionate share of indigent patients.
1603 Such rate shall be promulgated annually by the Commissioner of
1604 Social Services. Nothing contained in this section shall authorize a
1605 payment by the state for such services to any such hospital in excess of
1606 the charges made by such hospital for comparable services to the
1607 general public. Notwithstanding the provisions of this section, for the
1608 rate period beginning July 1, 2000, rates paid to freestanding chronic
1609 disease hospitals and freestanding psychiatric hospitals shall be
1610 increased by three per cent. For the rate period beginning July 1, 2001,
1611 a freestanding chronic disease hospital or freestanding psychiatric
1612 hospital shall receive a rate that is two and one-half per cent more than
1613 the rate it received in the prior fiscal year and such rate shall remain
1614 effective until December 31, 2002. Effective January 1, 2003, a
1615 freestanding chronic disease hospital or freestanding psychiatric
1616 hospital shall receive a rate that is two per cent more than the rate it
1617 received in the prior fiscal year. Notwithstanding the provisions of this
1618 subsection, for the period commencing July 1, 2001, and ending June

1619 30, 2003, the commissioner may pay an additional total of no more
1620 than three hundred thousand dollars annually for services provided to
1621 long-term ventilator patients. For purposes of this subsection, "long-
1622 term ventilator patient" means any patient at a freestanding chronic
1623 disease hospital on a ventilator for a total of sixty days or more in any
1624 consecutive twelve-month period. Effective [July 1, 2004] July 1, 2007,
1625 each freestanding chronic disease hospital shall receive a rate that is
1626 [two] four per cent more than the rate it received in the prior fiscal
1627 year.

1628 (b) Effective October 1, 1991, the rate to be paid by the state for the
1629 cost of special services rendered by such hospitals shall be established
1630 annually by the commissioner for each such hospital based on the
1631 reasonable cost to each hospital of such services furnished to state
1632 patients. Nothing contained herein shall authorize a payment by the
1633 state for such services to any such hospital in excess of the charges
1634 made by such hospital for comparable services to the general public.

1635 (c) The term "reasonable cost" as used in this section means the cost
1636 of care furnished such patients by an efficient and economically
1637 operated facility, computed in accordance with accepted principles of
1638 hospital cost reimbursement. The commissioner may adjust the rate of
1639 payment established under the provisions of this section for the year
1640 during which services are furnished to reflect fluctuations in hospital
1641 costs. Such adjustment may be made prospectively to cover anticipated
1642 fluctuations or may be made retroactive to any date subsequent to the
1643 date of the initial rate determination for such year or in such other
1644 manner as may be determined by the commissioner. In determining
1645 "reasonable cost" the commissioner may give due consideration to
1646 allowances for fully or partially unpaid bills, reasonable costs
1647 mandated by collective bargaining agreements with certified collective
1648 bargaining agents or other agreements between the employer and
1649 employees, provided "employees" shall not include persons employed
1650 as managers or chief administrators, requirements for working capital
1651 and cost of development of new services, including additions to and

1652 replacement of facilities and equipment. The commissioner shall not
1653 give consideration to amounts paid by the facilities to employees as
1654 salary, or to attorneys or consultants as fees, where the responsibility
1655 of the employees, attorneys or consultants is to persuade or seek to
1656 persuade the other employees of the facility to support or oppose
1657 unionization. Nothing in this subsection shall prohibit the
1658 commissioner from considering amounts paid for legal counsel related
1659 to the negotiation of collective bargaining agreements, the settlement
1660 of grievances or normal administration of labor relations.

1661 (d) The state shall also pay to such hospitals for each outpatient
1662 clinic and emergency room visit a reasonable rate to be established
1663 annually by the commissioner for each hospital, such rate to be
1664 determined by the reasonable cost of such services. The emergency
1665 room visit rates in effect June 30, 1991, shall remain in effect through
1666 June 30, 1993, except those which would have been decreased effective
1667 July 1, 1991, or July 1, 1992, shall be decreased. Nothing contained
1668 herein shall authorize a payment by the state for such services to any
1669 hospital in excess of the charges made by such hospital for comparable
1670 services to the general public. For those outpatient hospital services
1671 paid on the basis of a ratio of cost to charges, the ratios in effect June
1672 30, 1991, shall be reduced effective July 1, 1991, by the most recent
1673 annual increase in the consumer price index for medical care. For those
1674 outpatient hospital services paid on the basis of a ratio of cost to
1675 charges, the ratios computed to be effective July 1, 1994, shall be
1676 reduced by the most recent annual increase in the consumer price
1677 index for medical care. The emergency room visit rates in effect June
1678 30, 1994, shall remain in effect through December 31, 1994. The
1679 Commissioner of Social Services shall establish a fee schedule for
1680 outpatient hospital services to be effective on and after January 1, 1995.
1681 Except with respect to the rate periods beginning July 1, 1999, and July
1682 1, 2000, such fee schedule shall be adjusted annually beginning July 1,
1683 1996, to reflect necessary increases in the cost of services.
1684 Notwithstanding the provisions of this subsection, the fee schedule for
1685 the rate period beginning July 1, 2000, shall be increased by ten and

1686 one-half per cent, effective June 1, 2001. Notwithstanding the
1687 provisions of this subsection, outpatient rates in effect as of June 30,
1688 2003, shall remain in effect through June 30, 2005. Effective July 1, 2006,
1689 subject to available appropriations, the commissioner shall increase
1690 outpatient service fees for services that may include clinic, emergency
1691 room, magnetic resonance imaging, and computerized axial
1692 tomography. Not later than October 1, 2006, the commissioner shall
1693 submit a report, in accordance with section 11-4a, to the joint standing
1694 committees of the General Assembly having cognizance of matters
1695 relating to public health, human services and appropriations and the
1696 budgets of state agencies, identifying such fee increases and the
1697 associated cost increase estimates.

1698 (e) The commissioner shall adopt regulations, in accordance with
1699 the provisions of chapter 54, establishing criteria for defining
1700 emergency and nonemergency visits to hospital emergency rooms. All
1701 nonemergency visits to hospital emergency rooms shall be paid at the
1702 hospital's outpatient clinic services rate. Nothing contained in this
1703 subsection or the regulations adopted hereunder shall authorize a
1704 payment by the state for such services to any hospital in excess of the
1705 charges made by such hospital for comparable services to the general
1706 public.

1707 (f) On and after October 1, 1984, the state shall pay to an acute care
1708 general hospital for the inpatient care of a patient who no longer
1709 requires acute care a rate determined by the following schedule: For
1710 the first seven days following certification that the patient no longer
1711 requires acute care the state shall pay the hospital at a rate of fifty per
1712 cent of the hospital's actual cost; for the second seven-day period
1713 following certification that the patient no longer requires acute care the
1714 state shall pay seventy-five per cent of the hospital's actual cost; for the
1715 third seven-day period following certification that the patient no
1716 longer requires acute care and for any period of time thereafter, the
1717 state shall pay the hospital at a rate of one hundred per cent of the
1718 hospital's actual cost. On and after July 1, 1995, no payment shall be

1719 made by the state to an acute care general hospital for the inpatient
1720 care of a patient who no longer requires acute care and is eligible for
1721 Medicare unless the hospital does not obtain reimbursement from
1722 Medicare for that stay.

1723 (g) Effective June 1, 2001, the commissioner shall establish inpatient
1724 hospital rates in accordance with the method specified in regulations
1725 adopted pursuant to this section and applied for the rate period
1726 beginning October 1, 2000, except that the commissioner shall update
1727 each hospital's target amount per discharge to the actual allowable cost
1728 per discharge based upon the 1999 cost report filing multiplied by
1729 sixty-two and one-half per cent if such amount is higher than the target
1730 amount per discharge for the rate period beginning October 1, 2000, as
1731 adjusted for the ten per cent incentive identified in Section 4005 of
1732 Public Law 101-508. If a hospital's rate is increased pursuant to this
1733 subsection, the hospital shall not receive the ten per cent incentive
1734 identified in Section 4005 of Public Law 101-508. For rate periods
1735 beginning October 1, 2001, through September 30, 2006, the
1736 commissioner shall not apply an annual adjustment factor to the target
1737 amount per discharge. Effective April 1, 2005, the revised target
1738 amount per discharge for each hospital with a target amount per
1739 discharge less than three thousand seven hundred fifty dollars shall be
1740 three thousand seven hundred fifty dollars. [Effective October 1, 2006,
1741 subject to available appropriations, the commissioner shall establish an
1742 increased target amount per discharge of not less than four thousand
1743 dollars for each hospital with a target amount per discharge less than
1744 four thousand dollars for the rate period ending September 30, 2006,
1745 and the commissioner may apply an annual adjustment factor to the
1746 target amount per discharge for hospitals that are not increased as a
1747 result of the revised target amount per discharge. Not later than
1748 October 1, 2006, the commissioner shall submit a report, in accordance
1749 with section 11-4a, to the joint standing committees of the General
1750 Assembly having cognizance of matters relating to public health,
1751 human services and appropriations and the budgets of state agencies
1752 identifying the increased target amount per discharge and the

1753 associated cost increase estimates.] Effective October 1, 2007, the
1754 commissioner, in consultation with the Secretary of the Office of Policy
1755 and Management, shall establish, within available appropriations, an
1756 increased target amount per discharge of not less than four thousand
1757 two hundred fifty dollars for each hospital with a target amount per
1758 discharge less than four thousand two hundred fifty dollars for the
1759 rate period ending September 30, 2007, and the commissioner may
1760 apply an annual adjustment factor to the target amount per discharge
1761 for hospitals that are not increased as a result of this adjustment. Not
1762 later than October 1, 2008, the commissioner shall submit a report to
1763 the joint standing committees of the General Assembly having
1764 cognizance of matters relating to public health, human services and
1765 appropriations and the budgets of state agencies identifying any
1766 increased target amount per discharge established or annual
1767 adjustment factor applied on or after October 1, 2006, and the
1768 associated cost increase estimates related to such actions.

1769 Sec. 28. (*Effective July 1, 2007*) For the fiscal year ending June 30,
1770 2008, the Commissioner of Social Services, in consultation with the
1771 Secretary of the Office of Policy and Management, may expend up to
1772 thirty million dollars appropriated for Hospital Hardship to provide
1773 grants to hospitals. Such grants shall be provided as necessary to avoid
1774 the substantial deterioration of a given hospital's financial condition
1775 that may adversely affect patient care and for the continued operation
1776 of the hospital when such continued operation is determined necessary
1777 by the Commissioner of Social Services, in consultation with the
1778 Commissioner of Public Health, the Commissioner of the Office of
1779 Health Care Access and the executive director of the Connecticut
1780 Health and Educational Facilities Authority. The Commissioner of
1781 Social Services in determining eligibility for such grants shall, at a
1782 minimum, consider: (1) Hospital utilization by patients eligible for
1783 state assistance programs; (2) hospital licensure and certification
1784 compliance history; and (3) reasonableness of actual and projected
1785 revenues and expenses. A hospital applying for such grant shall
1786 submit an application on such forms as may be prescribed by the

1787 Commissioner of Social Services along with a plan that describes the
1788 hospital's operating savings and nongovernmental revenue
1789 enhancements. The Commissioner of Social Services may accept or
1790 require modification to any such plan submitted by a hospital. Each
1791 hospital shall file quarterly reports to the Commissioner of Social
1792 Services pertaining to plan implementation. The Commissioner of
1793 Social Services may cease grant payments if a hospital fails to report in
1794 accordance with this section. The Commissioner of Social Services
1795 shall, in accordance with section 11-4a of the general statutes, provide
1796 written quarterly reports to the joint standing committees of the
1797 General Assembly having cognizance of matters relating to human
1798 services and appropriations and the budgets of state agencies. Such
1799 quarterly reports shall identify each hospital requesting a grant, the
1800 amount of the requested grant for each hospital and the action taken
1801 by the Commissioner of Social Services.

