



General Assembly

**Substitute Bill No. 3**

January Session, 2007

\* SB00003HS 032207 \*

**AN ACT CONCERNING INCREASED ACCESS TO HEALTH CARE THROUGH THE HUSKY PROGRAM.**

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

1 Section 1. Section 17b-261 of the general statutes is repealed and the  
2 following is substituted in lieu thereof (*Effective July 1, 2007*):

3 (a) Medical assistance shall be provided for any otherwise eligible  
4 person whose income, including any available support from legally  
5 liable relatives and the income of the person's spouse or dependent  
6 child, is not more than one hundred forty-three per cent, pending  
7 approval of a federal waiver applied for pursuant to subsection (d) of  
8 this section, of the benefit amount paid to a person with no income  
9 under the temporary family assistance program in the appropriate  
10 region of residence and if such person is an institutionalized  
11 individual as defined in Section 1917(c) of the Social Security Act, 42  
12 USC 1396p(c), and has not made an assignment or transfer or other  
13 disposition of property for less than fair market value for the purpose  
14 of establishing eligibility for benefits or assistance under this section.  
15 Any such disposition shall be treated in accordance with Section  
16 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of  
17 property made on behalf of an applicant or recipient or the spouse of  
18 an applicant or recipient by a guardian, conservator, person  
19 authorized to make such disposition pursuant to a power of attorney

20 or other person so authorized by law shall be attributed to such  
21 applicant, recipient or spouse. A disposition of property ordered by a  
22 court shall be evaluated in accordance with the standards applied to  
23 any other such disposition for the purpose of determining eligibility.  
24 The commissioner shall establish the standards for eligibility for  
25 medical assistance at one hundred forty-three per cent of the benefit  
26 amount paid to a family unit of equal size with no income under the  
27 temporary family assistance program in the appropriate region of  
28 residence. [, pending federal approval, except that the] Except as  
29 provided in section 17b-277, as amended by this act, the medical  
30 assistance program shall provide coverage to persons under the age of  
31 nineteen [up to one hundred eighty-five per cent of the federal poverty  
32 level without an asset limit. Said medical assistance program shall also  
33 provide coverage to persons under the age of nineteen] and their  
34 parents and needy caretaker relatives, who qualify for coverage under  
35 Section 1931 of the Social Security Act, with family income up to one  
36 hundred [fifty] eighty-five per cent of the federal poverty level without  
37 an asset limit. [, upon the request of such a person or upon a  
38 redetermination of eligibility.] Such levels shall be based on the  
39 regional differences in such benefit amount, if applicable, unless such  
40 levels based on regional differences are not in conformance with  
41 federal law. Any income in excess of the applicable amounts shall be  
42 applied as may be required by said federal law, and assistance shall be  
43 granted for the balance of the cost of authorized medical assistance. All  
44 contracts entered into on and after July 1, 1997, pursuant to this section  
45 shall include provisions for collaboration of managed care  
46 organizations with the Nurturing Families Network established  
47 pursuant to section 17a-56. The Commissioner of Social Services shall  
48 provide applicants for assistance under this section, at the time of  
49 application, with a written statement advising them of (1) the effect of  
50 an assignment or transfer or other disposition of property on eligibility  
51 for benefits or assistance, (2) the effect that having income that exceeds  
52 the limits prescribed in this subsection will have with respect to  
53 program eligibility, (3) the availability of HUSKY Plan, Part B health  
54 insurance benefits for persons who are not eligible for assistance

55 pursuant to this subsection or who are subsequently determined  
56 ineligible for assistance pursuant to this subsection, and [(2)] (4) the  
57 availability of, and eligibility for, services provided by the Nurturing  
58 Families Network established pursuant to section 17a-56.

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

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

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

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

86 (f) To the extent permitted by federal law, Medicaid eligibility shall

87 be extended for one year to a family that becomes ineligible for  
88 medical assistance under Section 1931 of the Social Security Act due to  
89 income from employment by one of its members who is a caretaker  
90 relative or due to receipt of child support income. A family receiving  
91 extended benefits on July 1, 2005, shall receive the balance of such  
92 extended benefits, provided no such family shall receive more than  
93 twelve additional months of such benefits.

