



General Assembly

February Session, 2010

Governor's Bill No. 32

LCO No. 506

*00506 _____ *

Referred to Committee on Human Services

Introduced by:

SEN. MCKINNEY, 28th Dist.

REP. CAFERO, 142nd Dist.

***AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET
RECOMMENDATIONS CONCERNING SOCIAL SERVICES.***

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

1 Section 1. Section 17a-317 of the 2010 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective July 1, 2010*):

4 (a) Effective July 1, 2010, there shall be established a Department on
5 Aging which shall be under the direction and supervision of the
6 Commissioner on Aging who shall be appointed by the Governor in
7 accordance with the provisions of sections 4-5 to 4-8, inclusive, with
8 the powers and duties prescribed in said sections. The commissioner
9 shall be knowledgeable and experienced with respect to the conditions
10 and needs of elderly persons and shall serve on a full-time basis.

11 (b) The Commissioner on Aging shall administer all laws under the
12 jurisdiction of the Department on Aging and shall employ the most
13 efficient and practical means for the provision of care and protection of

14 elderly persons. The commissioner shall have the power and duty to
15 do the following: (1) Administer, coordinate and direct the operation
16 of the department; (2) adopt and enforce regulations, in accordance
17 with chapter 54, as necessary to implement the purposes of the
18 department as established by statute; (3) establish rules for the internal
19 operation and administration of the department; (4) establish and
20 develop programs and administer services to achieve the purposes of
21 the department; (5) contract for facilities, services and programs to
22 implement the purposes of the department; (6) act as advocate for
23 necessary additional comprehensive and coordinated programs for
24 elderly persons; (7) assist and advise all appropriate state, federal, local
25 and area planning agencies for elderly persons in the performance of
26 their functions and duties pursuant to federal law and regulation; (8)
27 plan services and programs for elderly persons; (9) coordinate
28 outreach activities by public and private agencies serving elderly
29 persons; and (10) consult and cooperate with area and private
30 planning agencies.

31 (c) The functions, powers, duties and personnel of the Division of
32 [Elderly Services] Aging Services of the Department of Social Services,
33 or any subsequent division or portion of a division with similar
34 functions, powers, personnel and duties, shall be transferred to the
35 Department on Aging pursuant to the provisions of sections 4-38d, 4-
36 38e and 4-39.

37 (d) The Department of Social Services shall administer programs
38 under the jurisdiction of the Department on Aging until the
39 Commissioner on Aging is appointed and administrative staff are
40 hired.

41 (e) The Governor may, with the approval of the Finance Advisory
42 Committee, transfer funds between the Department of Social Services
43 and the Department on Aging, pursuant to subsection (b) of section 4-
44 87, during the fiscal year ending June 30, 2011.

45 [(d)] (f) Any order or regulation of the Department of Social Services

46 or the Commission on Aging that is in force on [July 1, 2008] July 1,
47 2010, shall continue in force and effect as an order or regulation until
48 amended, repealed or superseded pursuant to law.

49 Sec. 2. Section 17b-421 of the general statutes is repealed and the
50 following is substituted in lieu thereof (*Effective July 1, 2010*):

51 The state shall be divided into five elderly planning and service
52 areas, in accordance with federal law and regulations, each having an
53 area agency on aging to carry out the mandates of the federal Older
54 Americans Act of 1965, as amended. The area agencies shall (1)
55 represent elderly persons within their geographic areas, (2) develop an
56 area plan for approval by the Department [of Social Services] on Aging
57 and upon such approval administer the plan, (3) coordinate and assist
58 local public and nonprofit, private agencies in the development of
59 programs, (4) receive and distribute federal and state funds for such
60 purposes, in accordance with applicable law, (5) carry out any
61 additional duties and functions required by federal law and
62 regulations.

63 Sec. 3. Section 17b-422 of the general statutes is repealed and the
64 following is substituted in lieu thereof (*Effective July 1, 2010*):

65 (a) The Department [of Social Services] on Aging shall equitably
66 allocate, in accordance with federal law, federal funds received under
67 Title IIIB and IIIC of the Older Americans Act to the five area agencies
68 on aging established pursuant to section 17b-421, as amended by this
69 act. The department, before seeking federal approval to spend any
70 amount above that allotted for administrative expenses under said act,
71 shall inform the joint standing committee of the General Assembly
72 having cognizance of matters relating to human services that it is
73 seeking such approval.

74 (b) Sixty per cent of the state funds appropriated to the five area
75 agencies on aging for elderly nutrition and social services shall be
76 allocated in the same proportion as allocations made pursuant to

77 subsection (a) of this section. Forty per cent of all state funds
78 appropriated to the five area agencies on aging for elderly nutrition
79 and social services used for purposes other than the required
80 nonfederal matching funds shall be allocated at the discretion of the
81 Commissioner [of Social Services] on Aging, in consultation with the
82 five area agencies on aging, based on their need for such funds. Any
83 state funds appropriated to the five area agencies on aging for
84 administrative expenses shall be allocated equally.

85 (c) The Department [of Social Services] on Aging, in consultation
86 with the five area agencies on aging, shall review the method of
87 allocation set forth in subsection (a) of this section and shall report any
88 findings or recommendations to the joint standing committees of the
89 General Assembly having cognizance of matters relating to
90 appropriations and the budgets of state agencies and human services.

91 (d) An area agency may request a person participating in the elderly
92 nutrition program to pay a voluntary fee for meals furnished, except
93 that no eligible person shall be denied a meal due to an inability to pay
94 such fee.

95 Sec. 4. Section 17b-424 of the general statutes is repealed and the
96 following is substituted in lieu thereof (*Effective July 1, 2010*):

97 The Commissioner [of Social Services] on Aging shall establish an
98 adult foster care program which shall provide room, board and
99 personal care services in a home or substantially equivalent
100 environment to elderly persons who volunteer and may otherwise be
101 placed in a nursing home or who are inappropriately institutionalized.
102 The commissioner shall adopt regulations, in accordance with the
103 provisions of chapter 54, to administer this program.

104 Sec. 5. Section 17b-425 of the general statutes is repealed and the
105 following is substituted in lieu thereof (*Effective July 1, 2010*):

106 The Department [of Social Services] on Aging may make a grant to

107 any city, town or borough or public or private agency, organization or
108 institution for the following purposes: (a) For community planning
109 and coordination of programs carrying out the purposes of the Older
110 Americans Act of 1965, as amended; (b) for demonstration programs or
111 activities particularly valuable in carrying out such purposes; (c) for
112 training of special personnel needed to carry out such programs and
113 activities; (d) for establishment of new or expansion of existing
114 programs to carry out such purposes, including establishment of new
115 or expansion of existing centers of service for elderly persons,
116 providing recreational, cultural and other leisure time activities, and
117 informational, transportation, referral and preretirement and
118 postretirement counseling services for elderly persons and assisting
119 such persons in providing volunteer community or civic services,
120 except that no costs of construction, other than for minor alterations
121 and repairs, shall be included in such establishment or expansion; (e)
122 for programs to develop or demonstrate approaches, methods and
123 techniques for achieving or improving coordination of community
124 services for elderly or aging persons and such other programs and
125 services as may be allowed under Title III of the Older Americans Act
126 of 1965, as amended, or to evaluate these approaches, techniques and
127 methods, as well as others which may assist elderly or aging persons
128 to enjoy wholesome and meaningful living and to continue to
129 contribute to the strength and welfare of the state and nation.

130 Sec. 6. Section 17b-426 of the general statutes is repealed and the
131 following is substituted in lieu thereof (*Effective July 1, 2010*):

132 The Department [of Social Services] on Aging may use moneys
133 appropriated for the purposes of section 17b-425, as amended by this
134 act, for the expenses of administering the grant program under said
135 section, provided the total of such moneys so used shall not exceed
136 five per cent of the moneys so appropriated.