1802 Sec. 29. (NEW) (*Effective July 1, 2007*) (a) The Commissioner of Social
1803 Services shall, within available appropriations, establish and operate a
1804 state-funded pilot program to allow not more than fifty persons with
1805 disabilities (1) who are age eighteen to sixty-four, inclusive, (2) who
1806 are inappropriately institutionalized or at risk of inappropriate
1807 institutionalization, and (3) whose assets, if single, do not exceed the
1808 minimum community spouse protected amount pursuant to section
1809 4022.05 of the Department of Social Services uniform policy manual or,
1810 if married, the couple's assets do not exceed one hundred fifty per cent
1811 of said community spouse protected amount to be eligible to receive
1812 the same services that are provided under the state-funded home care
1813 program for the elderly, established pursuant to subsection (i) of
1814 section 17b-342 of the general statutes. At the discretion of the
1815 Commissioner of Social Services, such persons may also be eligible to
1816 receive services that are necessary to meet needs attributable to
1817 disabilities in order to allow such persons to avoid institutionalization.

1818 (b) Any person participating in the pilot program whose income
1819 exceeds two hundred per cent of the federal poverty level shall

1820 contribute to the cost of care in accordance with the methodology
1821 established for recipients of medical assistance pursuant to sections
1822 5035.20 and 5035.25 of the department's uniform policy manual.

1823 (c) The annualized cost of services provided to an individual under
1824 the pilot program shall not exceed fifty per cent of the weighted
1825 average cost of care in nursing homes in the state.

1826 (d) If the number of persons eligible for the pilot program
1827 established pursuant to this section exceeds fifty persons or if the cost
1828 of the program exceeds available appropriations, the commissioner
1829 shall establish a waiting list designed to serve applicants by order of
1830 application date.

1831 Sec. 30. (NEW) (*Effective October 1, 2007*) As used in this section and
1832 sections 31 to 38, inclusive, of this act:

1833 (1) "Activities of daily living" means activities or tasks, that are
1834 essential for a person's healthful and safe existence, including, but not
1835 limited to, bathing, dressing, grooming, eating, meal preparation,
1836 shopping, housekeeping, transfers, bowel and bladder care, laundry,
1837 communication, self-administration of medication and ambulation.

1838 (2) "Assisted living services" means nursing services and assistance
1839 with activities of daily living provided to residents living within a
1840 managed residential community having supportive services that
1841 encourage persons primarily fifty-five years of age or older to maintain
1842 a maximum level of independence.

1843 (3) "Assisted living services agency" means an entity, licensed by the
1844 Department of Public Health pursuant to chapter 368v of the general
1845 statutes that provides, among other things, nursing services and
1846 assistance with activities of daily living to a population that is chronic
1847 and stable.

1848 (4) "Managed residential community" means a for-profit or not-for-
1849 profit facility consisting of private residential units that provides a

1850 managed group living environment consisting of housing and services
1851 for persons who are primarily fifty-five years of age or older.
1852 "Managed residential community" does not include any state-funded
1853 congregate housing facilities.

1854 (5) "Department" means the Department of Public Health.

1855 (6) "Private residential unit" means a private living environment
1856 designed for use and occupancy by a resident within a managed
1857 residential community that includes a full bathroom and access to
1858 facilities and equipment for the preparation and storage of food.

1859 (7) "Resident" means a person residing in a private residential unit
1860 of a managed residential community pursuant to the terms of a written
1861 agreement for occupancy of such unit.

1862 Sec. 31. (NEW) (*Effective October 1, 2007*) (a) All managed residential
1863 communities operating in the state shall:

1864 (1) Provide a written residency agreement to each resident in
1865 accordance with section 37 of this act;

1866 (2) Afford residents the ability to access services provided by an
1867 assisted living services agency. Such services shall be provided in
1868 accordance with a service plan developed in accordance with section
1869 36 of this act;

1870 (3) Upon the request of a resident, arrange, in conjunction with the
1871 assisted living services agency, for the provision of ancillary medical
1872 services on behalf of a resident, including physician and dental
1873 services, pharmacy services, restorative physical therapies, podiatry
1874 services, hospice care and home health agency services, provided the
1875 ancillary medical services are not administered by employees of the
1876 managed residential community, unless the resident chooses to receive
1877 such services;

1878 (4) Provide a formally established security program for the

1879 protection and safety of residents that is designed to protect residents
1880 from intruders;

1881 (5) Afford residents the rights and privileges guaranteed under title
1882 47a of the general statutes;

1883 (6) Comply with the provisions of subsection (c) of section 19-13-
1884 D105 of the regulations of Connecticut state agencies; and

1885 (7) Be subject to oversight and regulation by the Department of
1886 Public Health.

1887 (b) No managed residential community shall control or manage the
1888 financial affairs or personal property of any resident.

1889 Sec. 32. (NEW) (*Effective April 1, 2008*) The Department of Public
1890 Health shall receive and investigate any complaint alleging that a
1891 managed residential community is engaging in, or has engaged in
1892 activities, practices or omissions that would constitute a violation of
1893 sections 31 to 38, inclusive, of this act, the regulations adopted
1894 pursuant to section 38 of this act, or any other regulation applicable to
1895 managed residential communities, including the Public Health Code.
1896 The department shall include in its biennial review of a managed
1897 residential community, conducted in accordance with section 33 of this
1898 act, a review of the nature and type of any complaint received
1899 concerning the managed residential community, as well as the
1900 department's final determination made with respect to such complaint.

1901 Sec. 33. (NEW) (*Effective April 1, 2008*) (a) The Department of Public
1902 Health shall conduct biennial reviews of all managed residential
1903 communities. Biennial reviews conducted by the department in
1904 accordance with the provisions of this section, shall be in addition to,
1905 and not in lieu of, any inspections of such communities by state or
1906 local officials to ensure compliance with the Public Health Code, the
1907 State Building Code, the State Fire Code or any local zoning ordinance.
1908 In addition to the biennial review, the department may conduct at any

1909 time a review of a managed residential community when the
1910 department has probable cause to believe that a managed residential
1911 community is operating in violation of the provisions of sections 31 to
1912 38, inclusive, of this act, the regulations adopted pursuant to section 38
1913 of this act, or any other regulation applicable to managed residential
1914 communities, including the Public Health Code. The purpose of any
1915 biennial or investigatory review shall be to ensure that a managed
1916 residential community is operating in compliance with the provisions
1917 of sections 31 to 38, inclusive, of this act, the regulations adopted
1918 pursuant to section 38 of this act or any other regulation applicable to
1919 managed residential communities, including the Public Health Code.
1920 A biennial review shall include: (1) An inspection of all common areas
1921 of the managed residential community, including any common kitchen
1922 or meal preparation area located within the community; and (2) an
1923 inspection of private residential units, but only if prior to such
1924 inspection the residents occupying such units provide written consent
1925 to the inspection. In the course of conducting a biennial or
1926 investigatory review, an inspector may interview any manager, staff
1927 member or resident of the managed residential community. Interviews
1928 with any resident shall require the consent of the resident, be
1929 confidential and shall be conducted privately.

1930 (b) The department shall establish an administrative procedure for
1931 the preparation, completion and transmittal of written reports
1932 prepared as part of any review undertaken pursuant to this section or
1933 section 32 of this act. If after undertaking any such review the
1934 department determines that a managed residential community is in
1935 violation of the provisions of sections 31 to 38, inclusive, of this act, the
1936 department shall provide written notice of its determination of an
1937 alleged violation to the managed residential community. Such written
1938 notice shall advise the managed residential community of its right to
1939 request an administrative hearing in accordance with sections 4-176e to
1940 4-181a, inclusive, of the general statutes to contest such determination.
1941 A managed residential community shall request such hearing, in
1942 writing, not later than fifteen days after the date of receipt of the notice

1943 of an alleged violation from the department. The department may
1944 issue such remedial orders as deemed necessary by the department to
1945 ensure compliance with the provisions of sections 31 to 38, inclusive, of
1946 this act. Remedial orders available to the department shall include, but
1947 not be limited to, the imposition of a civil penalty against a managed
1948 residential community in an amount not to exceed five thousand
1949 dollars per violation. The department shall stay the imposition of any
1950 remedial order or civil penalty pending the outcome of an
1951 administrative hearing. The department shall maintain and make
1952 available for public inspection all completed reports, responses from
1953 managed residential communities and any remedial orders issued in
1954 accordance with the provisions of this section.

1955 (c) Upon the failure of a managed residential community to comply
1956 with a remedial order issued by the department, the Attorney General,
1957 at the request of the Commissioner of Public Health, may bring an
1958 action in the superior court for the judicial district of Hartford to
1959 enforce such order. All actions brought by the Attorney General
1960 pursuant to the provisions of this section shall have precedence in the
1961 order of trial as provided in section 52-191 of the general statutes. The
1962 court may issue such orders as are necessary to obtain compliance with
1963 the order of the department.

1964 Sec. 34. (NEW) (*Effective October 1, 2007*) (a) A managed residential
1965 community shall have a written bill of rights that prescribes the rights
1966 afforded to each resident. A designated staff person from the managed
1967 residential community shall provide and explain the bill of rights to
1968 the resident at the time that such resident enters into a residency
1969 agreement at the managed residential community. The bill of rights
1970 shall include, but not be limited to, that each resident has the right to:

1971 (1) Live in a clean, safe and habitable private residential unit;

1972 (2) Be treated with consideration, respect and due recognition of
1973 personal dignity, individuality and the need for privacy;

1974 (3) Privacy within a private residential unit, subject to rules of the
1975 managed residential community reasonably designed to promote the
1976 health, safety and welfare of the resident;

1977 (4) Retain and use one's own personal property within a private
1978 residential unit so as to maintain individuality and personal dignity
1979 provided the use of personal property does not infringe on the rights
1980 of other residents or threaten the health, safety and welfare of other
1981 residents;

1982 (5) Private communications, including receiving and sending
1983 unopened correspondence, telephone access and visiting with persons
1984 of one's choice;

1985 (6) Freedom to participate in and benefit from community services
1986 and activities so as to achieve the highest possible level of
1987 independence, autonomy and interaction within the community;

1988 (7) Directly engage or contract with licensed health care
1989 professionals and providers of one's choice to obtain necessary health
1990 care services in one's private residential unit, or such other space in the
1991 managed residential community as may be made available to residents
1992 for such purposes;

1993 (8) Manage one's own financial affairs;

1994 (9) Exercise civil and religious liberties;

1995 (10) Present grievances and recommend changes in policies,
1996 procedures and services to the manager or staff of the managed
1997 residential community, government officials or any other person
1998 without restraint, interference, coercion, discrimination or reprisal
1999 from the managed residential community, including access to
2000 representatives of the department or the Office of the Long-Term Care
2001 Ombudsman;

2002 (11) Upon request, obtain from the managed residential community

2003 the name of the service coordinator or any other persons responsible
2004 for resident care or the coordination of resident care;

2005 (12) Confidential treatment of all records and communications to
2006 the extent required by state and federal law;

2007 (13) Have all reasonable requests responded to promptly and
2008 adequately within the capacity of the managed residential community
2009 and with due consideration given to the rights of other residents;

2010 (14) Be fully advised of the relationship that the managed residential
2011 community has with any assisted living services agency, health care
2012 facility or educational institution to the extent that such relationship
2013 relates to resident medical care or treatment and to receive an
2014 explanation about the relationship;

2015 (15) Receive a copy of any rules or regulations of the managed
2016 residential community;

2017 (16) Privacy when receiving medical treatment or other services
2018 within the capacity of the managed residential community;

2019 (17) Refuse care and treatment and participate in the planning for
2020 the care and services the resident needs or receives, provided the
2021 refusal of care and treatment may preclude the resident from being
2022 able to continue to reside in the managed residential community; and

2023 (18) All rights and privileges afforded to tenants under title 47a of
2024 the general statutes.