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

108 [(h) The Commissioner of Social Services shall, to the extent  
109 permitted by federal law, or, pursuant to an approved waiver of  
110 federal law submitted by the commissioner, in accordance with the  
111 provisions of section 17b-8, impose the following cost-sharing  
112 requirements under the HUSKY Plan, on all parent and needy  
113 caretaker relatives with incomes exceeding one hundred per cent of the  
114 federal poverty level: (1) A twenty-five-dollar premium per month per  
115 parent or needy caretaker relative; and (2) a copayment of one dollar  
116 per visit for outpatient medical services delivered by an enrolled  
117 Medicaid or HUSKY Plan provider. The commissioner may implement  
118 policies and procedures necessary to administer the provisions of this  
119 subsection while in the process of adopting such policies and  
120 procedures as regulations, provided the commissioner publishes notice

121 of the intent to adopt regulations in the Connecticut Law Journal not  
122 later than twenty days after implementation. Policies and procedures  
123 implemented pursuant to this subsection shall be valid until the time  
124 final regulations are adopted.]

125 [(i)] (h) Medical assistance shall be provided, in accordance with the  
126 provisions of subsection (e) of section 17a-6, to any child under the  
127 supervision of the Commissioner of Children and Families who is not  
128 receiving Medicaid benefits, has not yet qualified for Medicaid benefits  
129 or is otherwise ineligible for such benefits because of institutional  
130 status. To the extent practicable, the Commissioner of Children and  
131 Families shall apply for, or assist such child in qualifying for, the  
132 Medicaid program.

133 [(j)] (i) The Commissioner of Social Services shall provide Early and  
134 Periodic Screening, Diagnostic and Treatment program services, as  
135 required and defined as of December 31, 2005, by 42 USC 1396a(a)(43),  
136 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal  
137 regulations, to all persons who are under the age of twenty-one and  
138 otherwise eligible for medical assistance under this section.

139 (j) Notwithstanding the provisions of this section, the Commissioner  
140 of Social Services, pursuant to 42 USC 1396a (r)(2), shall file an  
141 amendment to the Medicaid state plan that allows the commissioner,  
142 when making Medicaid income eligibility determinations, to establish  
143 and maintain the level of eligibility for persons who are aged, blind or  
144 disabled at the same income level used to determine eligibility for  
145 parents and needy caretaker relatives under the HUSKY Plan, Part A,  
146 by establishing a special income disregard that is applicable only to  
147 aged, blind or disabled individuals and only under the Medicaid  
148 program.

149 Sec. 2. Section 17b-297 of the general statutes is repealed and the  
150 following is substituted in lieu thereof (*Effective July 1, 2007*):

151 (a) The [commissioner] Commissioner of Social Services, in  
152 consultation with the Children's Health Council, the Medicaid

153 Managed Care Council and the 2-1-1 Infoline [of Connecticut]  
154 program, shall develop mechanisms [for outreach for] to increase  
155 outreach and maximize enrollment of eligible children and adults in  
156 the HUSKY Plan, Part A [and] or Part B, [, including, but not limited  
157 to, development of mail-in applications and appropriate outreach  
158 materials through the Department of Revenue Services, the Labor  
159 Department, the Department of Social Services, the Department of  
160 Public Health, the Department of Children and Families and the Office  
161 of Protection and Advocacy for Persons with Disabilities.] Such  
162 mechanisms shall include, but not be limited to, the development and  
163 implementation of a mail-in and on-line application systems. In  
164 addition, the Commissioner of Social Services shall develop  
165 appropriate outreach materials and in collaboration with the  
166 Departments of Public Health, Children and Families, Mental Health  
167 and Addiction Services, Mental Retardation, Education, Revenue  
168 Services and Motor Vehicles, the Labor Department and the Office of  
169 Protection and Advocacy for Persons with Disabilities and, as  
170 appropriate, disseminate such outreach materials. All outreach  
171 materials shall be approved by the commissioner pursuant to Subtitle J  
172 of Public Law 105-33.

173 [(b) The commissioner shall include in such outreach efforts  
174 information on the Medicaid program for the purpose of maximizing  
175 enrollment of eligible children and the use of federal funds.]