137 Sec. 7. Section 17b-427 of the general statutes is repealed and the
138 following is substituted in lieu thereof (*Effective July 1, 2010*):

139 (a) As used in this section:

140 (1) "CHOICES" means Connecticut's programs for health insurance
141 assistance, outreach, information and referral, counseling and
142 eligibility screening;

143 (2) "CHOICES health insurance assistance program" means the
144 federally recognized state health insurance assistance program funded
145 pursuant to P.L. 101-508 and administered by the Department [of
146 Social Services] on Aging, in conjunction with the area agencies on
147 aging and the Center for Medicare Advocacy, that provides free
148 information and assistance related to health insurance issues and
149 concerns of older persons and other Medicare beneficiaries in
150 Connecticut; and

151 (3) "Medicare organization" means any corporate entity or other
152 organization or group that contracts with the federal Centers for
153 Medicare and Medicaid Services to provide health care services to
154 Medicare beneficiaries in this state as an alternative to the traditional
155 Medicare fee-for-service plan.

156 (b) The Department [of Social Services] on Aging shall administer
157 the CHOICES health insurance assistance program, which shall be a
158 comprehensive Medicare advocacy program that provides assistance
159 to Connecticut residents who are Medicare beneficiaries. The program
160 shall: (1) Maintain a toll-free telephone number to provide advice and
161 information on Medicare benefits, including prescription drug benefits
162 available through the Medicare Part D program, the Medicare appeals
163 process, health insurance matters applicable to Medicare beneficiaries
164 and long-term care options available in the state at least five days per
165 week during normal business hours; (2) provide information, advice
166 and representation, where appropriate, concerning the Medicare
167 appeals process, by a qualified attorney or paralegal at least five days
168 per week during normal business hours; (3) prepare and distribute
169 written materials to Medicare beneficiaries, their families, senior
170 citizens and organizations regarding Medicare benefits, including

171 prescription drug benefits available through the Medicare Part D
172 program and long-term care options available in the state; (4) develop
173 and distribute a Connecticut Medicare consumers guide, after
174 consultation with the Insurance Commissioner and other organizations
175 involved in servicing, representing or advocating for Medicare
176 beneficiaries, which shall be available to any individual, upon request,
177 and shall include: (A) Information permitting beneficiaries to compare
178 their options for delivery of Medicare services; (B) information
179 concerning the Medicare plans available to beneficiaries, including the
180 traditional Medicare fee-for-service plan, Medicare Part D plans and
181 the benefits and services available through each plan; (C) information
182 concerning the procedure to appeal a denial of care and the procedure
183 to request an expedited appeal of a denial of care; (D) information
184 concerning private insurance policies and federal and state-funded
185 programs that are available to supplement Medicare coverage for
186 beneficiaries; (E) a worksheet for beneficiaries to use to evaluate the
187 various plans, including Medicare Part D programs; and (F) any other
188 information the program deems relevant to beneficiaries; (5)
189 collaborate with other state agencies and entities in the development of
190 consumer-oriented websites that provide information on Medicare
191 plans, including Medicare Part D plans, and long-term care options
192 that are available in the state; and (6) include any functions the
193 department deems necessary to conform to federal grant requirements.

194 (c) The Insurance Commissioner, in cooperation with, or on behalf
195 of, the Commissioner [of Social Services] on Aging, may require each
196 Medicare organization to: (1) Annually submit to the commissioner
197 any data, reports or information relevant to plan beneficiaries; and (2)
198 at any other times at which changes occur, submit information to the
199 commissioner concerning current benefits, services or costs to
200 beneficiaries. Such information may include information required
201 under section 38a-478c.

202 (d) Each Medicare organization that fails to file the annual data,
203 reports or information requested pursuant to subsection (c) of this

204 section shall pay a late fee of one hundred dollars per day for each day
205 from the due date of such data, reports or information to the date of
206 filing. Each Medicare organization that files incomplete annual data,
207 reports or information shall be so informed by the Insurance
208 Commissioner, shall be given a date by which to remedy such
209 incomplete filing and shall pay said late fee commencing from the new
210 due date.

211 (e) Not later than June 1, 2001, and annually thereafter, the
212 Insurance Commissioner, in conjunction with the Healthcare
213 Advocate, shall submit to the Governor and to the joint standing
214 committees of the General Assembly having cognizance of matters
215 relating to human services and insurance and to the select committee
216 of the General Assembly having cognizance of matters relating to
217 aging, a list of those Medicare organizations that have failed to file any
218 data, reports or information requested pursuant to subsection (c) of
219 this section.

220 (f) All hospitals, as defined in section 19a-490, which treat persons
221 covered by Medicare Part A shall: (1) Notify incoming patients covered
222 by Medicare of the availability of the services established pursuant to
223 subsection (b) of this section, (2) post or cause to be posted in a
224 conspicuous place therein the toll-free number established pursuant to
225 subsection (b) of this section, and (3) provide each Medicare patient
226 with the toll-free number and information on how to access the
227 CHOICES program.

228 Sec. 8. Section 17b-429 of the general statutes is repealed and the
229 following is substituted in lieu thereof (*Effective July 1, 2010*):

230 The Commissioner of Social Services, in coordination with the
231 Commissioner on Aging, shall, within available appropriations, make
232 information available to senior citizens and disabled persons
233 concerning any pharmaceutical company's drug program for indigent
234 persons by utilizing the ConnPACE program, the CHOICES health
235 insurance assistance program, as defined in section 17b-427, as

236 amended by this act, and Infoline of Connecticut to deliver such
237 information.

238 Sec. 9. Section 17b-349e of the 2010 supplement to the general
239 statutes is repealed and the following is substituted in lieu thereof
240 (*Effective July 1, 2010*):

241 (a) As used in this section:

242 (1) "Respite care services" means support services which provide
243 short-term relief from the demands of ongoing care for an individual
244 with Alzheimer's disease.

245 (2) "Caretaker" means a person who has the responsibility for the
246 care of an individual with Alzheimer's disease or has assumed the
247 responsibility for such individual voluntarily, by contract or by order
248 of a court of competent jurisdiction.

249 (3) "Copayment" means a payment made by or on behalf of an
250 individual with Alzheimer's disease for respite care services.

251 (4) "Individual with Alzheimer's disease" means an individual with
252 Alzheimer's disease or related disorders.

253 (b) The Commissioner [of Social Services] on Aging shall operate a
254 program, within available appropriations, to provide respite care
255 services for caretakers of individuals with Alzheimer's disease,
256 provided such individuals with Alzheimer's disease meet the
257 requirements set forth in subsection (c) of this section. Such respite
258 care services may include, but need not be limited to (1) homemaker
259 services; (2) adult day care; (3) temporary care in a licensed medical
260 facility; (4) home-health care; (5) companion services; or (6) personal
261 care assistant services. Such respite care services may be administered
262 directly by the department, or through contracts for services with
263 providers of such services, or by means of direct subsidy to caretakers
264 of individuals with Alzheimer's disease to purchase such services.

265 (c) (1) No individual with Alzheimer's disease may participate in the
266 program if such individual (A) has an annual income of more than
267 forty-one thousand dollars or liquid assets of more than one hundred
268 nine thousand dollars, or (B) is receiving services under the
269 Connecticut home-care program for the elderly. On July 1, 2009, and
270 annually thereafter, the commissioner shall increase such income and
271 asset eligibility criteria over that of the previous fiscal year to reflect
272 the annual cost of living adjustment in Social Security income, if any.

273 (2) No individual with Alzheimer's disease who participates in the
274 program may receive more than three thousand five hundred dollars
275 for services under the program in any fiscal year or receive more than
276 thirty days of out-of-home respite care services other than adult day
277 care services under the program in any fiscal year, except that the
278 commissioner shall adopt regulations pursuant to subsection (d) of this
279 section to provide up to seven thousand five hundred dollars for
280 services to a participant in the program who demonstrates a need for
281 additional services.

282 (3) The commissioner may require an individual with Alzheimer's
283 disease who participates in the program to pay a copayment for respite
284 care services under the program, except the commissioner may waive
285 such copayment upon demonstration of financial hardship by such
286 individual.

287 (d) The commissioner shall adopt regulations in accordance with the
288 provisions of chapter 54 to implement the provisions of this section.
289 Such regulations shall include, but need not be limited to (1) standards
290 for eligibility for respite care services; (2) the basis for priority in
291 receiving services; (3) qualifications and requirements of providers,
292 which shall include specialized training in Alzheimer's disease,
293 dementia and related disorders; (4) a requirement that providers
294 accredited by the Joint Commission on the Accreditation of Healthcare
295 Organizations, when available, receive preference in contracting for
296 services; (5) provider reimbursement levels; (6) limits on services and

297 cost of services; and (7) a fee schedule for copayments.