2025 (b) A managed residential community shall post in a prominent
2026 place in the managed residential community the resident's bill of
2027 rights, including those rights set forth in subsection (a) of this section.
2028 The posting of the resident's bill of rights shall include contact
2029 information for the Department of Public Health and the Office of the
2030 State Long-Term Care Ombudsman, including the names, addresses
2031 and telephone numbers of persons within such agencies who handle

2032 questions, comments or complaints concerning managed residential
2033 community.

2034 Sec. 35. (NEW) (*Effective October 1, 2007*) No managed residential
2035 community shall enter into a written residency agreement with any
2036 individual who requires twenty-four hour skilled nursing care, unless
2037 such individual establishes to the satisfaction of both the managed
2038 residential community and the assisted living services agency that the
2039 individual has, or has arranged for, such twenty-four hour care and
2040 maintains such care as a condition of residency if an assisted living
2041 services agency determines that such care is necessary.

2042 Sec. 36. (NEW) (*Effective October 1, 2007*) (a) An assisted living
2043 services agency shall develop and maintain an individualized service
2044 plan for any resident of a managed residential community that
2045 receives assisted living services. Such agency shall develop the
2046 individualized service plan after consultation with the resident and
2047 following an assessment of the resident by a registered nurse. The
2048 individualized service plan shall set forth in lay terms the needs of the
2049 resident for assisted living services, the providers or intended
2050 providers of needed services, the scope, type and frequency of such
2051 services, an itemized cost of such services and any other information
2052 that Department of Public Health may require. The individualized
2053 service plan and any periodic revisions thereto shall be confidential, in
2054 writing, signed by the resident, or the resident's legal representative,
2055 and a representative of the assisted living services agency and
2056 available for inspection by the resident and the department.

2057 (b) An assisted living services agency shall maintain written policies
2058 and procedures for the initial evaluation and regular, periodic
2059 reassessment of the functional and health status and service
2060 requirements of each resident who requires assisted living services.

2061 Sec. 37. (NEW) (*Effective October 1, 2007*) A managed residential
2062 community shall enter into a written residency agreement with each
2063 resident that clearly sets forth the rights and responsibilities of the

2064 resident and the managed residential community, including the duties
2065 set forth in section 19a-562 of the general statutes. The residency
2066 agreement shall be set forth in plain language and printed in not less
2067 than fourteen-point type. The residency agreement shall be signed by
2068 the managed residential community's authorized agent and by the
2069 resident, or the resident's legal representative, prior to the resident
2070 taking possession of a private residential unit and shall include, at a
2071 minimum:

2072 (1) An itemization of assisted living services, transportation
2073 services, recreation services and any other services and goods, lodging
2074 and meals to be provided on behalf of the resident by the managed
2075 residential community;

2076 (2) A full and fair disclosure of all charges, fees, expenses and costs
2077 to be borne by the resident;

2078 (3) A schedule of payments and disclosure of all late fees or
2079 potential penalties;

2080 (4) The grievance procedure with respect to enforcement of the
2081 terms of the residency agreement;

2082 (5) The managed residential community's covenant to comply with
2083 all municipal, state and federal laws and regulations regarding
2084 consumer protection and protection from financial exploitation;

2085 (6) The managed residential community's covenant to afford
2086 residents all rights and privileges afforded under title 47a of the
2087 general statutes;

2088 (7) The conditions under which the agreement can be terminated by
2089 either party;

2090 (8) Full disclosure of the rights and responsibilities of the resident
2091 and the managed residential community in situations involving
2092 serious deterioration in the health of the resident, hospitalization of the

2093 resident or death of the resident, including a provision that specifies
2094 that in the event that a resident of the community dies, the estate or
2095 family of such resident shall only be responsible for further payment to
2096 the community for a period of time not to exceed fifteen days
2097 following the date of death of such resident as long as the private
2098 residential unit formerly occupied by the resident has been vacated;
2099 and

2100 (9) Any adopted rules of the managed residential community
2101 reasonably designed to promote the health, safety and welfare of
2102 residents.

2103 Sec. 38. (NEW) (*Effective October 1, 2007*) (a) A managed residential
2104 community shall meet the requirements of all applicable federal and
2105 state laws and regulations, including, but not limited to, the Public
2106 Health Code, State Building Code and the State Fire Safety Code, and
2107 federal and state laws and regulations governing handicapped
2108 accessibility.

2109 (b) The Commissioner of Public Health shall adopt regulations, in
2110 accordance with chapter 54 of the general statutes, to carry out the
2111 provisions of sections 30 to 38, inclusive, of this act.

2112 Sec. 39. Subsection (e) of section 8-206e of the general statutes is
2113 repealed and the following is substituted in lieu thereof (*Effective*
2114 *October 1, 2007*):

2115 (e) The Commissioner of Economic and Community Development
2116 shall establish criteria for making disbursements under the provisions
2117 of subsection (d) of this section which shall include, but are not limited
2118 to: (1) Size of the United States Department of Housing and Urban
2119 Development, Section 202 and Section 236 elderly housing
2120 developments; (2) geographic locations in which the developments are
2121 located; (3) anticipated social and health value to the resident
2122 population; (4) each Section 202 and Section 236 housing
2123 development's designation as a managed residential community, as

2124 defined in section [19-13-D105 of the regulations of Connecticut state
2125 agencies] 30 of this act; and (5) the potential community development
2126 benefit to the relevant municipality. Such criteria may specify who
2127 may apply for grants, the geographic locations determined to be
2128 eligible for grants, and the eligible costs for which a grant may be
2129 made. For the purposes of the demonstration program, multiple
2130 properties with overlapping board membership or ownership may be
2131 considered a single applicant.

2132 Sec. 40. Subsection (a) of section 17b-365 of the general statutes is
2133 repealed and the following is substituted in lieu thereof (*Effective*
2134 *October 1, 2007*):

2135 (a) The Commissioner of Social Services may, within available
2136 appropriations, establish and operate a pilot program to allow
2137 individuals to receive assisted living services, provided by an assisted
2138 living services agency licensed by the Department of Public Health in
2139 accordance with chapter 368v. In order to be eligible for the program,
2140 an individual shall: (1) Reside in a managed residential community, as
2141 defined [by the regulations of the Department of Public Health] in
2142 section 30 of this act; (2) be ineligible to receive assisted living services
2143 under any other assisted living pilot program established by the
2144 General Assembly; and (3) be eligible for services under the Medicaid
2145 waiver portion of the Connecticut home-care program for the elderly
2146 established under section 17b-342. The total number of individuals
2147 enrolled in said pilot program, when combined with the total number
2148 of individuals enrolled in the pilot program established pursuant to
2149 section 17b-366, as amended by this act, shall not exceed seventy-five
2150 individuals. The Commissioner of Social Services shall operate said
2151 pilot program in accordance with the Medicaid rules established
2152 pursuant to 42 USC 1396p(c), as from time to time amended.

2153 Sec. 41. Subsection (a) of section 17b-366 of the general statutes is
2154 repealed and the following is substituted in lieu thereof (*Effective*
2155 *October 1, 2007*):

2156 (a) The Commissioner of Social Services may, within available
2157 appropriations, establish and operate a pilot program to allow
2158 individuals to receive assisted living services, provided by an assisted
2159 living services agency licensed by the Department of Public Health, in
2160 accordance with chapter 368v. In order to be eligible for the pilot
2161 program, an individual shall: (1) Reside in a managed residential
2162 community, as defined [by the regulations of the Department of Public
2163 Health] in section 30 of this act; (2) be ineligible to receive assisted
2164 living services under any other assisted living pilot program
2165 established by the General Assembly; and (3) be eligible for services
2166 under the state-funded portion of the Connecticut home-care program
2167 for the elderly established under section 17b-342. The total number of
2168 individuals enrolled in said pilot program, when combined with the
2169 total number of individuals enrolled in the pilot program established
2170 pursuant to section 17b-365, shall not exceed seventy-five individuals.
2171 The Commissioner of Social Services shall operate said pilot program
2172 in accordance with the Medicaid rules established pursuant to 42 USC
2173 1396p(c), as from time to time amended.

2174 Sec. 42. Subsections (a) and (b) of section 17b-417 of the general
2175 statutes are repealed and the following is substituted in lieu thereof
2176 (*Effective October 1, 2007*):

2177 (a) The Office of the Long-Term Care Ombudsman shall develop
2178 and implement a pilot program, within available appropriations, to
2179 provide assistance and education to residents of managed residential
2180 communities, as defined in section [19-13-D105 of the regulations of
2181 Connecticut state agencies] 30 of this act, who receive assisted living
2182 services from an assisted living services agency licensed by the
2183 Department of Public Health in accordance with chapter 368v. The
2184 assistance and education provided under such pilot program shall
2185 include, but not be limited to: (1) Assistance and education for
2186 residents who are temporarily discharged to a hospital or long-term
2187 care facility and return to a managed residential community; (2)
2188 assistance and education for residents with issues relating to an

2189 admissions contract for a managed residential community; and (3)
2190 assistance and education for residents to assure adequate and
2191 appropriate services are being provided including, but not limited to,
2192 adequate and appropriate services for individuals with cognitive
2193 impairments.

2194 (b) The Office of the Long-Term Care Ombudsman shall develop
2195 and implement the pilot program in cooperation with managed
2196 residential communities and assisted living services agencies. Priority
2197 of assistance and education shall be given to residents of managed
2198 residential communities who participate in subsidized assisted living
2199 programs authorized under sections 8-206e, as amended by this act,
2200 17b-347e, 17b-365, as amended by this act, 17b-366, as amended by this
2201 act, and 19a-6c. To the extent allowed by available appropriations, the
2202 Long-Term Care Ombudsman shall also provide assistance and
2203 education under the pilot program to residents in managed residential
2204 communities who do not participate in said subsidized assisted living
2205 programs.