176 [(c)] (b) The commissioner shall, within available appropriations,  
177 contract with severe need schools and community-based organizations  
178 for purposes of public education, outreach and recruitment of eligible  
179 children and adults, including the distribution of applications and  
180 information regarding enrollment in the HUSKY Plan, Part A and Part  
181 B. In awarding such contracts, the commissioner shall consider the  
182 marketing, outreach and recruitment efforts of organizations. For the  
183 purposes of this subsection, (1) "community-based organizations" shall  
184 include, but not be limited to, day care centers, schools, school-based  
185 health clinics, community-based diagnostic and treatment centers and  
186 hospitals, and (2) "severe need school" means a school in which forty

187 per cent or more of the lunches served are served to students who are  
188 eligible for free or reduced price lunches.

189 [(d) All outreach materials shall be approved by the commissioner  
190 pursuant to Subtitle J of Public Law 105-33.]

191 [(e)] (c) Not later than January 1, [1999] 2008, and annually  
192 thereafter, the commissioner shall [submit a] report, in accordance  
193 with section 11-4a, to the Governor and the joint standing committees  
194 of the General Assembly having cognizance of matters relating to  
195 human services, public health and appropriations and the budgets of  
196 state agencies on the implementation of and the results of the  
197 [community-based outreach program] outreach efforts specified in  
198 subsections (a) [to (c), inclusive,] and (b) of this section.

199 Sec. 3. Section 17b-297b of the general statutes is repealed and the  
200 following is substituted in lieu thereof (*Effective July 1, 2007*):

201 (a) Each local or regional board of education or similar body  
202 governing a nonpublic school or schools shall, at the beginning of each  
203 school year, provide to the parent or guardian of any pupil attending  
204 such school outreach materials concerning eligibility for health  
205 insurance coverage under the HUSKY Plan, Part A or Part B. Such  
206 outreach materials shall be developed by the Department of Social  
207 Services in accordance with the provisions of sections 17b-297, as  
208 amended by this act, and disseminated by the department to schools.

209 [(a)] (b) To the extent permitted by federal law, the Commissioners  
210 of Social Services and Education shall jointly establish procedures for  
211 the sharing of information contained in applications for free and  
212 reduced price meals under the National School Lunch Program for the  
213 purpose of determining whether children participating in said  
214 program are eligible for coverage under the HUSKY Plan, Part A and  
215 Part B. The Commissioner of Social Services shall take all actions  
216 necessary to ensure that children identified as eligible for the HUSKY  
217 Plan are able to enroll in said plan.

218 [(b)] (c) The Commissioner of Education shall establish procedures  
219 whereby an individual may apply for the HUSKY Plan, Part A or Part  
220 B, at the same time such individual applies for the National School  
221 Lunch Program.

222 Sec. 4. (NEW) (*Effective July 1, 2007*) (a) The Department of Social  
223 Services, in consultation with the Department of Public Health, shall  
224 establish a joint program between public and private entities for the  
225 establishment and implementation of a multiyear, state-wide public  
226 information campaign for the purpose of promoting enrollment in the  
227 HUSKY Plan, Parts A and B of all persons who may be eligible for such  
228 health insurance benefits.

229 (b) Notwithstanding the provisions of sections 4-212 to 4-219,  
230 inclusive, of the general statutes the Department of Social Services, in  
231 consultation with the Department of Public Health, shall solicit bids  
232 from private organizations for the design and operation of said media  
233 campaign. Such bids shall be solicited by sending notice to prospective  
234 organizations and by posting notice on public bulletin boards within  
235 said departments. Each bid shall be opened publicly at the time stated  
236 in the notice soliciting such bid. Acceptance of a bid by said  
237 departments shall be based on standard specifications adopted by said  
238 departments. The Department of Social Services may accept gifts,  
239 donations, bequests, grants or funds from public or private agencies  
240 for any or all of the purposes of this section.

241 (c) On January 1, 2008, and annually thereafter, the Commissioner  
242 of Social Services shall report, in accordance with section 11-4a of the  
243 general statutes, to the joint standing committees of the General  
244 Assembly having cognizance of matters relating to human services,  
245 public health and appropriations and the budgets of state agencies on  
246 the status of the program established pursuant to this section.