298 [(e) The Commissioner of Social Services may allocate any funds
299 appropriated in excess of five hundred thousand dollars for the
300 program among the five area agencies on aging according to need, as
301 determined by said commissioner.]

302 Sec. 10. Subsection (a) of section 17b-792 of the general statutes is
303 repealed and the following is substituted in lieu thereof (*Effective July*
304 *1, 2010*):

305 (a) The Department [of Social Services] on Aging shall be
306 responsible for the administration of programs which provide
307 nutritionally sound diets to needy elderly persons and for the
308 expansion of such programs when possible. Such programs shall be
309 continued in such a manner as to fully utilize congregate feeding and
310 nutrition education of elderly citizens who qualify for such program.

311 Sec. 11. Section 17b-400 of the general statutes is repealed and the
312 following is substituted in lieu thereof (*Effective July 1, 2010*):

313 (a) As used in this chapter:

314 (1) "State agency" means the [Division of Elderly Services of the
315 Department of Social Services] Department on Aging.

316 (2) "Office" means the Office of the Long-Term Care Ombudsman
317 established in this section.

318 (3) "State Ombudsman" means the State Ombudsman established in
319 this section.

320 (4) "Program" means the long-term care ombudsman program
321 established in this section.

322 (5) "Representative" includes a regional ombudsman, a residents'
323 advocate or an employee of the Office of the Long-Term Care
324 Ombudsman who is individually designated by the ombudsman.

325 (6) "Resident" means an older individual who resides in or is a
326 patient in a long-term care facility who is sixty years of age or older.

327 (7) "Long-term care facility" means any skilled nursing facility, as
328 defined in Section 1819(a) of the Social Security Act, (42 USC 1395i-
329 3(a)) any nursing facility, as defined in Section 1919(a) of the Social
330 Security Act, (42 USC 1396r(a)) a board and care facility as defined in
331 Section 102(19) of the federal Older Americans Act, (42 USC 3002(19))
332 and for purposes of ombudsman program coverage, an institution
333 regulated by the state pursuant to Section 1616(e) of the Social Security
334 Act, (42 USC 1382e(e)) and any other adult care home similar to a
335 facility or nursing facility or board and care home.

336 (8) "Commissioner" means the Commissioner [of Social Services] on
337 Aging.

338 [(9) "Director" means the director of the Division of Elderly Services
339 of the Department of Social Services.]

340 [(10)] (9) "Applicant" means an older individual who has applied for
341 admission to a long-term care facility.

342 (b) There is established an independent Office of the Long-Term
343 Care Ombudsman within the Department [of Social Services] on
344 Aging. The Commissioner [of Social Services] on Aging shall appoint a
345 State Ombudsman who shall be selected from among individuals with
346 expertise and experience in the fields of long-term care and advocacy
347 to head the office and the State Ombudsman shall appoint assistant
348 regional ombudsmen. In the event the State Ombudsman or an
349 assistant regional ombudsman is unable to fulfill the duties of the
350 office, the commissioner shall appoint an acting State Ombudsman and
351 the State Ombudsman shall appoint an acting assistant regional
352 ombudsman.

353 (c) Notwithstanding the provisions of subsection (b) of this section,
354 on and after July 1, 1990, the positions of State Ombudsman and

355 regional ombudsmen shall be classified service positions. The State
356 Ombudsman and regional ombudsmen holding said positions on said
357 date shall continue to serve in their positions as if selected through
358 classified service procedures. As vacancies occur in such positions
359 thereafter, such vacancies shall be filled in accordance with classified
360 service procedures.

361 Sec. 12. Section 17b-405 of the general statutes is repealed and the
362 following is substituted in lieu thereof (*Effective July 1, 2010*):

363 The regional ombudsmen shall, in accordance with the policies and
364 procedures established by the Office of the Long-Term Care
365 Ombudsman and the [director] Commissioner on Aging:

366 (1) Provide services to protect the health, safety, welfare and rights
367 of residents;

368 (2) Ensure that residents in service areas have regular timely access
369 to representatives of the program and timely responses to complaints
370 and requests for assistance;

371 (3) Identify, investigate and resolve complaints made by or on
372 behalf of residents that relate to action, inaction or decisions that may
373 adversely affect the health, safety, welfare or rights of the residents or
374 by, or on behalf of, applicants in relation to issues concerning
375 applications to long-term care facilities;

376 (4) Represent the interests of residents and applicants, in relation to
377 their applications to long-term care facilities, before government
378 agencies and seek administrative, legal and other remedies to protect
379 the health, safety, welfare and rights of the residents;

380 (5) (A) Review and, if necessary, comment on any existing and
381 proposed laws, regulations and other government policies and actions
382 that pertain to the rights and well-being of residents and applicants in
383 relation to their applications to long-term care facilities, and (B)
384 facilitate the ability of the public to comment on the laws, regulations,

385 policies and actions;

386 (6) Support the development of resident and family councils; and

387 (7) Carry out other activities that the State Ombudsman determines
388 to be appropriate.

389 Sec. 13. Section 17b-406 of the general statutes is repealed and the
390 following is substituted in lieu thereof (*Effective July 1, 2010*):

391 (a) Residents' advocates, under supervision of the regional
392 ombudsmen, shall assist the regional ombudsmen in the performance
393 of all duties and responsibilities of the regional ombudsmen as
394 described in section 17b-405, as amended by this act.

395 (b) All long-term care facilities shall post or cause to be posted in a
396 conspicuous place therein a list of the names of the appropriate
397 residents' advocates and the names, addresses, and telephone numbers
398 of the appropriate ombudsmen.

399 (c) The Commissioner [of Social Services] on Aging shall have
400 authority to seek funding for the purposes contained in this section
401 from public and private sources, including, but not limited to, any
402 federal or state funded programs.

403 Sec. 14. Section 17b-407 of the general statutes is repealed and the
404 following is substituted in lieu thereof (*Effective July 1, 2010*):

405 (a) Any physician or surgeon licensed under the provisions of
406 chapter 370, any resident physician or intern in any hospital in this
407 state, whether or not so licensed, and any registered nurse, licensed
408 practical nurse, medical examiner, dentist, optometrist, chiropractor,
409 podiatrist, social worker, clergyman, police officer, pharmacist,
410 physical therapist, long-term care facility administrator, nurse's aide or
411 orderly in a long-term care facility, any person paid for caring for a
412 patient in a long-term care facility, any staff person employed by a
413 long-term care facility and any person who is a sexual assault

414 counselor or a battered women's counselor as defined in section
415 52-146k who has reasonable cause to suspect or believe that a resident
416 in a long-term care facility has been abused, neglected, exploited or
417 abandoned, or is in a condition that is the result of such abuse, neglect,
418 exploitation or abandonment, shall, not later than seventy-two hours
419 after such suspicion or belief arose, report such information or cause a
420 report to be made in any reasonable manner to the Commissioner [of
421 Social Services] on Aging pursuant to chapter 319dd. Any person
422 required to report under the provision of this section who fails to make
423 such report within the prescribed time period shall be fined not more
424 than five hundred dollars, except that, if such person intentionally fails
425 to make such report within the prescribed time period, such person
426 shall be guilty of a class C misdemeanor for the first offense and a class
427 A misdemeanor for any subsequent offense.

428 (b) Such report shall contain the name and address of the long-term
429 care facility, the name of the involved resident, information regarding
430 the nature and extent of the abuse, neglect, exploitation or
431 abandonment and any other information which the reporter believes
432 might be helpful in an investigation of the case and for the protection
433 of the resident.

434 (c) Any other person having reasonable cause to believe that a
435 resident in a long-term care facility is being, or has been, abused,
436 neglected, exploited or abandoned, or any person who wishes to file
437 any other complaint regarding a long-term care facility, shall report
438 such information in accordance with subsection (b) of this section in
439 any reasonable manner to the Commissioner [of Social Services] on
440 Aging who shall inform the resident of the services of the Office of the
441 Long-Term Care Ombudsman.