2206 Sec. 43. Section 19a-6c of the general statutes is repealed and the
2207 following is substituted in lieu thereof (*Effective October 1, 2007*):

2208 (a) The Commissioner of Public Health shall allow state-funded
2209 congregate housing facilities to provide assisted living services
2210 through licensed assisted living services agencies, as defined in section
2211 19a-490.

2212 (b) In order to facilitate the development of assisted living services
2213 in state-funded congregate housing facilities, the Commissioner of
2214 Public Health may waive any provision of the regulations for assisted
2215 living services agencies, as defined in section 19a-490, which provide
2216 services in state-funded congregate housing facilities. No waiver of
2217 such regulations shall be made if the commissioner determines that the
2218 waiver would: (1) Endanger the life, safety or health of any resident
2219 receiving assisted living services in a state-funded congregate housing
2220 facility; (2) impact the quality or provision of services provided to a

2221 resident in a state-funded congregate housing facility; (3) revise or
2222 eliminate the requirements for an assisted living services agency's
2223 quality assurance program; (4) revise or eliminate the requirements for
2224 an assisted living services agency's grievance and appeals process; or
2225 (5) revise or eliminate the assisted living services agency's
2226 requirements relative to a client's bill of rights and responsibilities. The
2227 commissioner, upon the granting of a waiver of any provision of such
2228 regulations, may impose conditions which assure the health, safety
2229 and welfare of residents receiving assisted living services in a state-
2230 funded congregate housing facility. The commissioner may revoke
2231 such a waiver upon a finding (A) that the health, safety or welfare of
2232 any such resident is jeopardized, or (B) that such facility has failed to
2233 comply with such conditions as the commissioner may impose
2234 pursuant to this subsection.

2235 (c) The provisions of sections 30 to 38, inclusive, of this act shall not
2236 apply to any state-funded congregate housing facility.

2237 ~~[(c)]~~ (d) The Commissioner of Public Health may adopt regulations,
2238 in accordance with the provisions of chapter 54, to implement the
2239 provisions of this section. Said commissioner may implement the
2240 waiver of provisions as specified in subsection (b) of this section until
2241 January 1, 2002, while in the process of adopting criteria for the waiver
2242 process in regulation form, provided notice of intent to adopt the
2243 regulations is published in the Connecticut Law Journal within twenty
2244 days after implementation.

2245 Sec. 44. Section 17b-295 of the general statutes, as amended by
2246 section 7 of public act 07-185, is repealed and the following is
2247 substituted in lieu thereof (*Effective July 1, 2007*):

2248 (a) The commissioner shall impose cost-sharing requirements,
2249 including the payment of a premium or copayment, in connection with
2250 services provided under the HUSKY Plan, Part B, to the extent
2251 permitted by federal law, and in accordance with the following
2252 limitations:

2253 (1) The commissioner may increase the maximum annual aggregate
2254 cost-sharing requirements, provided such cost-sharing requirements
2255 shall not exceed five per cent of the family's gross annual income. The
2256 commissioner may impose a premium requirement on families whose
2257 income exceeds two hundred thirty-five per cent of the federal poverty
2258 level as a component of the family's cost-sharing responsibility,
2259 provided: (A) The family's annual combined premiums and
2260 copayments do not exceed the maximum annual aggregate cost-
2261 sharing requirement, and (B) premium requirements [for a family with
2262 income that exceeds two hundred thirty-five per cent of the federal
2263 poverty level but does not exceed three hundred per cent of the federal
2264 poverty level] shall not exceed the sum of thirty dollars per month per
2265 child, with a maximum premium of fifty dollars per month per family,
2266 [, and (C) premium requirements for a family with income that exceeds
2267 three hundred per cent of the federal poverty level but does not exceed
2268 four hundred per cent of the federal poverty level who does not have
2269 any access to employer- sponsored health insurance coverage shall not
2270 exceed the sum of fifty dollars per child, with a maximum premium of
2271 seventy-five dollars per month.] The commissioner shall not impose a
2272 premium requirement on families whose income exceeds one hundred
2273 eighty-five per cent of the federal poverty level but does not exceed
2274 two hundred thirty-five per cent of the federal poverty level; and

2275 (2) The commissioner shall require each managed care plan to
2276 monitor copayments and premiums under the provisions of
2277 subdivision (1) of this subsection.

2278 (b) (1) Except as provided in subdivision (2) of this subsection, the
2279 commissioner may impose limitations on the amount, duration and
2280 scope of benefits under the HUSKY Plan, Part B.

2281 (2) The limitations adopted by the commissioner pursuant to
2282 subdivision (1) of this subsection shall not preclude coverage of any
2283 item of durable medical equipment or service that is medically
2284 necessary.

2285 Sec. 45. Section 27-118 of the general statutes is repealed and the
2286 following is substituted in lieu thereof (*Effective July 1, 2007*):

2287 When any veteran dies, not having sufficient estate to pay the
2288 necessary expenses of [his] the veteran's last sickness and burial, as
2289 determined by the commissioner after consultation with the probate
2290 court for the district in which the veteran resided, the state shall pay
2291 the sum of [one hundred fifty] one thousand eight hundred dollars
2292 toward such funeral expenses, and the burial shall be in some
2293 cemetery or plot not used exclusively for the burial of the pauper dead,
2294 and the same amount shall be paid if the body is cremated, but no
2295 amount shall be paid for the expenses for burial or cremation unless
2296 claim therefor is made within one year from the date of death, [;
2297 provided,] except that in cases of death occurring abroad, such claim
2298 may be made within one year after the remains of such veteran have
2299 been interred in this country. No provision of this section shall prevent
2300 the payment of the sum above named for the burial of any person,
2301 otherwise entitled to the same, on account of such burial being made
2302 outside the limits of this state. Upon satisfactory proof by the person
2303 who has paid or provided for the funeral or burial expense to the
2304 commissioner of the identity of the deceased, the time and place of
2305 [his] the deceased's death and burial and the approval thereof by the
2306 commissioner, said sum of [one hundred fifty] one thousand eight
2307 hundred dollars shall be paid by the Comptroller to the person who
2308 has paid the funeral or burial expense or, upon assignment by such
2309 person, to the funeral director who has provided the funeral.
2310 Whenever the Comptroller has lawfully paid any sum toward the
2311 expenses of the burial of any deceased veteran and it afterwards
2312 appears that the deceased left any estate, the Comptroller may present
2313 a claim in behalf of the state against the estate of such deceased veteran
2314 for the sum so paid, and the claim shall be a preferred claim against
2315 such estate and shall be paid to the Treasurer of the state. The
2316 commissioner, upon the advice of the Attorney General, may make
2317 application for administration upon the estate of any such deceased
2318 veteran if no other person authorized by law makes such application

2319 within sixty days after such payment has been made by the
2320 Comptroller.

2321 Sec. 46. (NEW) (*Effective July 1, 2008*) (a) The Department of
2322 Veterans' Affairs may establish and maintain, within available
2323 resources, a registry of data on members of the armed forces, as
2324 defined in section 27-103 of the general statutes, who have completed a
2325 period of active service. The department may develop surveys for
2326 members or their health care providers to voluntarily provide data
2327 during or after such active service. The surveys and data shall be
2328 collected and maintained in accordance with the requirements of the
2329 federal Health Insurance Portability and Accountability Act of 1996
2330 (P.L. 104-191) (HIPAA), as amended from time to time, or regulations
2331 adopted thereunder.

2332 (b) The surveys and data shall be related to members' illnesses and
2333 potential correlations to environmental hazards, including, but not
2334 limited to, vaccinations, infections, chemicals, pesticides, microwaves,
2335 depleted uranium, pyridostigmine bromide, and chemical and
2336 biological warfare agents. Within available resources, the department
2337 may use the data in the registry to (1) study the potential short-term
2338 and long-term effects of such hazards on such members, and (2)
2339 inform, customize and coordinate the provision of health care services
2340 to such members.

2341 (c) No individually identifiable health information may be released
2342 by the department without the consent of the member to whom the
2343 information pertains in accordance with the requirements of the
2344 federal Health Insurance Portability and Accountability Act of 1996
2345 (P.L. 104-191) (HIPAA), as amended from time to time, or regulations
2346 adopted thereunder.

2347 (d) The surveys and data in the registry shall be subject to disclosure
2348 under the Freedom of Information Act, as defined in section 1-200 of
2349 the general statutes, except that no individually identifiable health
2350 information may be disclosed.

2351 Sec. 47. Section 19a-111a of the general statutes is repealed and the
2352 following is substituted in lieu thereof (*Effective October 1, 2007*):

2353 (a) The [Commissioner] Department of Public Health shall be the
2354 lead state agency for lead poisoning prevention in this state. The
2355 Commissioner of Public Health shall (1) identify the state and local
2356 agencies in this state with responsibilities related to lead poisoning
2357 prevention, and (2) schedule a meeting of such state agencies and
2358 representative local agencies at least once annually in order to
2359 coordinate lead poisoning prevention efforts in this state.

2360 (b) The commissioner shall establish a lead poisoning prevention
2361 program [Such program shall] to provide screening, diagnosis,
2362 consultation, inspection and treatment services, including, but not
2363 limited to, the prevention and elimination of lead poisoning through
2364 research, abatement, education and epidemiological and clinical
2365 activities. Such program shall include, but need not be limited to, the
2366 screening services provided pursuant to section 48 of this act.

2367 [(b)] (c) Within available appropriations, the [Commissioner of
2368 Public Health] commissioner may contract with individuals, groups or
2369 agencies for the provision of necessary services and enter into
2370 assistance agreements with municipalities, cities, boroughs or district
2371 departments of health or special service districts for the development
2372 and implementation of comprehensive lead poisoning prevention
2373 programs consistent with the provisions of sections 19a-110 to 19a-
2374 111c, inclusive.

2375 Sec. 48. (NEW) (*Effective January 1, 2009*) (a) Each primary care
2376 provider giving pediatric care in this state, excluding a hospital
2377 emergency department and its staff: (1) Shall conduct lead screening at
2378 least annually for each child nine to thirty-five months of age,
2379 inclusive, in accordance with the Childhood Lead Poisoning
2380 Prevention Screening Advisory Committee Recommendations for
2381 Childhood Lead Screening in Connecticut; (2) shall conduct lead
2382 screening for any child thirty-six to seventy-two months of age,

2383 inclusive, who has not been previously screened or for any child under
2384 seventy-two months of age, if clinically indicated as determined by the
2385 primary care provider in accordance with the Childhood Lead
2386 Poisoning Prevention Screening Advisory Committee
2387 Recommendations for Childhood Lead Screening in Connecticut; (3)
2388 shall conduct a medical risk assessment at least annually for each child
2389 thirty-six to seventy-one months of age, inclusive, in accordance with
2390 the Childhood Lead Poisoning Prevention Screening Advisory
2391 Committee Recommendations for Childhood Lead Screening in
2392 Connecticut; (4) may conduct a medical risk assessment at any time for
2393 any child thirty-six months of age or younger who is determined by
2394 the primary care provider to be in need of such risk assessment in
2395 accordance with the Childhood Lead Poisoning Prevention Screening
2396 Advisory Committee Recommendations for Childhood Lead Screening
2397 in Connecticut.