247 Sec. 5. Section 17b-289 of the general statutes is repealed and the  
248 following is substituted in lieu thereof (*Effective July 1, 2007*):

249 (a) Sections 17b-289 to 17b-303, inclusive, and section 16 of public

250 act 97-1 of the October 29 special session\* shall be known as the  
251 "HUSKY and HUSKY Plus Act".

252 (b) Children, caretaker relatives and pregnant women receiving  
253 assistance under section 17b-261 or 17b-277 shall be participants in the  
254 HUSKY Plan, Part A and children receiving assistance under sections  
255 17b-289 to 17b-303, inclusive, and section 16 of public act 97-1 of the  
256 October 29 special session\* shall be participants in the HUSKY Plan,  
257 Part B. For purposes of marketing and outreach and enrollment of  
258 persons eligible for assistance, both parts shall be known as the  
259 HUSKY Plan.

260 Sec. 6. Section 17b-292 of the general statutes is repealed and the  
261 following is substituted in lieu thereof (*Effective July 1, 2007*):

262 (a) A child who resides in a household with a family income which  
263 exceeds one hundred eighty-five per cent of the federal poverty level  
264 and does not exceed three hundred per cent of the federal poverty  
265 level may be eligible for subsidized benefits under the HUSKY Plan,  
266 Part B.

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

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

273 (d) A child who has been determined to be eligible for benefits  
274 under either the HUSKY Plan, Part A or Part B shall remain eligible for  
275 such plan for a period of twelve months from such child's  
276 determination of eligibility unless the child attains the age of nineteen  
277 or is no longer a resident of the state. An adult who has been  
278 determined to be eligible for benefits under the HUSKY Plan, Part A  
279 shall remain eligible for such plan for a period of twelve months from  
280 such adult's determination of eligibility unless the adult is no longer a

281 resident of the state. During the twelve-month period following the  
282 date that an adult or child is determined eligible for the HUSKY Plan,  
283 Part A or Part B, the adult or family of such child shall comply with  
284 federal requirements concerning the reporting of information to the  
285 department, including, but not limited to, change of address  
286 information.

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

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

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

308 [(g)] (h) The commissioner shall enter into a contract with an entity  
309 to be a single point of entry servicer for applicants and enrollees under  
310 the HUSKY Plan, Part A and Part B. [The servicer] The commissioner,  
311 in consultation with the servicer, shall establish a centralized unit that  
312 is responsible for processing all applications for assistance under the

313 HUSKY Plan, Part A and Part B. The department, through its contract  
314 with the servicer, shall ensure that a child who is determined to be  
315 eligible for benefits under the HUSKY Plan, Part A, or the HUSKY  
316 Plan, Part B has uninterrupted health insurance coverage for as long as  
317 the parent or guardian elects to enroll or re-enroll such child in the  
318 HUSKY Plan, Part A or Part B. The commissioner, in consultation with  
319 the servicer, and in accordance with the provisions of section 17b-297,  
320 as amended by this act, shall jointly market both Part A and Part B  
321 together as the HUSKY Plan [. Such servicer] and shall develop and  
322 implement public information and outreach activities with community  
323 programs. Such servicer shall electronically transmit data with respect  
324 to enrollment and disenrollment in the HUSKY Plan, Part A and Part B  
325 to the commissioner.

326 [(h)] (i) Upon the expiration of any contractual provisions entered  
327 into pursuant to subsection [(g)] (h) of this section, the commissioner  
328 shall develop a new contract for single point of entry services and  
329 managed care enrollment brokerage services. The commissioner may  
330 enter into one or more contractual arrangements for such services for a  
331 contract period not to exceed seven years. Such contracts shall include  
332 performance measures, including, but not limited to, specified time  
333 limits for the processing of applications, parameters setting forth the  
334 requirements for a completed and reviewable application and the  
335 percentage of applications forwarded to the department in a complete  
336 and timely fashion. Such contracts shall also include a process for  
337 identifying and correcting noncompliance with established  
338 performance measures, including sanctions applicable for instances of  
339 continued noncompliance with performance measures.