442 (d) Such report or complaint shall not be deemed a public record,
443 and shall not be subject to the provisions of section 1-210. Information
444 derived from such reports or complaints for which reasonable grounds
445 are determined to exist after investigation as provided for in section

446 17b-408, including the identity of the long-term care facility, the
447 number of complaints received, the number of complaints
448 substantiated and the types of complaints, may be disclosed by the
449 Commissioner [of Social Services] on Aging, except that in no case
450 shall the name of the resident or the complainant be revealed, unless
451 such person specifically requests such disclosure or unless a judicial
452 proceeding results from such report or complaint.

453 (e) Any person who makes a report or complaint pursuant to this
454 section or who testifies in any administrative or judicial proceeding
455 arising from the report shall be immune from any civil or criminal
456 liability on account of such report or complaint or testimony, except
457 for liability for perjury, unless such person acted in bad faith or with
458 malicious purpose.

459 (f) Any person who is discharged or in any manner discriminated or
460 retaliated against for making, in good faith, a report or complaint
461 pursuant to this section shall be entitled to all remedies available
462 under law including, but not limited to, remedies available under
463 sections 19a-532 and 31-51m, as applicable.

464 (g) The person filing a report or complaint pursuant to the
465 provisions of this section shall be notified of the findings of any
466 investigation conducted by the Commissioner [of Social Services] on
467 Aging, upon request.

468 [(h) The Commissioner of Social Services shall maintain a registry of
469 the reports received, the investigations made, the findings and the
470 actions recommended and taken.]

471 Sec. 15. Section 17b-411 of the general statutes is repealed and the
472 following is substituted in lieu thereof (*Effective July 1, 2010*):

473 The Commissioner [of Social Services] on Aging, after consultation
474 with the State Ombudsman, shall adopt regulations in accordance with
475 the provisions of chapter 54, to carry out the provisions of sections

476 17b-400 to 17b-412, inclusive, as amended by this act, 19a-531, as
477 amended by this act, and 19a-532.

478 Sec. 16. Section 19a-530 of the general statutes is repealed and the
479 following is substituted in lieu thereof (*Effective July 1, 2010*):

480 The Commissioner of Public Health, within ten working days, shall
481 furnish the Commissioner on Aging and the Commissioner of Social
482 Services a written report of any action taken pursuant to sections
483 19a-524 to 19a-527, inclusive, on any report or complaint referred to the
484 Commissioner of Public Health in accordance with the provisions of
485 section 17b-408.

486 Sec. 17. Section 19a-531 of the general statutes is repealed and the
487 following is substituted in lieu thereof (*Effective July 1, 2010*):

488 Any employee of the Department of Public Health or the
489 Department [of Social Services] on Aging or any regional ombudsman
490 who gives or causes to be given any advance notice to any nursing
491 home facility, directly or indirectly, that an investigation or inspection
492 is under consideration or is impending or gives any information
493 regarding any complaint submitted pursuant to section 17b-408, or
494 19a-523, as amended by this act, prior to an on-the-scene investigation
495 or inspection of such facility, unless specifically mandated by federal
496 or state regulations to give advance notice, shall be guilty of a class B
497 misdemeanor and may be subject to dismissal, suspension or demotion
498 in accordance with chapter 67.

499 Sec. 18. Section 17b-412 of the general statutes is repealed and the
500 following is substituted in lieu thereof (*Effective July 1, 2010*):

501 The [director] Commissioner on Aging shall require the State
502 Ombudsman to:

503 (1) Prepare an annual report:

504 (A) Describing the activities carried out by the office in the year for

505 which the report is prepared;

506 (B) Containing and analyzing the data collected under section 17b-
507 413, as amended by this act;

508 (C) Evaluating the problems experienced by and the complaints
509 made by or on behalf of residents;

510 (D) Containing recommendations for (i) improving the quality of
511 the care and life of the residents, and (ii) protecting the health, safety,
512 welfare and rights of the residents;

513 (E) (i) Analyzing the success of the program including success in
514 providing services to residents of long-term care facilities; and (ii)
515 identifying barriers that prevent the optimal operation of the program;
516 and

517 (F) Providing policy, regulatory and legislative recommendations to
518 solve identified problems, to resolve the complaints, to improve the
519 quality of the care and life of residents, to protect the health, safety,
520 welfare and rights of residents and to remove the barriers that prevent
521 the optimal operation of the program.

522 (2) Analyze, comment on and monitor the development and
523 implementation of federal, state and local laws, regulations and other
524 government policies and actions that pertain to long-term care facilities
525 and services, and to the health, safety, welfare and rights of residents
526 in the state, and recommend any changes in such laws, regulations and
527 policies as the office determines to be appropriate.

528 (3) (A) Provide such information as the office determines to be
529 necessary to public and private agencies, legislators and other persons,
530 regarding (i) the problems and concerns of older individuals residing
531 in long-term care facilities; and (ii) recommendations related to the
532 problems and concerns; and (B) make available to the public and
533 submit to the federal assistant secretary for aging, the Governor, the
534 General Assembly, the Department of Public Health and other

535 appropriate governmental entities, each report prepared under
536 subdivision (1) of this section.

537 Sec. 19. Section 17b-413 of the general statutes is repealed and the
538 following is substituted in lieu thereof (*Effective July 1, 2010*):

539 The [state agency] Commissioner on Aging shall establish a state-
540 wide uniform system to: (1) [~~Collect and~~] Document reports or
541 complaints received, investigations conducted, including the findings
542 of such investigations, actions recommended and actions taken as a
543 result of such investigations; (2) analyze data relating to complaints
544 and conditions in long-term care facilities and to residents for the
545 purpose of identifying and resolving significant problems; and [(2)] (3)
546 submit the data, on a regular basis to: (A) The Department of Public
547 Health; (B) the Department of Social Services; [(B)] (C) other state and
548 federal entities that the State Ombudsman determines to be
549 appropriate; and [(C)] (D) the National Ombudsman Resource Center,
550 established in Section 202(a)(21) of the federal Older Americans Act of
551 1965, as amended from time to time.

552 Sec. 20. (NEW) (*Effective July 1, 2010*) (a) The Department of Social
553 Services may provide necessary services to deaf and hearing impaired
554 persons, including, but not limited to, nonreimbursable interpreter
555 services and message relay services for persons using
556 telecommunications devices for the deaf.

557 (b) The department may accept and receive any bequest or gift of
558 personal property and, subject to the consent of the Governor and
559 Attorney General as provided in section 4b-22 of the general statutes,
560 any devise or gift of real property made to said department, and may
561 hold and use such property for the purposes, if any, specified in
562 connection with such bequest, devise or gift.

563 Sec. 21. Section 46a-28 of the general statutes is repealed and the
564 following is substituted in lieu thereof (*Effective July 1, 2010*):

565 (a) A commission is hereby created to advocate, strengthen and
566 implement state policies affecting deaf and hearing impaired
567 individuals and their relationship to the public, industry, health care
568 and educational opportunity.

569 [(a)] (b) The commission shall consist of twenty-one members, three
570 of whom shall be ex officio. The ex-officio members shall consist of the
571 following individuals: The consultant appointed by the State Board of
572 Education in accordance with section 10-316a, the president of the
573 Connecticut Council of Organizations Serving the Deaf and the
574 superintendent of the American School for the Deaf. The following
575 members shall be voting members: The Commissioners of Public
576 Health, Social Services, Mental Health, Education, Developmental
577 Services, and Children and Families and the Labor Commissioner or
578 their designees and eleven members appointed by the Governor. Of
579 the members appointed by the Governor one shall be a physician
580 licensed to practice medicine in this state and specializing in
581 otolaryngology; one a parent of a student in a predominantly oral
582 education program, one a parent of a student at the American School
583 for the Deaf and one a parent of a student in a public school hearing
584 impaired program, and seven deaf persons, one of whom shall be a
585 parent.

586 [(b)] (c) The commission shall meet at least quarterly or more often
587 at the call of the chairperson or a majority of the members. A majority
588 of the voting members in office but not less than seven voting
589 members shall constitute a quorum.