2398 (b) The requirements of this section do not apply to any child whose
2399 parents or guardians object to blood testing as being in conflict with
2400 their religious tenets and practice.

2401 Sec. 49. Subsection (a) of section 19a-110 of the general statutes is
2402 repealed and the following is substituted in lieu thereof (*Effective*
2403 *October 1, 2007*):

2404 (a) [Each institution licensed under the provisions of sections 19a-
2405 490 to 19a-503, inclusive, and each private clinical laboratory licensed
2406 under section 19a-30 shall, within] Not later than forty-eight hours [of
2407 receipt of knowledge thereof,] after receiving or completing a report of
2408 a person found to have a level of lead in the blood equal to or greater
2409 than ten micrograms per deciliter of blood or any other abnormal body
2410 burden of lead, each institution licensed under sections 19a-490 to 19a-
2411 503, inclusive, as amended, and each clinical laboratory licensed under
2412 section 19a-30 shall report to (1) the Commissioner of Public Health,
2413 and to the director of health of the town, city or borough in which the
2414 person resides: [(1)] (A) The name, full residence address, date of birth,

2415 gender, race and ethnicity of each person found to have a level of lead
2416 in the blood equal to or greater than ten micrograms per deciliter of
2417 blood or any other abnormal body burden of lead; [(2)] (B) the name,
2418 address and telephone number of the health care provider who
2419 ordered the test; [(3)] (C) the sample collection date, analysis date, type
2420 and blood lead analysis result; and [(4)] (D) such other information as
2421 the commissioner may require, and (2) the health care provider who
2422 ordered the test, the results of the test. With respect to a child under
2423 three years of age, not later than seventy-two hours after the provider
2424 receives such results, the provider shall make reasonable efforts to
2425 notify the parent or guardian of the child of the blood lead analysis
2426 results. Any institution or laboratory making an accurate report in
2427 good faith shall not be liable for the act of disclosing said report to the
2428 commissioner or to the director of health. The commissioner, after
2429 consultation with the Chief Information Officer of the Department of
2430 Information Technology, shall determine the method and format of
2431 transmission of data contained in said report.

2432 Sec. 50. Subsection (d) of section 19a-110 of the general statutes is
2433 repealed and the following is substituted in lieu thereof (*Effective*
2434 *January 1, 2009*):

2435 (d) The director of health of the town, city or borough shall provide
2436 or cause to be provided, to the parent or guardian of a child reported,
2437 pursuant to subsection (a) of this section, with information describing
2438 the dangers of lead poisoning, precautions to reduce the risk of lead
2439 poisoning, information about potential eligibility for services for
2440 children from birth to three years of age pursuant to sections 17a-248
2441 to 17a-248g, inclusive, and laws and regulations concerning lead
2442 abatement. Said information shall be developed by the Department of
2443 Public Health and provided to each local and district director of health.
2444 With respect to the child reported, the director shall conduct an on-site
2445 inspection to identify the source of the lead causing a confirmed
2446 venous blood lead level equal to or greater than fifteen micrograms per
2447 deciliter but less than twenty micrograms per deciliter in two tests

2448 taken at least three months apart and order remediation of such
2449 sources by the appropriate persons responsible for the conditions at
2450 such source. On and after January 1, 2012, if one per cent or more of
2451 children in this state under the age of six report blood lead levels equal
2452 to or greater than ten micrograms per deciliter, the director shall
2453 conduct such on-site inspection and order such remediation for any
2454 child having a confirmed venous blood lead level equal to or greater
2455 than ten micrograms per deciliter in two tests taken at least three
2456 months apart.

2457 Sec. 51. (NEW) (*Effective January 1, 2009*) Each individual health
2458 insurance policy providing coverage of the type specified in
2459 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
2460 statutes delivered, issued for delivery, amended, renewed or
2461 continued in this state on or after January 1, 2009, shall provide
2462 coverage for blood lead screening and risk assessments ordered by a
2463 primary care provider pursuant to section 48 of this act.

2464 Sec. 52. Subsection (b) of section 38a-535 of the general statutes is
2465 repealed and the following is substituted in lieu thereof (*Effective*
2466 *January 1, 2009*):

2467 (b) [Every] Each group health insurance policy providing coverage
2468 of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of
2469 section 38a-469 delivered, issued for delivery or renewed on or after
2470 October 1, 1989, or continued as defined in section 38a-531, on or after
2471 October 1, 1990, shall provide benefits for preventive pediatric care for
2472 any child covered by the policy or contract at approximately the
2473 following age intervals: Every two months from birth to six months of
2474 age, every three months from nine to eighteen months of age and
2475 annually from two through six years of age. Any such policy may
2476 provide that services rendered during a periodic review shall be
2477 covered to the extent that such services are provided by or under the
2478 supervision of a single physician during the course of one visit. On and
2479 after January 1, 2009, each such policy shall also provide coverage for

2480 blood lead screening and risk assessments ordered by a primary care
2481 provider pursuant to section 48 of this act. Such benefits shall be
2482 subject to any policy provisions which apply to other services covered
2483 by such policy.

2484 Sec. 53. (NEW) (*Effective October 1, 2007*) Not later than January 1,
2485 2008, the Commissioner of Public Health shall review the data
2486 collected by the Department of Public Health regarding lead poisoning
2487 to determine if the data is recorded in a format that is compatible with
2488 the information reported by institutions and laboratories pursuant to
2489 section 19a-110 of the general statutes, as amended by this act. If the
2490 commissioner finds that such data should be reported in a different
2491 manner, the commissioner shall adopt regulations, in accordance with
2492 chapter 54 of the general statutes, to establish the manner for reporting
2493 such data.

2494 Sec. 54. Section 19a-111c of the general statutes is repealed and the
2495 following is substituted in lieu thereof (*Effective October 1, 2007*):

2496 (a) The owner of any dwelling in which the paint, plaster or other
2497 [materials] material is found to contain toxic levels of lead and in
2498 which children under the age of six reside, shall abate, remediate or
2499 manage such dangerous materials consistent with regulations adopted
2500 pursuant to this section. The Commissioner of Public Health shall
2501 adopt regulations, in accordance with [the provisions of] chapter 54,
2502 [establishing removal and] to establish requirements and procedures
2503 for testing, remediation, abatement [requirements and procedures for]
2504 and management of materials containing toxic levels of lead. For the
2505 purposes of this section, "remediation" means the use of interim
2506 controls, including, but not limited to, paint stabilization, spot point
2507 repair, dust control, specialized cleaning and covering of soil with
2508 mulch.

2509 (b) The commissioner shall authorize the use of any liquid,
2510 cementitious or flexible lead encapsulant product which complies with
2511 an appropriate standard for such products developed by the American

2512 Society for Testing and Materials or similar testing organization
2513 acceptable to the commissioner for the abatement [of toxic levels of
2514 lead, unless the commissioner disapproves the use of any such
2515 product] and remediation of lead hazards. The commissioner shall
2516 maintain a list of all such approved lead encapsulant products that
2517 may be used in this state for the abatement [of toxic levels of lead] and
2518 remediation of lead hazards.

2519 (c) (1) The Commissioner of Public Health may adopt regulations, in
2520 accordance with chapter 54, to regulate paint removal from the exterior
2521 of any building or structure where the paint removal project may
2522 present a health hazard to neighboring premises. The regulations may
2523 establish: (A) Definitions, (B) applicability and exemption criteria, (C)
2524 procedures for submission of notifications, (D) appropriate work
2525 practices, and (E) penalties for noncompliance.

2526 (2) The Commissioner of Public Health may adopt regulations, in
2527 accordance with chapter 54, to regulate the standards and procedures
2528 for testing, remediation, as defined in this section, abatement and
2529 management of materials containing toxic levels of lead in any
2530 premises.

2531 Sec. 55. Section 19a-206 of the general statutes is repealed and the
2532 following is substituted in lieu thereof (*Effective October 1, 2007*):

2533 (a) Town, city and borough directors of health or their authorized
2534 agents shall, within their respective jurisdictions, examine all
2535 nuisances and sources of filth injurious to the public health, cause such
2536 nuisances to be abated or remediated and cause to be removed all filth
2537 which in their judgment may endanger the health of the inhabitants.
2538 Any owner or occupant of any property who maintains such property,
2539 whether real or personal, or any part thereof, in a manner which
2540 violates the provisions of the Public Health Code enacted pursuant to
2541 the authority of sections 19a-36 and 19a-37 shall be deemed to be
2542 maintaining a nuisance or source of filth injurious to the public health.
2543 Any local director of health or his authorized agent or a sanitarian

2544 authorized by such director may enter all places within his jurisdiction
2545 where there is just cause to suspect any nuisance or source of filth
2546 exists, and abate or remediate or cause to be abated or remediated such
2547 nuisance and remove or cause to be removed such filth.

2548 (b) When any such nuisance or source of filth is found on private
2549 property, such director of health shall order the owner or occupant of
2550 such property, or both, to remove, [or] abate or remediate the same
2551 within such time as the director directs. If such order is not complied
2552 with [,] within the time fixed by such director: (1) Such director, or any
2553 official of such town, city or borough authorized to institute actions on
2554 behalf of such town, city or borough, may institute and maintain a civil
2555 action for injunctive relief in any court of competent jurisdiction to
2556 require the abatement or remediation of such nuisance, the removal of
2557 such filth and the restraining and prohibiting of acts which caused
2558 such nuisance or filth, and such court shall have power to grant such
2559 injunctive relief upon notice and hearing; (2) (A) the owner or
2560 occupant of such property, or both, shall be subject to a civil penalty of
2561 two hundred fifty dollars per day for each day such nuisance is
2562 maintained or such filth is allowed to remain after the time fixed by
2563 the director in his order has expired, except that the owner or occupant
2564 of such property or any part thereof on which a public eating place is
2565 conducted shall not be subject to the provisions of this subdivision, but
2566 shall be subject to the provisions of subdivision (3) [. Such] of this
2567 subsection, and (B) such civil penalty may be collected in a civil
2568 proceeding by the director of health or any official of such town, city or
2569 borough authorized to institute civil actions and shall be payable to the
2570 treasurer of such city, town or borough; [,] and (3) the owner or
2571 occupant of such property, or both, shall be subject to the provisions of
2572 sections 19a-36, 19a-220 and 19a-230.

2573 (c) If the director institutes an action for injunctive relief seeking the
2574 abatement or remediation of a nuisance or the removal of filth, the
2575 maintenance of which is of so serious a nature as to constitute an
2576 immediate hazard to the health of persons other than the persons

2577 maintaining such nuisance or filth, he may, upon a verified complaint
2578 stating the facts which show such immediate hazard, apply for an ex
2579 parte injunction requiring the abatement or remediation of such
2580 nuisance or the removal of such filth and restraining and prohibiting
2581 the acts which caused such nuisance or filth to occur, and for a hearing
2582 on an order to show cause why such ex parte injunction should not be
2583 continued pending final determination on the merits of such action. If
2584 the court finds that an immediate hazard to the health of persons other
2585 than those persons maintaining such nuisance or source of filth exists,
2586 such ex parte injunction shall be issued, provided a hearing on its
2587 continuance pending final judgment is ordered held within seven days
2588 thereafter and provided further that any persons so enjoined may
2589 make a written request to the court or judge issuing such injunction for
2590 a hearing to vacate such injunction, in which event such hearing shall
2591 be held within three days after such request is filed.