340 [(i)] (j) The single point of entry servicer shall send [an application]  
341 all applications and supporting documents to the commissioner for  
342 determination of eligibility. [of a child who resides in a household with  
343 a family income of one hundred eighty-five per cent or less of the  
344 federal poverty level.] The servicer shall enroll eligible beneficiaries in  
345 the applicant's choice of managed care plan. Upon enrollment in a  
346 managed care plan, an eligible HUSKY Plan Part A or Part B

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

352 [(j)] (k) Not [more than twelve] later than ten months after the  
353 determination of eligibility for benefits under the HUSKY Plan, Part A  
354 and Part B and annually thereafter, the commissioner or the servicer,  
355 as the case may be, shall determine if the child continues to be eligible  
356 for the plan. The commissioner or the servicer shall mail or, upon  
357 request of a participant, electronically transmit an application form to  
358 each participant in the plan for the purposes of obtaining information  
359 to make a determination on continued eligibility beyond the twelve  
360 months of initial eligibility. To the extent permitted by federal law, in  
361 determining eligibility for benefits under the HUSKY Plan, Part A or  
362 Part B with respect to family income, the commissioner or the servicer  
363 shall rely upon information provided in such form by the participant  
364 unless the commissioner or the servicer has reason to believe that such  
365 information is inaccurate or incomplete. The Department of Social  
366 Services shall annually review a random sample of cases to confirm  
367 that, based on the statistical sample, relying on such information is not  
368 resulting in ineligible clients receiving benefits under HUSKY Plan  
369 Part A or Part B. The determination of eligibility shall be coordinated  
370 with health plan open enrollment periods.

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

374 [(l)] (m) The commissioner shall adopt regulations, in accordance  
375 with chapter 54, to establish residency requirements and income  
376 eligibility for participation in the HUSKY Plan, Part B and procedures  
377 for a simplified mail-in application process. Notwithstanding the  
378 provisions of section 17b-257b, such regulations shall provide that any  
379 child adopted from another country by an individual who is a citizen

380 of the United States and a resident of this state shall be eligible for  
381 benefits under the HUSKY Plan, Part B upon arrival in this state.

382 Sec. 7. Section 17b-192 of the general statutes is repealed and the  
383 following is substituted in lieu thereof (*Effective July 1, 2007*):

384 (a) The Commissioner of Social Services shall implement a state  
385 medical assistance component of the state-administered general  
386 assistance program for persons with income that does not exceed one  
387 hundred per cent of the federal poverty level and who are ineligible  
388 for Medicaid. [Not later than October 1, 2003, each] Earned monthly  
389 gross income of up to one hundred fifty dollars shall be disregarded.  
390 Unearned income shall not be disregarded. No person who has family  
391 assets exceeding one thousand dollars shall be eligible. No person shall  
392 be eligible for assistance under this section if such person made,  
393 during the three months prior to the month of application, an  
394 assignment or transfer or other disposition of property for less than  
395 fair market value. The number of months of ineligibility due to such  
396 disposition shall be determined by dividing the fair market value of  
397 such property, less any consideration received in exchange for its  
398 disposition, by five hundred dollars. Such period of ineligibility shall  
399 commence in the month in which the person is otherwise eligible for  
400 benefits. Any assignment, transfer or other disposition of property, on  
401 the part of the transferor, shall be presumed to have been made for the  
402 purpose of establishing eligibility for benefits or services unless such  
403 person provides convincing evidence to establish that the transaction  
404 was exclusively for some other purpose.