590 [(c)] (d) Any appointed member who fails to attend three
591 consecutive meetings or who fails to attend fifty per cent of all
592 meetings held during any calendar year shall be deemed to have
593 resigned. Vacancies occurring otherwise than by expiration of term in
594 the membership of the commission shall be filled by the officer
595 authorized to make the original appointments.

596 [(d)] (e) The members of the commission shall be reimbursed for

597 actual and necessary expenses incurred in the performance of their
598 duties.

599 [(e) There shall be established the position of executive director who
600 shall be the chief executive officer of the commission. His qualifications
601 and compensation shall be determined by the Commissioner of
602 Administrative Services, subject to the approval of the Secretary of the
603 Office of Policy and Management, pursuant to section 4-40. Said
604 executive director shall function under the direction of the
605 commission.

606 (f) Subject to the provisions of chapter 67, the commission is
607 authorized to employ such clerical and other assistance as it requires to
608 carry out the provisions of sections 46a-27 to 46a-32, inclusive.]

609 (f) The commission shall serve as an advisor to the Department of
610 Social Services on matters affecting deaf and hearing impaired
611 individuals.

612 (g) The functions, powers, duties and personnel of the commission
613 as of July 1, 2010, shall be transferred to the Department of Social
614 Services pursuant to the provisions of sections 4-38d, 4-38e and 4-39.
615 Any order or regulation of the Commission on the Deaf and Hearing
616 Impaired that is in force on July 1, 2010, shall continue in force and
617 effect as an order or regulation until amended, repealed or superseded
618 pursuant to law.

619 Sec. 22. Section 46a-33a of the 2010 supplement to the general
620 statutes is repealed and the following is substituted in lieu thereof
621 (*Effective July 1, 2010*):

622 (a) For the purposes of this section:

623 (1) "Interpreting" means the translating or transliterating of English
624 concepts to a language concept used by a person who is deaf or hard of
625 hearing or means the translating of a deaf or hard of hearing person's
626 language concept to English concepts. Language concepts include, but

627 are not limited to, the use of American Sign Language, English-based
628 sign language, cued speech, oral transliterating and information
629 received tactually;

630 (2) "Legal setting" means any criminal or civil action involving a
631 court of competent jurisdiction, any investigation conducted by a duly
632 authorized law enforcement agency, employment related hearings and
633 appointments requiring the presence of an attorney;

634 (3) "Medical setting" means medical related situations including
635 mental health treatment, psychological evaluations, substance abuse
636 treatment, crisis intervention and appointments or treatment requiring
637 the presence of a doctor, nurse or other health care professional; and

638 (4) "Educational setting" means a school or other educational
639 institution, including elementary, high school and post-graduation
640 schools where interpretive services are provided to a student.

641 (b) [Commencing October 1, 1998, and annually thereafter, all] All
642 persons providing interpreting services shall register with the
643 [Commission on the Deaf and Hearing Impaired] Department of Social
644 Services. Such registration shall be on a form prescribed or furnished
645 by the [commission] department and shall include the registrant's
646 name, address, phone number, place of employment as interpreter and
647 interpreter certification or credentials. [Commencing July 1, 2001, and
648 annually thereafter, the commission] The department shall issue
649 identification cards for those who register in accordance with this
650 section.

651 (c) No person shall provide interpreting services unless such person
652 is registered with the [commission] department according to the
653 provisions of this section and (1) has passed the National Registry of
654 Interpreters for the Deaf written generalist test or the National
655 Association of the Deaf-National Registry of Interpreters for the Deaf
656 certification knowledge examination, holds a level three certification
657 provided by the National Association of the Deaf, documents the

658 achievement of two continuing education units per year for a
659 maximum of five years of [commission-approved] department-
660 approved training, and on or before the fifth anniversary of having
661 passed the National Registry of Interpreters for the Deaf written
662 generalist test or the National Association of the Deaf-National
663 Registry of Interpreters for the Deaf certification knowledge
664 examination, has passed the National Registry of Interpreters for the
665 Deaf performance examination or the National Association of the
666 Deaf-National Registry of Interpreters for the Deaf national interpreter
667 certification examination, (2) has passed the National Registry of
668 Interpreters for the Deaf written generalist test or the National
669 Association of the Deaf-National Registry of Interpreters for the Deaf
670 certification knowledge examination and is a graduate of an accredited
671 interpreter training program and documents the achievement of two
672 continuing education units per year for a maximum of five years of
673 [commission-approved] department-approved training, and on or
674 before the fifth anniversary of having passed the National Registry of
675 Interpreters for the Deaf written generalist test or the National
676 Association of the Deaf-National Registry of Interpreters for the Deaf
677 certification knowledge examination, has passed the National Registry
678 of Interpreters for the Deaf performance examination or the National
679 Association of the Deaf-National Registry of Interpreters for the Deaf
680 national interpreter certification examination, (3) holds a level four or
681 higher certification from the National Association of the Deaf, (4) holds
682 certification by the National Registry of Interpreters for the Deaf, (5)
683 for situations requiring an oral interpreter only, holds oral certification
684 from the National Registry of Interpreters for the Deaf, (6) for
685 situations requiring a cued speech transliterator only, holds
686 certification from the National Training, Evaluation and Certification
687 Unit and has passed the National Registry of Interpreters for the Deaf
688 written generalist test, (7) holds a reverse skills certificate or is a
689 certified deaf interpreter under the National Registry of Interpreters
690 for the Deaf, or (8) holds a National Association of the Deaf-National
691 Registry of Interpreters for the Deaf national interpreting certificate.

692 (d) No person shall provide interpreting services in a medical
693 setting unless such person is registered with the [commission]
694 department according to the provisions of this section and (1) holds a
695 comprehensive skills certificate from the National Registry of
696 Interpreters for the Deaf, (2) holds a certificate of interpretation or a
697 certificate of transliteration from the National Registry of Interpreters
698 for the Deaf, (3) holds a level four or higher certification from the
699 National Association of the Deaf, (4) holds a reverse skills certificate or
700 is a certified deaf interpreter under the National Registry of
701 Interpreters for the Deaf, (5) for situations requiring an oral interpreter
702 only, holds oral certification from the National Registry of Interpreters
703 for the Deaf, (6) for situations requiring a cued speech transliterator
704 only, holds certification from the National Training, Evaluation and
705 Certification Unit and has passed the National Registry of Interpreters
706 for the Deaf written generalist test, or (7) holds a National Association
707 of the Deaf-National Registry of Interpreters for the Deaf national
708 interpreting certificate.

709 (e) No person shall provide interpreting services in a legal setting
710 unless such person is registered with the [commission] department
711 according to the provisions of this section and (1) holds a
712 comprehensive skills certificate from the National Registry of
713 Interpreters for the Deaf, (2) holds a certificate of interpretation and a
714 certificate of transliteration from the National Registry of Interpreters
715 for the Deaf, (3) holds a level five certification from the National
716 Association of the Deaf, (4) holds a reverse skills certificate or is a
717 certified deaf interpreter under the National Registry of Interpreters
718 for the Deaf, (5) for situations requiring an oral interpreter only, holds
719 oral certification from the National Registry of Interpreters for the
720 Deaf, (6) for situations requiring a cued speech transliterator only,
721 holds certification from the National Training, Evaluation and
722 Certification Unit and has passed the National Registry of Interpreters
723 for the Deaf written generalist test, or (7) holds a National Association
724 of the Deaf-National Registry of Interpreters for the Deaf national
725 interpreting certificate.

726 (f) The requirements of this section shall apply to persons who
727 receive compensation for the provision of interpreting services and
728 include those who provide interpreting services as part of their job
729 duties.

730 [(g) The provisions of subsection (c) of this section shall not apply to
731 any person providing interpreting services in an educational setting
732 until July 1, 2003.]

733 Sec. 23. Section 46a-33b of the 2010 supplement to the general
734 statutes is repealed and the following is substituted in lieu thereof
735 (*Effective July 1, 2010*):

736 Upon the request of any person or any public or private entity, the
737 [Commission on the Deaf and Hearing Impaired] Department of Social
738 Services shall provide interpreting services to assist such person or
739 entity to the extent such persons who provide interpreting services are
740 available. Any person or entity receiving interpreting services through
741 the [commission] department shall reimburse the [commission]
742 department for such services at a rate set by the [commission]
743 department. The [commission] department shall adopt regulations in
744 accordance with the provisions of chapter 54 to establish the manner of
745 rate setting.