2592 (d) In each town, except in a town having a city or borough within
2593 its limits, the town director of health shall have and exercise all the
2594 power for preserving the public health and preventing the spread of
2595 diseases; and, in any town within which there exists a city or borough,
2596 the limits of which are not coterminous with the limits of such town,
2597 such town director of health shall exercise the powers and duties of his
2598 office only in such part of such town as is outside the limits of such city
2599 or borough, except that when such city or borough has not appointed a
2600 director of health, the town director of health shall, for the purposes of
2601 this section, exercise the powers and duties of his office throughout the
2602 town, including such city or borough, until such city or borough
2603 appoints a director of health.

2604 (e) When such nuisance is abated or remediated or the source of
2605 filth is removed from private property, such abatement, [or]
2606 remediation or removal shall be at the expense of the owner or, where
2607 applicable, the occupant of such property, or both, and damages and
2608 costs for such abatement, remediation or removal may be recovered
2609 against [them] the owner or, where applicable, the occupant, or both,

2610 by the town, city or borough in a civil action as provided in subsection
2611 (b) of this section or in a separate civil action brought by the director of
2612 health or any official of such city, town or borough authorized to
2613 institute civil actions.

2614 Sec. 56. Section 47a-52 of the general statutes is repealed and the
2615 following is substituted in lieu thereof (*Effective October 1, 2007*):

2616 (a) As used in this section, "rented dwelling" means any structure or
2617 portion thereof which is rented, leased, or hired out to be occupied as
2618 the home or residence of one or two families and any mobile
2619 manufactured home in a mobile manufactured home park which,
2620 although owned by its resident, sits upon a space or lot which is
2621 rented, leased or hired out, but shall not include a tenement house as
2622 defined in section 19a-355 or in section 47a-1.

2623 (b) "Department of health" means the health authority of each city,
2624 borough or town, by whatever name such health authority may be
2625 known.

2626 (c) When any defect in the plumbing, sewerage, water supply,
2627 drainage, lighting, ventilation, or sanitary condition of a rented
2628 dwelling, or of the premises on which it is situated, in the opinion of
2629 the department of health of the municipality [wherein] where such
2630 dwelling is located, constitutes a danger to life or health, the
2631 department may order the responsible party to correct the same in
2632 such manner as it specifies. If the order is not complied with within the
2633 time limit set by the department, the person in charge of the
2634 department may institute a civil action for injunctive relief, in
2635 accordance with chapter 916, to require the abatement of such danger.

2636 (d) Paint on the exposed surfaces of the interior of a rented dwelling
2637 shall not be cracked, chipped, blistered, flaking, loose or peeling so as
2638 to constitute a health hazard. Testing, remediation, abatement and
2639 management of lead-based paint at a rented dwelling or its premises
2640 shall be as defined in, and in accordance with, the regulations, if any,

2641 adopted pursuant to section 19a-111c, as amended by this act.

2642 [(d)] (e) When the department of health certifies that any such
2643 rented dwelling or premises are unfit for human habitation, by reason
2644 of defects which may cause sickness or endanger the health of the
2645 occupants, the department may issue an order requiring the rented
2646 dwelling, premises or any portion thereof to be vacated within not less
2647 than twenty-four hours or more than ten days.

2648 [(e)] (f) Any person who violates or assists in violating, or fails to
2649 comply with, any provision of this section or any legal order of a
2650 department of health made under any such provision shall be fined
2651 not more than two hundred dollars or imprisoned not more than sixty
2652 days or both.

2653 [(f)] (g) Any person aggrieved by an order issued under this section
2654 may appeal, pursuant to section 19a-229, to the Commissioner of
2655 Public Health.

2656 Sec. 57. Section 47a-54f of the general statutes is repealed and the
2657 following is substituted in lieu thereof (*Effective October 1, 2007*):

2658 (a) In each tenement, lodging or boarding house the walls of any
2659 court, shaft, hall or room shall be whitewashed or painted a light color
2660 whenever, in the opinion of the board of health or enforcing agency,
2661 such whitewashing or painting is needed for the better lighting of any
2662 room, hall or water closet compartment.

2663 (b) Paint on the [accessible] exposed surfaces of the interior of a
2664 tenement house shall not be cracked, chipped, blistered, flaking, loose,
2665 or peeling so as to constitute a health hazard. Testing, remediation,
2666 abatement and management of lead-based paint at a tenement house
2667 or its premises shall be as defined in, and in accordance with, the
2668 regulations, if any, adopted pursuant to section 19a-111c, as amended
2669 by this act.

2670 Sec. 58. (NEW) (*Effective October 1, 2007*) (a) On or before January 1,

2671 2009, and annually thereafter, the Commissioner of Public Health shall
2672 report, in accordance with section 11-4a of the general statutes, to the
2673 joint standing committees of the General Assembly having cognizance
2674 of matters relating to public health and human services on the status of
2675 lead poisoning prevention efforts in the state. Such report shall
2676 include, but not be limited to, (1) the number of children screened for
2677 lead poisoning during the preceding calendar year, (2) the number of
2678 children diagnosed with elevated blood levels during the preceding
2679 calendar year, and (3) the amount of testing, remediation, abatement
2680 and management of materials containing toxic levels of lead in all
2681 premises during the preceding calendar year.

2682 (b) On or before January 1, 2011, the Commissioner of Public Health
2683 shall (1) evaluate the lead screening and risk assessment conducted
2684 pursuant to section 48 of this act and section 19a-110 of the general
2685 statutes, as amended by section 50 of this act, and (2) report, in
2686 accordance with section 11-4a of the general statutes, to the joint
2687 standing committees of the General Assembly having cognizance of
2688 matters relating to public health and human services on the
2689 effectiveness of such screening and assessment, including a
2690 recommendation as to whether such screening and assessment should
2691 be continued as specified in said section 48 and said section 19a-110.

2692 Sec. 59. (NEW) (*Effective July 1, 2007*) The Department of Public
2693 Health shall, within available appropriations, establish and administer
2694 a program of financial assistance to local health departments for
2695 expenses incurred in complying with applicable provisions of sections
2696 19a-110, 19a-111a, 19a-206, 47a-52 and 47a-54f of the general statutes,
2697 as amended by this act. The Commissioner of Public Health may
2698 adopt, in accordance with chapter 54 of the general statutes, such
2699 regulations as the commissioner deems necessary to carry out the
2700 purposes of this section.

2701 Sec. 60. (NEW) (*Effective October 1, 2007*) All standards adopted by
2702 the federal Occupational Safety and Health Administration, including,

2703 but not limited to, standards listed in 29 CFR 1910.1025 and 1926.62, as
2704 adopted pursuant to chapter 571 of the general statutes, or 29 USC 651
2705 et seq., as from time to time amended, as appropriate, and only as
2706 those standards apply to employers and employees, shall apply to the
2707 provisions of sections 19a-111c, 19a-206, 47a-52 and 47a-54f of the
2708 general statutes, as amended by this act.

2709 Sec. 61. Section 19a-202 of the general statutes is repealed and the
2710 following is substituted in lieu thereof (*Effective July 1, 2007*):

2711 Upon application to the Department of Public Health any municipal
2712 health department shall annually receive from the state an amount
2713 equal to [ninety-four] one dollar and eighteen cents per capita,
2714 provided such municipality (1) employs a full-time director of health,
2715 except that if a vacancy exists in the office of director of health or the
2716 office is filled by an acting director for more than three months, such
2717 municipality shall not be eligible for funding unless the Commissioner
2718 of Public Health waives this requirement; (2) submits a public health
2719 program and budget which is approved by the Commissioner of
2720 Public Health; and (3) appropriates not less than one dollar per capita,
2721 from the annual tax receipts, for health department services. Such
2722 municipal department of health [is authorized to] may use additional
2723 funds, which the Department of Public Health may secure from federal
2724 agencies or any other source and which it may allot to such municipal
2725 department of health. The money so received shall be disbursed upon
2726 warrants approved by the chief executive officer of such municipality.
2727 The Comptroller shall annually in July and upon a voucher of the
2728 Commissioner of Public Health, draw the Comptroller's order on the
2729 State Treasurer in favor of such municipal department of health for the
2730 amount due in accordance with the provisions of this section and
2731 under rules prescribed by the commissioner. Any moneys remaining
2732 unexpended at the end of a fiscal year shall be included in the budget
2733 of such municipal department of health for the ensuing year. This aid
2734 shall be rendered from appropriations made from time to time by the
2735 General Assembly to the Department of Public Health for this purpose.

2736 Sec. 62. Section 19a-245 of the general statutes is repealed and the
2737 following is substituted in lieu thereof (*Effective July 1, 2007*):

2738 Upon application to the Department of Public Health, each health
2739 district shall annually receive from the state an amount equal to [one
2740 dollar and ninety-four] two dollars and forty-three cents per capita for
2741 each town, city and borough of such district which has a population of
2742 five thousand or less, and [one dollar and sixty-six] two dollars and
2743 eight cents per capita for each town, city and borough of such district
2744 which has a population of more than five thousand, provided (1) the
2745 Commissioner of Public Health approves the public health program
2746 and budget of such health district, and (2) the towns, cities and
2747 boroughs of such district appropriate for the maintenance of the health
2748 district not less than one dollar per capita from the annual tax receipts.
2749 Such district departments of health are authorized to use additional
2750 funds, which the Department of Public Health may secure from federal
2751 agencies or any other source and which it may allot to such district
2752 departments of health. The district treasurer shall disburse the money
2753 so received upon warrants approved by a majority of the board and
2754 signed by its chairman and secretary. The Comptroller shall quarterly,
2755 in July, October, January and April, upon such application and upon
2756 the voucher of the Commissioner of Public Health, draw the
2757 Comptroller's order on the State Treasurer in favor of such district
2758 department of health for the amount due in accordance with the
2759 provisions of this section and under rules prescribed by the
2760 commissioner. Any moneys remaining unexpended at the end of a
2761 fiscal year shall be included in the budget of the district for the ensuing
2762 year. This aid shall be rendered from appropriations made from time
2763 to time by the General Assembly to the Department of Public Health
2764 for this purpose.

2765 Sec. 63. Section 17b-359 of the general statutes is repealed and the
2766 following is substituted in lieu thereof (*Effective July 1, 2007*):

2767 (a) For purposes of this section, the terms "mentally ill" and

2768 "specialized services" shall be as defined in Subsections (e)(7)(G)(i) and
2769 (iii) of Section 1919 of the Social Security Act and federal regulations.