405 (b) Each person eligible for state-administered general assistance  
406 shall be entitled to receive medical care through a federally qualified  
407 health center or other primary care provider as determined by the  
408 commissioner. The Commissioner of Social Services shall determine  
409 appropriate service areas and shall, in the commissioner's discretion,  
410 contract with community health centers, other similar clinics, and  
411 other primary care providers, if necessary, to assure access to primary  
412 care services for recipients who live farther than a reasonable distance

413 from a federally qualified health center. The commissioner shall assign  
414 and enroll eligible persons in federally qualified health centers and  
415 with any other providers contracted for the program because of access  
416 needs. [Not later than October 1, 2003, each] Each person eligible for  
417 state-administered general assistance shall be entitled to receive  
418 hospital services. Medical services under the program shall be limited  
419 to the services provided by a federally qualified health center, hospital,  
420 or other provider contracted for the program at the commissioner's  
421 discretion because of access needs. The commissioner shall ensure that  
422 ancillary services and specialty services are provided by a federally  
423 qualified health center, hospital, or other providers contracted for the  
424 program at the commissioner's discretion. Ancillary services include,  
425 but are not limited to, radiology, laboratory, and other diagnostic  
426 services not available from a recipient's assigned primary-care  
427 provider, and durable medical equipment. Specialty services are  
428 services provided by a physician with a specialty that are not included  
429 in ancillary services. In no event shall ancillary or specialty services  
430 provided under the program exceed such services provided under the  
431 state-administered general assistance program on July 1, 2003.  
432 [Eligibility criteria concerning income shall be the same as the  
433 medically needy component of the Medicaid program, except that  
434 earned monthly gross income of up to one hundred fifty dollars shall  
435 be disregarded. Unearned income shall not be disregarded. No person  
436 who has family assets exceeding one thousand dollars shall be eligible.  
437 No person eligible for Medicaid shall be eligible to receive medical  
438 care through the state-administered general assistance program. No  
439 person shall be eligible for assistance under this section if such person  
440 made, during the three months prior to the month of application, an  
441 assignment or transfer or other disposition of property for less than  
442 fair market value. The number of months of ineligibility due to such  
443 disposition shall be determined by dividing the fair market value of  
444 such property, less any consideration received in exchange for its  
445 disposition, by five hundred dollars. Such period of ineligibility shall  
446 commence in the month in which the person is otherwise eligible for  
447 benefits. Any assignment, transfer or other disposition of property, on

448 the part of the transferor, shall be presumed to have been made for the  
449 purpose of establishing eligibility for benefits or services unless such  
450 person provides convincing evidence to establish that the transaction  
451 was exclusively for some other purpose.]

452 [(b) Recipients covered by a general assistance program operated by  
453 a town shall be assigned and enrolled in federally qualified health  
454 centers and with any other providers in the same manner as recipients  
455 of medical assistance under the state-administered general assistance  
456 program pursuant to subsection (a) of this section.]

457 (c) [On and after October 1, 2003, pharmacy] Pharmacy services  
458 shall be provided to recipients of state-administered general assistance  
459 through the federally qualified health center to which they are  
460 assigned or through a pharmacy with which the health center  
461 contracts. [Prior to said date, pharmacy services shall be provided as  
462 provided under the Medicaid program.] Recipients who are assigned  
463 to a community health center or similar clinic or primary care provider  
464 other than a federally qualified health center or to a federally qualified  
465 health center that does not have a contract for pharmacy services shall  
466 receive pharmacy services at pharmacies designated by the  
467 commissioner. The Commissioner of Social Services or the managed  
468 care organization or other entity performing administrative functions  
469 for the program as permitted in subsection (d) of this section, shall  
470 require prior authorization for coverage of drugs for the treatment of  
471 erectile dysfunction. The commissioner or the managed care  
472 organization or other entity performing administrative functions for  
473 the program may limit or exclude coverage for drugs for the treatment  
474 of erectile dysfunction for persons who have been convicted of a sexual  
475 offense who are required to register with the Commissioner of Public  
476 Safety pursuant to chapter 969.

477 (d) The Commissioner of Social Services shall contract with  
478 federally qualified health centers or other primary care providers as  
479 necessary to provide medical services to eligible state-administered  
480 general assistance recipients pursuant to this section. The

481 commissioner shall, within available appropriations, make payments  
482 to such centers based on their pro rata share of the cost of services  
483 provided or the number of clients served, or both. The Commissioner  
484 of Social Services shall, within available appropriations, make  
485 payments to other providers based on a methodology determined by  
486 the commissioner. The Commissioner of Social Services may reimburse  
487 for extraordinary medical services, provided such services are  
488 documented to the satisfaction of the commissioner. For purposes of  
489 this section, the commissioner may contract with a managed care  
490 organization or other entity to perform administrative functions,  
491 including a grievance process for recipients to access review of a denial  
492 of coverage for a specific medical service, and to operate the program  
493 in whole or in part. Provisions of a contract for medical services  
494 entered into by the commissioner pursuant to this section shall  
495 supersede any inconsistent provision in the regulations of Connecticut  
496 state agencies. A recipient who has exhausted the grievance process  
497 established through such contract and wishes to seek further review of  
498 the denial of coverage for a specific medical service may request a  
499 hearing in accordance with the provisions of section 17b-60.