746 Sec. 24. Subsection (g) of section 4-89 of the 2010 supplement to the
747 general statutes is repealed and the following is substituted in lieu
748 thereof (*Effective July 1, 2010*):

749 (g) The provisions of this section shall not apply to appropriations
750 to the [Commission on the Deaf and Hearing Impaired] Department of
751 Social Services in an amount not greater than the amount of
752 reimbursements of prior year expenditures for the services of
753 interpreters received by the [commission] department during the fiscal
754 year pursuant to section 46a-33b, as amended by this act, and such
755 appropriations shall not lapse until the end of the fiscal year
756 succeeding the fiscal year of the appropriation.

757 Sec. 25. Subsection (d) of section 51-245 of the general statutes is
758 repealed and the following is substituted in lieu thereof (*Effective July*
759 *1, 2010*):

760 (d) Notwithstanding the provisions of subsections (a) and (b) of this
761 section, if any juror is deaf or hearing impaired, such juror shall have
762 the assistance of a qualified interpreter who shall be present
763 throughout the proceeding and when the jury assembles for
764 deliberation. Such interpreter shall be provided by the [Commission
765 on the Deaf and Hearing Impaired] Department of Social Services at
766 the request of the juror or the court. Such interpreter shall be subject to
767 rules adopted pursuant to section 51-245a, as amended by this act.

768 Sec. 26. Section 16-256b of the general statutes is repealed and the
769 following is substituted in lieu thereof (*Effective July 1, 2010*):

770 (a) Each telephone company and each certified telecommunications
771 provider that makes equipment available to customers shall make
772 special telecommunications equipment capable of serving the needs of
773 deaf and hearing and speech impaired persons available for rental or
774 purchase and be responsible for the maintenance and repair of any
775 such equipment it leases or sells.

776 (b) (1) Each domestic telephone company having at least one
777 hundred thousand customers shall pay into a Special
778 Telecommunications Equipment Fund twenty thousand dollars not
779 later than July 1, 1992. The fund shall be administered by the
780 [Commission on the Deaf and Hearing Impaired] Department of Social
781 Services. The Department of Public Utility Control shall include all
782 payments made by a company into said fund as operating expenses of
783 the company for purposes of rate-making under section 16-19.

784 (2) Except for the funding specified in subdivision (1) of this
785 subsection, the [State Commission on the Deaf and Hearing Impaired]
786 Department of Social Services may draw on funds obtained through
787 agreements between the state and domestic telephone companies in

788 accordance with a plan developed, after notice and hearing, by the
789 [commission] department, in consultation with the Commission on the
790 Deaf and Hearing Impaired, not later than January first, annually, and
791 approved by the joint standing committee of the General Assembly
792 having cognizance of matters relating to public utilities. The plan shall
793 provide for the distribution of moneys from the funds to deaf and
794 hearing and speech impaired persons for the purchase, upgrading,
795 rental, maintenance and repair of special telecommunications
796 equipment capable of serving the needs of such persons or to vendors
797 providing such equipment or servicing. The plan may also provide for
798 the distribution of moneys from the funds for the provision of message
799 relay services for persons using telecommunication devices for the
800 deaf, upon a determination by the [commission] department that such
801 moneys are needed to ensure that such services are made available to
802 such persons and that there are adequate moneys in the funds for
803 special telecommunications equipment purposes. The plan shall
804 provide that not more than ten per cent of the moneys annually paid
805 into the fund shall be allocated to the [commission] department to
806 carry out its administrative responsibilities under this subdivision and
807 not more than five per cent of the moneys annually paid by a
808 telephone company into the fund shall be allocated to such corporation
809 to carry out its responsibilities under subdivision (1) of this subsection.
810 All moneys allocated to the [commission] department shall be paid to
811 the State Treasurer for deposit in the General Fund.

812 (3) The [Commission on the Deaf and Hearing Impaired]
813 Department of Social Services shall, not later than March first,
814 annually, submit a written financial report on the fund it administers
815 under subdivision (2) of this section to the General Assembly and the
816 Auditors of Public Accounts. Such report shall include a balance sheet
817 and income and expense statement for the preceding calendar year,
818 clearly setting forth the fund's income and expenses and all amounts
819 spent for the direct purpose of the fund.

820 (c) (1) Each telephone company and each certified

821 telecommunications provider shall, in consultation with the
822 [Commission on the Deaf and Hearing Impaired] Department of Social
823 Services, prepare and submit to the Department of Public Utility
824 Control and the joint standing committee of the General Assembly
825 having cognizance of matters relating to public utilities a plan which
826 shall provide that, to the extent possible, (A) not less than eighty per
827 cent of the coin and coinless telephones installed for public use by the
828 telephone company or certified telecommunications provider shall be
829 equipped [, not later than July 1, 1995,] with controls for the
830 amplification of incoming transmissions, [and not less than eighty per
831 cent of the coin and coinless telephones installed for public use by the
832 telephone company or certified telecommunications provider after July
833 1, 1995, shall be equipped with such controls,] and (B) not less than
834 fifty per cent of the coin and coinless telephones installed for
835 semipublic use by the telephone company or certified
836 telecommunications provider pursuant to tariffs shall be equipped [,
837 not later than July 1, 1995,] with such controls. [and not less than fifty
838 per cent of the coin and coinless telephones installed for semipublic
839 use by the telephone company or certified telecommunications
840 provider pursuant to tariffs after July 1, 1995, shall be equipped with
841 such controls.]

842 (2) Not later than July first, annually, each such telephone company
843 and each such certified telecommunications provider shall submit a
844 report to [said commission, department and joint standing committee]
845 the Department of Public Utility Control, the Department of Social
846 Services and the joint standing committee of the General Assembly
847 having cognizance of matters relating to public utilities on the
848 implementation of the plan prepared under subdivision (1) of this
849 subsection, provided, if a telephone company or a certified
850 telecommunications provider documents in any such report that it has
851 fully complied with the provisions of subdivision (1) of this subsection,
852 it shall not be required to submit additional annual reports.

853 (3) The cost of compliance with the provisions of this subsection

854 shall be recoverable from ratepayers through the overall rate structure
855 approved by the Department of Public Utility Control.

856 (d) Not less than eighty per cent of the coin and coinless telephones
857 installed for public use [on or after July 1, 1993,] by any person, other
858 than a telephone company or a certified telecommunications provider
859 shall be equipped with such amplification controls at the time the
860 telephones are installed.

861 Sec. 27. Subsection (c) of section 9-20 of the general statutes is
862 repealed and the following is substituted in lieu thereof (*Effective July*
863 *1, 2010*):

864 (c) The application for admission as an elector shall include a
865 statement that (1) specifies each eligibility requirement, (2) contains an
866 attestation that the applicant meets each such requirement, and (3)
867 requires the signature of the applicant under penalty of perjury. Each
868 registrar of voters and town clerk shall maintain a copy of such
869 statement in braille, large print and audio form. The [Commission on
870 the Deaf and Hearing Impaired] Department of Social Services shall
871 produce a videotape presenting such statement in voice and sign
872 language and provide the videotape to the Secretary of the State who
873 shall make copies of the videotape and provide a copy to the registrars
874 of voters of any municipality, upon request and at a cost equal to the
875 cost of making the copy. If a person applies for admission as an elector
876 in person to an admitting official, such admitting official shall, upon
877 the request of the applicant, administer the elector's oath.

878 Sec. 28. (NEW) (*Effective July 1, 2010*) (a) The Commissioner of
879 Mental Health and Addiction Services shall certify intermediate care
880 beds in general hospitals to provide inpatient mental health services
881 for adults with serious and persistent mental illness.

882 (b) The commissioner shall adopt regulations, in accordance with
883 the provisions of chapter 54, to establish requirements for certification
884 of intermediate care beds in general hospitals and the process by

885 which such beds shall be certified. In adopting such regulations, the
886 commissioner shall consider the need for such beds.