2770 (b) No nursing facility shall admit any person, irrespective of source
2771 of payment, who has not undergone a preadmission screening process
2772 by which the Department of Mental Health and Addiction Services
2773 determines, based upon an independent physical and mental
2774 evaluation performed by or under the auspices of the Department of
2775 Social Services, whether the person is mentally ill and, if so, whether
2776 such person requires the level of services provided by a nursing
2777 facility and, if such person is mentally ill and does require such level of
2778 services, whether the person requires specialized services. A person
2779 who is determined to be mentally ill and not to require nursing facility
2780 level services shall not be admitted to a nursing facility. In order to
2781 implement the preadmission review requirements of this section and
2782 to identify applicants for admission who may be mentally ill and
2783 subject to the requirements of this section, nursing facilities may not
2784 admit any person, irrespective of source of payment, unless an
2785 identification screen developed, or in the case of out-of-state residents
2786 approved, by the Department of Social Services has been completed
2787 and filed in accordance with federal law.

2788 (c) No payment from any source shall be due to any nursing facility
2789 that admits a resident in violation of the preadmission screening
2790 requirements of this section.

2791 (d) A nursing facility shall notify the Department of Mental Health
2792 and Addiction Services when a resident who is mentally ill undergoes
2793 a significant change in condition or when a resident who has not
2794 previously been diagnosed as mentally ill undergoes a change in
2795 condition which may require specialized services. Upon such
2796 notifications, the Department of Mental Health and Addiction
2797 Services, under the auspices of the Department of Social Services, shall
2798 perform an evaluation to determine whether the resident requires the
2799 level of services provided by a nursing facility or requires specialized

2800 services for mental illness.

2801 (e) The Department of Mental Health and Addiction Services, in
2802 consultation with the Department of Social Services, may no less than
2803 annually review, within available appropriations, the status of each
2804 resident in a nursing facility who is mentally ill to determine whether
2805 the resident requires (1) the level of services provided by a nursing
2806 facility, or (2) specialized services for mental illness. Nursing facilities
2807 shall grant to the Department of Mental Health and Addiction Services
2808 and the Department of Social Services access to nursing facility
2809 residents and their medical records for the purposes of this section.

2810 [(e)] (f) In the case of a mentally ill resident who is determined
2811 under subsection (b), (d) or (e) of this section not to require the level of
2812 services provided by a nursing facility but to require specialized
2813 services for mental illness and who has continuously resided in a
2814 nursing facility for at least thirty months before the date of the
2815 determination, the resident may elect to remain in the facility or to
2816 receive services covered by Medicaid in an alternative appropriate
2817 institutional or noninstitutional setting in accordance with the
2818 alternative disposition plan submitted by the Department of Social
2819 Services to the Secretary of the United States Department of Health
2820 and Human Services, and consistent with the Department of Mental
2821 Health and Addiction Services requirements for the provision of
2822 specialized services.

2823 [(f)] (g) In the case of a mentally ill resident who is determined
2824 under subsection (b), (d) or (e) of this section not to require the level of
2825 services provided by a nursing facility but to require specialized
2826 services for mental illness and who has not continuously resided in a
2827 nursing facility for at least thirty months before the date of the
2828 determination, the nursing facility in consultation with the Department
2829 of Mental Health and Addiction Services shall arrange for the safe and
2830 orderly discharge of the resident from the facility. If the department
2831 determines that the provision of specialized services requires an

2832 alternate residential placement, the discharge and transfer of the
2833 resident shall be made in accordance with the alternative disposition
2834 plan submitted by the Department of Social Services and approved by
2835 the Secretary of the United States Department of Health and Human
2836 Services, except if an alternate residential placement is not available,
2837 the resident shall not be transferred.

2838 [(g)] (h) In the case of a resident who is determined under
2839 subsection (b), (d) or (e) of this subsection not to require the level of
2840 services provided by a nursing facility and not to require specialized
2841 services, the nursing facility shall arrange for the safe and orderly
2842 discharge of the resident from the facility.

2843 [(h)] (i) Any person seeking admittance to a nursing facility or any
2844 resident of a nursing facility who is adversely affected by a
2845 determination of the Department of Mental Health and Addiction
2846 Services under this section may appeal such determination to the
2847 Department of Social Services within fifteen days of the receipt of the
2848 notice of a determination by the Department of Mental Health and
2849 Addiction Services. If an appeal is taken to the Department of Social
2850 Services the determination of the Department of Mental Health and
2851 Addiction Services shall be stayed pending determination by the
2852 Department of Social Services.

2853 Sec. 64. Section 38a-497 of the general statutes, as amended by
2854 section 16 of public act 07-185, is repealed and the following is
2855 substituted in lieu thereof (*Effective January 1, 2009*):

2856 Every individual health insurance policy providing coverage of the
2857 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of
2858 section 38a-469 delivered, issued for delivery, amended or renewed in
2859 this state on or after [October 1, 2007] January 1, 2009, shall provide
2860 that coverage of a child shall terminate no earlier than the policy
2861 anniversary date on or after whichever of the following occurs first, the
2862 date on which the child marries, [ceases to be a resident of the state] or
2863 attains the age of twenty-six as long as the child is a resident of the

2864 state except for full-time attendance at an out-of-state accredited
2865 institution of higher education or resides out of state with a custodial
2866 parent pursuant to a child custody determination, as defined in section
2867 46b-115a.

2868 Sec. 65. Subsection (b) of section 38a-554 of the general statutes, as
2869 amended by section 17 of public act 07-185, is repealed and the
2870 following is substituted in lieu thereof (*Effective January 1, 2009*):

2871 (b) The plan shall provide the option to continue coverage under
2872 each of the following circumstances until the individual is eligible for
2873 other group insurance, except as provided in subdivisions (3) and (4)
2874 of this subsection: (1) Notwithstanding any provision of this section,
2875 upon layoff, reduction of hours, leave of absence, or termination of
2876 employment, other than as a result of death of the employee or as a
2877 result of such employee's "gross misconduct" as that term is used in 29
2878 USC 1163(2), continuation of coverage for such employee and such
2879 employee's covered dependents for the periods set forth for such event
2880 under federal extension requirements established by the federal
2881 Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272),
2882 as amended from time to time, (COBRA), except that if such reduction
2883 of hours, leave of absence or termination of employment results from
2884 an employee's eligibility to receive Social Security income,
2885 continuation of coverage for such employee and such employee's
2886 covered dependents until midnight of the day preceding such person's
2887 eligibility for benefits under Title XVIII of the Social Security Act; (2)
2888 upon the death of the employee, continuation of coverage for the
2889 covered dependents of such employee for the periods set forth for such
2890 event under federal extension requirements established by the
2891 Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272),
2892 as amended from time to time, (COBRA); (3) regardless of the
2893 employee's or dependent's eligibility for other group insurance, during
2894 an employee's absence due to illness or injury, continuation of
2895 coverage for such employee and such employee's covered dependents
2896 during continuance of such illness or injury or for up to twelve months

2897 from the beginning of such absence; (4) regardless of an individual's
2898 eligibility for other group insurance, upon termination of the group
2899 plan, coverage for covered individuals who were totally disabled on
2900 the date of termination shall be continued without premium payment
2901 during the continuance of such disability for a period of twelve
2902 calendar months following the calendar month in which the plan was
2903 terminated, provided claim is submitted for coverage within one year
2904 of the termination of the plan; (5) the coverage of any covered
2905 individual shall terminate: (A) As to a child, the plan shall provide the
2906 option for said child to continue coverage for the longer of the
2907 following periods: (i) At the end of the month following the month in
2908 which the child marries, [ceases to reside in the state] or attains the age
2909 of twenty-six, provided the child is a resident of the state except for
2910 full-time attendance at an out-of-state accredited institution of higher
2911 education or resides out of state with a custodial parent pursuant to a
2912 child custody determination, as defined in section 46b-115a. If on the
2913 date specified for termination of coverage on a child, the child is
2914 unmarried and incapable of self-sustaining employment by reason of
2915 mental or physical handicap and chiefly dependent upon the
2916 employee for support and maintenance, the coverage on such child
2917 shall continue while the plan remains in force and the child remains in
2918 such condition, provided proof of such handicap is received by the
2919 carrier within thirty-one days of the date on which the child's coverage
2920 would have terminated in the absence of such incapacity. The carrier
2921 may require subsequent proof of the child's continued incapacity and
2922 dependency but not more often than once a year thereafter, or (ii) for
2923 the periods set forth for such child under federal extension
2924 requirements established by the Consolidated Omnibus Budget
2925 Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time,
2926 (COBRA); (B) as to the employee's spouse, at the end of the month
2927 following the month in which a divorce, court-ordered annulment or
2928 legal separation is obtained, whichever is earlier, except that the plan
2929 shall provide the option for said spouse to continue coverage for the
2930 periods set forth for such events under federal extension requirements

2931 established by the Consolidated Omnibus Budget Reconciliation Act of
2932 1985 (P.L. 99-272), as amended from time to time, (COBRA); and (C) as
2933 to the employee or dependent who is sixty-five years of age or older,
2934 as of midnight of the day preceding such person's eligibility for
2935 benefits under Title XVIII of the federal Social Security Act; (6) as to
2936 any other event listed as a "qualifying event" in 29 USC 1163, as
2937 amended from time to time, continuation of coverage for such periods
2938 set forth for such event in 29 USC 1162, as amended from time to time,
2939 provided such plan may require the individual whose coverage is to be
2940 continued to pay up to the percentage of the applicable premium as
2941 specified for such event in 29 USC 1162, as amended from time to time.
2942 Any continuation of coverage required by this section except
2943 subdivision (4) or (6) of this subsection may be subject to the
2944 requirement, on the part of the individual whose coverage is to be
2945 continued, that such individual contribute that portion of the premium
2946 the individual would have been required to contribute had the
2947 employee remained an active covered employee, except that the
2948 individual may be required to pay up to one hundred two per cent of
2949 the entire premium at the group rate if coverage is continued in
2950 accordance with subdivision (1), (2) or (5) of this subsection. The
2951 employer shall not be legally obligated by sections 38a-505, 38a-546
2952 and 38a-551 to 38a-559, inclusive, to pay such premium if not paid
2953 timely by the employee.

2954 Sec. 66. (NEW) (*Effective July 1, 2007*) (a) The Department of Public
2955 Health and The University of Connecticut Health Center may, within
2956 available appropriations, develop a Connecticut Health Information
2957 Network plan to securely integrate state health and social services
2958 data, consistent with state and federal privacy laws, within and across
2959 The University of Connecticut Health Center, the Office of Health Care
2960 Access and the Departments of Public Health, Mental Retardation and
2961 Children and Families. Data from other state agencies may be
2962 integrated into the network as funding permits and as permissible
2963 under federal law.

2964 (b) The Department of Public Health and The Center for Public
2965 Health and Health Policy at The University of Connecticut Health
2966 Center shall collaborate with the Departments of Information
2967 Technology, Mental Retardation, Children and Families and the Office
2968 of Health Care Access to develop the Connecticut Health Information
2969 Network plan.

2970 (c) The plan shall: (1) Include research in and describe existing
2971 health and human services data; (2) inventory the various health and
2972 human services data aggregation initiatives currently underway; (3)
2973 include a framework and options for the implementation of a
2974 Connecticut Health Information Network, including query
2975 functionality to obtain aggregate data on key health indicators within
2976 the state; (4) identify and comply with confidentiality, security and
2977 privacy standards; and (5) include a detailed cost estimate for
2978 implementation and potential sources of funding.