500 (e) Each federally qualified health center participating in the  
501 program shall [, within thirty days of August 20, 2003,] enroll in the  
502 federal Office of Pharmacy Affairs Section 340B drug discount  
503 program established pursuant to 42 USC 256b to provide pharmacy  
504 services to recipients at Federal Supply Schedule costs. Each such  
505 health center may establish an on-site pharmacy or contract with a  
506 commercial pharmacy to provide such pharmacy services.

507 (f) The Commissioner of Social Services shall, within available  
508 appropriations, make payments to hospitals for inpatient services  
509 based on their pro rata share of the cost of services provided or the  
510 number of clients served, or both. The Commissioner of Social Services  
511 shall, within available appropriations, make payments for any  
512 ancillary or specialty services provided to state-administered general  
513 assistance recipients under this section based on a methodology  
514 determined by the commissioner.

515 (g) On or before [March 1, 2004,] January 1, 2008, the Commissioner  
516 of Social Services shall seek a waiver of federal law [under the Health  
517 Insurance Flexibility and Accountability demonstration initiative] for  
518 the purpose of extending health insurance coverage under Medicaid to  
519 persons qualifying for medical assistance under the state-administered  
520 general assistance program. The provisions of section 17b-8 shall apply  
521 to this section.

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

529 Sec. 8. Subsection (a) of section 17b-277 of the general statutes is  
530 repealed and the following is substituted in lieu thereof (*Effective July*  
531 *1, 2007*):

532 (a) The Commissioner of Social Services shall provide, in accordance  
533 with federal law and regulations, medical assistance under the  
534 Medicaid program to needy pregnant women [and children up to one  
535 year of age] whose families have an income [up to one hundred eighty-  
536 five] not exceeding three hundred per cent of the federal poverty level.

537 Sec. 9. (NEW) (*Effective July 1, 2007*) On or before January 1, 2008,  
538 the Commissioner of Social Services, shall seek a waiver under federal  
539 law under the Health Insurance Flexibility and Accountability  
540 demonstration proposal to provide health insurance coverage to  
541 pregnant women, who do not otherwise have creditable coverage, as  
542 defined in 42 USC 300gg(c), and with incomes above one hundred  
543 eighty-five per cent of the federal poverty level but not in excess of  
544 three hundred per cent of the federal poverty level. The waiver  
545 submitted by the commissioner shall specify that funding for such  
546 health insurance coverage shall be provided through a reallocation of

547 unspent state children's health insurance plan funds.

548 Sec. 10. Section 17b-282b of the general statutes is repealed and the  
549 following is substituted in lieu thereof (*Effective July 1, 2007*):

550 [(a) Not later than July 1, 2004, and prior to the implementation of a  
551 state-wide dental plan that provides for the administration of the  
552 dental services portion of the department's medical assistance, the  
553 Commissioner of Social Services shall amend the federal waiver  
554 approved pursuant to Section 1915(b) of the Social Security Act. Such  
555 waiver amendment shall be submitted to the joint standing committees  
556 of the General Assembly having cognizance of matters relating to  
557 human services and appropriations and the budgets of state agencies  
558 in accordance with the provisions of section 17b-8.

559 (b) Prior to the implementation of a state-wide dental plan that  
560 provides for the administration of the dental services portion of the  
561 department's medical assistance program, the Commissioner of Social  
562 Services shall review eliminating prior authorization requirements for  
563 basic and routine dental services. In the event the commissioner adopts  
564 regulations to eliminate such prior authorization requirements, the  
565 commissioner may implement policies and procedures for the  
566 purposes of this subsection while in the process of adopting such  
567 regulations, provided the commissioner prints notice of intention to  
568 adopt the regulations in the Connecticut Law Journal not later than  
569 twenty days after implementing the policies and procedures.]