887 (c) The commissioner shall implement policies and procedures to
888 carry out the provisions of this section while in the process of adopting
889 such policies and procedures in regulation form, provided notice of
890 intent to adopt the regulations is published in the Connecticut Law
891 Journal not later than twenty days after implementation. Such policies
892 and procedures shall be valid until the time the final regulations are
893 adopted.

894 Sec. 29. Subsection (a) of section 17b-295 of the general statutes is
895 repealed and the following is substituted in lieu thereof (*Effective July*
896 *1, 2010*):

897 (a) The commissioner shall impose cost-sharing requirements,
898 including the payment of a premium or copayment, in connection with
899 services provided under the HUSKY Plan, Part B, to the extent
900 permitted by federal law. [, and] Copayments under the HUSKY Plan,
901 Part B, shall be the same as those in effect for active state employees
902 enrolled in a point-of-enrollment health care plan, provided the
903 family's annual combined premiums and copayments do not exceed
904 the maximum annual aggregate cost-sharing requirement. The cost-
905 sharing requirements imposed by the commissioner shall be in
906 accordance with the following limitations:

907 (1) The commissioner may increase the maximum annual aggregate
908 cost-sharing requirements, provided such cost-sharing requirements
909 shall not exceed five per cent of the family's gross annual income. (2)
910 The commissioner may impose a premium requirement on families
911 whose income exceeds two hundred thirty-five per cent of the federal
912 poverty level as a component of the family's cost-sharing
913 responsibility, provided: (A) The family's annual combined premiums
914 and copayments do not exceed the maximum annual aggregate cost-
915 sharing requirement, and (B) premium requirements shall not exceed
916 the sum of [thirty] fifty dollars per month [per] for families with one

917 child, with a maximum premium of [fifty] seventy-five dollars per
918 month per family. The commissioner shall not impose a premium
919 requirement on families whose income exceeds one hundred eighty-
920 five per cent of the federal poverty level but does not exceed two
921 hundred thirty-five per cent of the federal poverty level. [; and

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

925 Sec. 30. (NEW) (*Effective July 1, 2010*) To the extent permitted by
926 federal law, no payment shall be provided for eyeglasses, contact
927 lenses or services provided by an optician under any medical
928 assistance program administered by the Department of Social Services.

929 Sec. 31. (NEW) (*Effective July 1, 2010*) Notwithstanding any
930 provision of the general statutes, on and after July 1, 2010, no payment
931 shall be made under a medical assistance program administered by the
932 Department of Social Services for an over-the-counter drug, except for
933 insulin and insulin syringes and as may be required by federal law.

934 Sec. 32. Section 17b-197 of the general statutes is repealed and the
935 following is substituted in lieu thereof (*Effective July 1, 2010*):

936 [(a)] If a recipient of state-administered general assistance or person
937 receiving aid under both the Social Security Disability Income Program
938 and the state supplement to the federal Supplemental Security Income
939 Program has been denied aid under the federal Supplemental Security
940 Income Program, or has been notified by the Social Security
941 Administration that his benefits under such program will be
942 terminated, the Commissioner of Social Services shall advise the
943 recipient [as to] of his right [of] to appeal and the availability of local
944 legal counsel. The attorney chosen by the recipient shall be reimbursed
945 [by the state for his reasonable fees, on a contingency basis, limited to
946 the amount approved by the Department of Social Services,] pursuant
947 to the provisions of 42 USC 406 and limited to the amount approved

948 by the Social Security Administration pursuant to the provisions of 42
949 USC 406. [when such approval is required by federal regulations for
950 such appeals.] Such attorney's fees [shall not] may be recoverable from
951 such recipient or his estate. The full amount of any interim assistance
952 reimbursement received by the state shall be applied to reduce any
953 obligation owed to the town by such recipient.

954 [(b) Those persons receiving aid under both the federal Social
955 Security Administration Disability Program and the state supplement
956 to the federal Supplemental Security Income Program, who have been
957 notified that their benefits under the federal program will be
958 terminated by the Social Security Administration, shall be eligible for
959 the payment of attorney's fees, on a contingency basis, incurred in
960 appealing such termination. The attorney chosen by the recipient shall
961 be reimbursed by the state for his reasonable fees, on a contingency
962 basis, limited to the amount approved by the Department of Social
963 Services and limited to the amount approved by the Social Security
964 Administration when such approval is required by federal regulations
965 for such appeals. Such attorney's fees shall not be recoverable from
966 such recipient or his estate.]

967 Sec. 33. Subsection (f) of section 17b-274d of the 2010 supplement to
968 the general statutes is repealed and the following is substituted in lieu
969 thereof (*Effective July 1, 2010*):

970 (f) Nonpreferred drugs in the classes of drugs included on the
971 preferred drug lists shall be subject to prior authorization. [Prior
972 authorization is not required for any mental-health-related drug that
973 has been filled or refilled, in any dosage, at least one time in the one-
974 year period prior to the date the individual presents a prescription for
975 the drug at a pharmacy. If prior authorization is granted for a drug not
976 included on a preferred drug list, the authorization shall be valid for
977 one year from the date the prescription is first filled.] Antiretroviral
978 classes of drugs shall not be included on the preferred drug lists.

979 Sec. 34. (NEW) (*Effective July 1, 2010*) The Commissioner of Social

980 Services shall, to the extent permitted by federal law, impose cost
981 sharing requirements on Medicaid recipients, except copayments shall
982 not be imposed for the following services: (1) Inpatient hospitalization;
983 (2) hospital emergency; (3) home health care; (4) those under a home
984 and community-based waiver; (5) laboratory; (6) emergency
985 ambulance; and (7) nonemergency medical transportation. The
986 aggregate cost-sharing requirements for prescription drugs shall not
987 exceed twenty dollars per month.

988 Sec. 35. Subsection (c) of section 17b-265d of the 2010 supplement to
989 the general statutes is repealed and the following is substituted in lieu
990 thereof (*Effective July 1, 2010*):

991 (c) A full benefit dually eligible Medicare Part D beneficiary shall be
992 responsible for any Medicare Part D prescription drug copayments
993 imposed pursuant to Public Law 108-173, the Medicare Prescription
994 Drug, Improvement, and Modernization Act of 2003, in amounts not to
995 exceed [~~fifteen~~] twenty dollars per month. The department shall be
996 responsible for payment, on behalf of such beneficiary, of any
997 Medicare Part D prescription drug copayments in any month in which
998 such copayment amounts exceed [~~fifteen~~] twenty dollars in the
999 aggregate.

1000 Sec. 36. (NEW) (*Effective from passage*) (a) The terms "medically
1001 necessary" and "medical necessity", as used by the Department of
1002 Social Services to administer the department's medical assistance
1003 program, mean those health services required to prevent, identify,
1004 diagnose, treat, rehabilitate or ameliorate a health problem or its
1005 effects, or to maintain health and functioning, provided such services
1006 are: (1) Consistent with generally accepted standards of medical
1007 practice; (2) clinically appropriate in terms of type, frequency, timing,
1008 site and duration; (3) demonstrated through scientific evidence to be
1009 safe and effective and the least costly among similarly effective
1010 alternatives, where adequate scientific evidence exists; and (4) efficient
1011 in regard to avoidance of waste and refraining from provision of

1012 services that, on the basis of the best available scientific evidence, are
1013 not likely to produce benefits.

1014 (b) Not later than July 1, 2010, the Department of Social Services
1015 shall apply the definition of "medically necessary" and "medical
1016 necessity" in subsection (a) of this section in administering the medical
1017 assistance program. The department may amend or repeal any
1018 inconsistent definitions in the regulations of Connecticut state agencies
1019 that are used in administering the department's medical assistance
1020 program.

1021 Sec. 37. Section 17b-28e of the 2010 supplement to the general
1022 statutes is repealed and the following is substituted in lieu thereof
1023 (*Effective July 1, 2010*):

1024 (a) The Commissioner of Social Services shall amend the Medicaid
1025 state plan to include, on and after January 1, 2009, hospice services as
1026 optional services covered under the Medicaid program. Said state plan
1027 amendment shall supersede any regulations of Connecticut state
1028 agencies concerning such optional services.