2979 Sec. 67. Subsection (a) of section 30 of public act 07-185 is repealed
2980 and the following is substituted in lieu thereof (*Effective from passage*):

2981 (a) There is established a HealthFirst Connecticut Authority
2982 composed of the following members: Two appointed by the speaker of
2983 the House of Representatives, one of whom is a health care provider
2984 and one of whom represents businesses with fifty or more employees;
2985 two appointed by the president pro tempore of the Senate, one of
2986 whom has experience in community-based health care and one of
2987 whom represents businesses with fewer than fifty employees; one
2988 appointed by the majority leader of the House of Representatives who
2989 represents consumers; one appointed by the majority leader of the
2990 Senate who represents the interests of labor; one appointed by the
2991 minority leader of the House of Representatives who represents health
2992 insurance companies; one appointed by the minority leader of the
2993 Senate who represents hospitals; and two appointed by the Governor,
2994 one of whom advocates for health care quality or patient safety and
2995 one with experience in information technology. The Insurance

2996 Commissioner and the Commissioners of Public Health and Social
2997 Services or their designees, the Healthcare Advocate or the Healthcare
2998 Advocate's designee and the Comptroller or Comptroller's designee
2999 shall be ex-officio, nonvoting members.

3000 Sec. 68. (NEW) (*Effective July 1, 2007*) (a) As used in this section:

3001 (1) "Electronic health information system" means an information
3002 processing system, involving both computer hardware and software
3003 that deals with the storage, retrieval, sharing and use of health care
3004 information, data and knowledge for communication and decision
3005 making, and includes: (A) An electronic health record that provides
3006 access in real-time to a patient's complete medical record; (B) a
3007 personal health record through which an individual, and anyone
3008 authorized by such individual, can maintain and manage such
3009 individual's health information; (C) computerized order entry
3010 technology that permits a health care provider to order diagnostic and
3011 treatment services, including prescription drugs electronically; (D)
3012 electronic alerts and reminders to health care providers to improve
3013 compliance with best practices, promote regular screenings and other
3014 preventive practices, and facilitate diagnoses and treatments; (E) error
3015 notification procedures that generate a warning if an order is entered
3016 that is likely to lead to a significant adverse outcome for a patient; and
3017 (F) tools to allow for the collection, analysis and reporting of data on
3018 adverse events, near misses, the quality and efficiency of care, patient
3019 satisfaction and other healthcare-related performance measures.

3020 (2) "Interoperability" means the ability of two or more systems or
3021 components to exchange information and to use the information that
3022 has been exchanged and includes: (A) The capacity to physically
3023 connect to a network for the purpose of exchanging data with other
3024 users; (B) the ability of a connected user to demonstrate appropriate
3025 permissions to participate in the instant transaction over the network;
3026 and (C) the capacity of a connected user with such permissions to
3027 access, transmit, receive and exchange usable information with other

3028 users.

3029 (3) "Standard electronic format" means a format using open
3030 electronic standards that: (A) Enable health information technology to
3031 be used for the collection of clinically specific data; (B) promote the
3032 interoperability of health care information across health care settings,
3033 including reporting to local, state and federal agencies; and (C)
3034 facilitate clinical decision support.

3035 (b) On or before November 30, 2007, the Department of Public
3036 Health, in consultation with the Office of Health Care Access and
3037 within available appropriations, shall contract, through a competitive
3038 bidding process, for the development of a state-wide health
3039 information technology plan. The entity awarded such contract shall
3040 be designated the lead health information exchange organization for
3041 the state of Connecticut for the period commencing December 1, 2007,
3042 and ending June 30, 2009. The state-wide health information
3043 technology plan shall include, but not be limited to:

3044 (1) General standards and protocols for health information
3045 exchange.

3046 (2) Electronic data standards to facilitate the development of a state-
3047 wide, integrated electronic health information system for use by health
3048 care providers and institutions that are funded by the state. Such
3049 electronic data standards shall (A) include provisions relating to
3050 security, privacy, data content, structures and format, vocabulary and
3051 transmission protocols, (B) be compatible with any national data
3052 standards in order to allow for interstate interoperability, (C) permit
3053 the collection of health information in a standard electronic format,
3054 and (D) be compatible with the requirements for an electronic health
3055 information system.

3056 (3) Pilot programs for health information exchange, and projected
3057 costs and sources of funding for such pilot programs.

3058 (c) Not later than December 1, 2008, and annually thereafter, the
3059 Department of Public Health, in consultation with Office of Health
3060 Care Access, shall report, in accordance with section 11-4a of the
3061 general statutes, to the joint standing committees of the General
3062 Assembly having cognizance of matters relating to public health,
3063 human services, government administration and appropriations and
3064 the budgets of state agencies on the status of the state-wide health
3065 information technology plan.

3066 Sec. 69. (*Effective from passage*) Sections 16 and 17 of public act 07-185
3067 shall take effect January 1, 2009.

3068 Sec. 70. (*Effective July 1, 2007*) During the fiscal year ending June 30,
3069 2008, the Department of Public Health shall, within available
3070 appropriations, expand school-based health clinic services for (1)
3071 priority school districts pursuant to section 10-266p of the general
3072 statutes, and (2) areas designated by the federal Health Resources and
3073 Services Administration as health professional shortage areas,
3074 medically underserved areas or areas with a medically underserved
3075 population.

3076 Sec. 71. (*Effective July 1, 2007*) For the fiscal year ending June 30,
3077 2008, the Commissioner of Public Health, in consultation with the
3078 Secretary of the Office of Policy and Management, may (1) make
3079 payments to providers for the purpose of addressing funding
3080 reductions under Part A and Part B of the federal Ryan White
3081 Program, and (2) enter into contracts with health departments located
3082 in the Hartford or New Haven Transitional Grant Areas for the
3083 purpose of addressing funding reductions under the federal Ryan
3084 White Program.

3085 Sec. 72. Sections 10, 12, 24 to 28, inclusive, and 34 to 43, inclusive, of
3086 public act 07-185 and section 501 of house amendment schedule B to
3087 substitute house bill 7163 of the January 2007 session are repealed.
3088 (*Effective July 1, 2007*)

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| This act shall take effect as follows and shall amend the following sections: | | |
| Section 1 | July 1, 2007 | 17b-321(a) and (b) |
| Sec. 2 | July 1, 2007 | 17b-104(a) and (b) |
| Sec. 3 | July 1, 2007 | 17b-106(a) |
| Sec. 4 | July 1, 2007 | 17b-265e |
| Sec. 5 | July 1, 2007 | 17b-369 |
| Sec. 6 | July 1, 2007 | 17b-285 |
| Sec. 7 | July 1, 2007 | 17b-261 |
| Sec. 8 | July 1, 2007 | New section |
| Sec. 9 | July 1, 2007 | 17b-277 |
| Sec. 10 | July 1, 2007 | PA 07-185, Sec. 13 |
| Sec. 11 | July 1, 2007 | 17b-340(f)(4) |
| Sec. 12 | July 1, 2007 | 17b-340(g) |
| Sec. 13 | July 1, 2007 | 17b-244(a) |
| Sec. 14 | July 1, 2007 | 17b-192 |
| Sec. 15 | July 1, 2007 | 17b-733 |
| Sec. 16 | July 1, 2007 | New section |
| Sec. 17 | July 1, 2007 | 17b-292 |
| Sec. 18 | July 1, 2007 | 17b-137(a) |
| Sec. 19 | July 1, 2007 | New section |
| Sec. 20 | July 1, 2007 | 17b-265 |
| Sec. 21 | from passage | New section |
| Sec. 22 | July 1, 2007 | 17b-340(f)(11) |
| Sec. 23 | July 1, 2008 | New section |
| Sec. 24 | July 1, 2007 | New section |
| Sec. 25 | from passage | 17a-317 |
| Sec. 26 | July 1, 2007 | 17b-790a |
| Sec. 27 | July 1, 2007 | 17b-239 |
| Sec. 28 | July 1, 2007 | New section |
| Sec. 29 | July 1, 2007 | New section |
| Sec. 30 | October 1, 2007 | New section |
| Sec. 31 | October 1, 2007 | New section |
| Sec. 32 | April 1, 2008 | New section |
| Sec. 33 | April 1, 2008 | New section |
| Sec. 34 | October 1, 2007 | New section |
| Sec. 35 | October 1, 2007 | New section |
| Sec. 36 | October 1, 2007 | New section |
| Sec. 37 | October 1, 2007 | New section |

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| Sec. 38 | <i>October 1, 2007</i> | New section |
| Sec. 39 | <i>October 1, 2007</i> | 8-206e(e) |
| Sec. 40 | <i>October 1, 2007</i> | 17b-365(a) |
| Sec. 41 | <i>October 1, 2007</i> | 17b-366(a) |
| Sec. 42 | <i>October 1, 2007</i> | 17b-417(a) and (b) |
| Sec. 43 | <i>October 1, 2007</i> | 19a-6c |
| Sec. 44 | <i>July 1, 2007</i> | 17b-295 |
| Sec. 45 | <i>July 1, 2007</i> | 27-118 |
| Sec. 46 | <i>July 1, 2008</i> | New section |
| Sec. 47 | <i>October 1, 2007</i> | 19a-111a |
| Sec. 48 | <i>January 1, 2009</i> | New section |
| Sec. 49 | <i>October 1, 2007</i> | 19a-110(a) |
| Sec. 50 | <i>January 1, 2009</i> | 19a-110(d) |
| Sec. 51 | <i>January 1, 2009</i> | New section |
| Sec. 52 | <i>January 1, 2009</i> | 38a-535(b) |
| Sec. 53 | <i>October 1, 2007</i> | New section |
| Sec. 54 | <i>October 1, 2007</i> | 19a-111c |
| Sec. 55 | <i>October 1, 2007</i> | 19a-206 |
| Sec. 56 | <i>October 1, 2007</i> | 47a-52 |
| Sec. 57 | <i>October 1, 2007</i> | 47a-54f |
| Sec. 58 | <i>October 1, 2007</i> | New section |
| Sec. 59 | <i>July 1, 2007</i> | New section |
| Sec. 60 | <i>October 1, 2007</i> | New section |
| Sec. 61 | <i>July 1, 2007</i> | 19a-202 |
| Sec. 62 | <i>July 1, 2007</i> | 19a-245 |
| Sec. 63 | <i>July 1, 2007</i> | 17b-359 |
| Sec. 64 | <i>January 1, 2009</i> | 38a-497 |
| Sec. 65 | <i>January 1, 2009</i> | 38a-554(b) |
| Sec. 66 | <i>July 1, 2007</i> | New section |
| Sec. 67 | <i>from passage</i> | PA 07-185, Sec. 30(a) |
| Sec. 68 | <i>July 1, 2007</i> | New section |
| Sec. 69 | <i>from passage</i> | New section |
| Sec. 70 | <i>July 1, 2007</i> | New section |
| Sec. 71 | <i>July 1, 2007</i> | New section |
| Sec. 72 | <i>July 1, 2007</i> | Repealer section |