570 (a) The Commissioner of Social Services shall establish a fee  
571 schedule for dental services provided to children under nineteen years  
572 of age who are eligible for medical assistance under section 17b-261, as  
573 amended by this act, or section 17b-292, as amended by this act. The  
574 schedule shall provide for a fee for each dental service provided on or  
575 after July 1, 2007, except for an orthodontic service, that is equal to the  
576 seventieth percentile of normal and customary private provider fees,  
577 as defined by the National Dental Advisory Service Comprehensive  
578 Fee Report. The schedule shall provide for a fee for each orthodontic

579 service, which may be less than the seventieth percentile of normal and  
580 customary private provider fees, as defined by the National Dental  
581 Advisory Service Comprehensive Fee Report.

582 (b) The Commissioner of Social Services shall evaluate whether the  
583 fee schedule established pursuant to subsection (a) of this section, as  
584 amended, results in improved access to oral health care for medical  
585 assistance recipients under nineteen years of age, as measured by the  
586 increase in the number of providers registered to provide dental  
587 services under the medical assistance programs described in section  
588 17b-261, as amended by this act, and section 17b-292, as amended by  
589 this act. Not later than December 31, 2008, the commissioner shall  
590 submit the evaluation and any recommendations that the  
591 commissioner may have with respect to improving access to oral  
592 health care for medical assistance recipients to the joint standing  
593 committees of the General Assembly having cognizance of matters  
594 relating to human services, public health and appropriation and the  
595 budgets of state agencies, in accordance with the provisions of section  
596 11-4a.

597 Sec. 11. (NEW) (*Effective July 1, 2007*) The Commissioner of Social  
598 Services shall reimburse providers of medical services under the  
599 medical assistance program, operated in accordance with section 17b-  
600 261 of the general statutes, as amended by this act, at a rate that is  
601 equal to the rate paid for the provision of such services under the  
602 Medicare program.

603 Sec. 12. Section 17b-28e of the general statutes is repealed and the  
604 following is substituted in lieu thereof (*Effective July 1, 2007*):

605 (a) Not later than September 30, 2002, the Commissioner of Social  
606 Services shall submit an amendment to the Medicaid state plan to  
607 implement the provisions of public act 02-1 of the May 9 special  
608 session\* concerning optional services under the Medicaid program.  
609 Said state plan amendment shall supersede any regulations of  
610 Connecticut state agencies concerning such optional services.

611        (b) The Commissioner of Social Services shall amend the Medicaid  
 612 state plan to include foreign language interpreter services provided to  
 613 any beneficiary with limited English proficiency as a covered service  
 614 under the Medicaid program.

615        Sec. 13. Section 17b-261c of the general statutes is repealed. (*Effective*  
 616 *July 1, 2007*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2007</i>	17b-261
Sec. 2	<i>July 1, 2007</i>	17b-297
Sec. 3	<i>July 1, 2007</i>	17b-297b
Sec. 4	<i>July 1, 2007</i>	New section
Sec. 5	<i>July 1, 2007</i>	17b-289
Sec. 6	<i>July 1, 2007</i>	17b-292
Sec. 7	<i>July 1, 2007</i>	17b-192
Sec. 8	<i>July 1, 2007</i>	17b-277(a)
Sec. 9	<i>July 1, 2007</i>	New section
Sec. 10	<i>July 1, 2007</i>	17b-282b
Sec. 11	<i>July 1, 2007</i>	New section
Sec. 12	<i>July 1, 2007</i>	17b-28e
Sec. 13	<i>July 1, 2007</i>	Repealer section

**Statement of Legislative Commissioners:**

Section 10 of the committee bill concerning an amendment to the Medicaid state plan with respect to eligibility determinations for the aged, blind and disabled was deleted for clarity and to maintain consistency with the purposes set forth in subsection (j) of section 1 that also requires the commissioner to file an amendment to the Medicaid state plan for the same purpose as was contained in the former section 10.

**HS**            *Joint Favorable Subst.*