1029 (b) Not later than February 1, 2011, the Commissioner of Social
1030 Services shall [amend the Medicaid state plan to include] enter into a
1031 contract to provide foreign language interpreter services [provided] to
1032 any Medicaid beneficiary with limited English proficiency, [as a
1033 covered service under the Medicaid program. Not later than February
1034 1, 2011, the commissioner shall develop and implement the use of
1035 medical billing codes for foreign language interpreter services for the
1036 HUSKY Plan, Part A and Part B, and for the fee-for-services Medicaid
1037 programs.]

1038 [(c) Each managed care organization that enters into a contract with
1039 the Department of Social Services to provide foreign language
1040 interpreter services under the HUSKY Plan, Part A shall report, semi-
1041 annually, to the department on the interpreter services provided to
1042 recipients of benefits under the program. Such written reports shall be

1043 submitted to the department not later than June first and December
1044 thirty-first each year. Not later than thirty days after receipt of such
1045 report, the department shall submit a copy of the report, in accordance
1046 with the provisions of section 11-4a, to the Medicaid Managed Care
1047 Council.]

1048 Sec. 38. (NEW) (*Effective July 1, 2010*) (a) The Commissioner of Social
1049 Services shall only authorize payment for the mode of transportation
1050 service that is medically necessary for a recipient of assistance under a
1051 medical assistance program administered by the Department of Social
1052 Services. Notwithstanding any provisions of the general statutes or
1053 regulations of Connecticut state agencies, a recipient who requires
1054 nonemergency transportation and who must be transported in a prone
1055 position but who does not require medical services during transport
1056 may be transported in a stretcher van. The commissioner shall
1057 establish rates for nonemergency transportation provided by stretcher
1058 van.

1059 (b) Notwithstanding any provision of the general statutes or the
1060 regulations of Connecticut state agencies, the Commissioner of
1061 Transportation shall adopt regulations, in accordance with chapter 54
1062 of the general statutes, to establish oversight of stretcher vans as a
1063 livery service for which a permit is required, provided certification
1064 issued by the Department of Public Health to provide transportation
1065 on a stretcher shall be sufficient qualification to be issued a stretcher
1066 van permit by the Commissioner of Transportation.

1067 Sec. 39. Subsection (a) of section 19a-180 of the 2010 supplement to
1068 the general statutes is repealed and the following is substituted in lieu
1069 thereof (*Effective July 1, 2010*):

1070 (a) No person shall operate any ambulance service, rescue service or
1071 management service [or otherwise transport in a motor vehicle a
1072 patient on a stretcher] without either a license or a certificate issued by
1073 the commissioner. No person shall operate a commercial ambulance
1074 service or commercial rescue service or a management service without

1075 a license issued by the commissioner. A certificate shall be issued to
1076 any volunteer or municipal ambulance service which shows proof
1077 satisfactory to the commissioner that it meets the minimum standards
1078 of the commissioner in the areas of training, equipment and personnel.
1079 No license or certificate shall be issued to any volunteer, municipal or
1080 commercial ambulance service, rescue service or management service,
1081 as defined in subdivision (19) of section 19a-175, as amended by this
1082 act, unless it meets the requirements of subsection (e) of section 14-
1083 100a. Applicants for a license shall use the forms prescribed by the
1084 commissioner and shall submit such application to the commissioner
1085 accompanied by an annual fee of two hundred dollars. In considering
1086 requests for approval of permits for new or expanded emergency
1087 medical services in any region, the commissioner shall consult with the
1088 Office of Emergency Medical Services and the emergency medical
1089 services council of such region and shall hold a public hearing to
1090 determine the necessity for such services. Written notice of such
1091 hearing shall be given to current providers in the geographic region
1092 where such new or expanded services would be implemented,
1093 provided, any volunteer ambulance service which elects not to levy
1094 charges for services rendered under this chapter shall be exempt from
1095 the provisions concerning requests for approval of permits for new or
1096 expanded emergency medical services set forth in this subsection. A
1097 primary service area responder that operates in the service area
1098 identified in the application shall, upon request, be granted intervenor
1099 status with opportunity for cross-examination. Each applicant for
1100 licensure shall furnish proof of financial responsibility which the
1101 commissioner deems sufficient to satisfy any claim. The commissioner
1102 may adopt regulations, in accordance with the provisions of chapter
1103 54, to establish satisfactory kinds of coverage and limits of insurance
1104 for each applicant for either licensure or certification. Until such
1105 regulations are adopted, the following shall be the required limits for
1106 licensure: (1) For damages by reason of personal injury to, or the death
1107 of, one person on account of any accident, at least five hundred
1108 thousand dollars, and more than one person on account of any

1109 accident, at least one million dollars, (2) for damage to property at least
1110 fifty thousand dollars, and (3) for malpractice in the care of one
1111 passenger at least two hundred fifty thousand dollars, and for more
1112 than one passenger at least five hundred thousand dollars. In lieu of
1113 the limits set forth in subdivisions (1) to (3), inclusive, of this
1114 subsection, a single limit of liability shall be allowed as follows: (A) For
1115 damages by reason of personal injury to, or death of, one or more
1116 persons and damage to property, at least one million dollars; and (B)
1117 for malpractice in the care of one or more passengers, at least five
1118 hundred thousand dollars. A certificate of such proof shall be filed
1119 with the commissioner. Upon determination by the commissioner that
1120 an applicant is financially responsible, properly certified and otherwise
1121 qualified to operate a commercial ambulance service, rescue service or
1122 management service, the commissioner shall issue the appropriate
1123 license effective for one year to such applicant. If the commissioner
1124 determines that an applicant for either a certificate or license is not so
1125 qualified, the commissioner shall notify such applicant of the denial of
1126 the application with a statement of the reasons for such denial. Such
1127 applicant shall have thirty days to request a hearing on the denial of
1128 the application.

1129 Sec. 40. Subdivision (11) of section 19a-175 of the 2010 supplement
1130 to the general statutes is repealed and the following is substituted in
1131 lieu thereof (*Effective July 1, 2010*):

1132 (11) "Invalid coach" means a vehicle used exclusively for the
1133 transportation of nonambulatory patients [, who are not confined to
1134 stretchers,] to or from either a medical facility or the patient's home in
1135 nonemergency situations or utilized in emergency situations as a
1136 backup vehicle when insufficient emergency vehicles exist;

1137 Sec. 41. Section 17b-266 of the 2010 supplement to the general
1138 statutes is repealed and the following is substituted in lieu thereof
1139 (*Effective July 1, 2010*):

1140 (a) The Commissioner of Social Services may, when the

1141 commissioner finds it to be in the public interest, fund part or all of the
1142 cost of benefits to any recipient under sections 17b-260 to 17b-262,
1143 inclusive, 17b-264 to 17b-285, inclusive, as amended by this act, 17b-
1144 357 to 17b-361, inclusive, 17b-289 to 17b-303, inclusive, as amended by
1145 this act, and section 16 of public act 97-1 of the October 29 special
1146 session*, through the purchase of insurance from any organization
1147 authorized to do a health insurance business in this state or from any
1148 organization specified in subsection (b) of this section.

1149 (b) The Commissioner of Social Services may require recipients of
1150 Medicaid or other public assistance to receive medical care on a
1151 prepayment or per capita basis, in accordance with federal law and
1152 regulations, if such prepayment is anticipated to result in lower
1153 medical assistance costs to the state. The commissioner may enter into
1154 contracts for the provision of comprehensive health care on a
1155 prepayment or per capita basis in accordance with federal law and
1156 regulations, with the following: (1) A health care center subject to the
1157 provisions of chapter 698a; (2) a consortium of federally-qualified
1158 community health centers and other community-based providers of
1159 health services which are funded by the state; (3) other consortia of
1160 providers of health care services established for the purposes of this
1161 subsection; or (4) an integrated service network providing care
1162 management and comprehensive health care on a prepayment or per
1163 capita basis to elderly and disabled recipients of Medicaid who may
1164 also be eligible for Medicare.

1165 (c) Providers of comprehensive health care services as described in
1166 subdivisions (2), (3) and (4) of subsection (b) of this section shall not be
1167 subject to the provisions of chapter 698a or, in the case of an integrated
1168 service network, sections 17b-239 to 17b-245, inclusive, 17b-281, 17b-
1169 340, 17b-342 and 17b-343. Any such provider shall be certified by the
1170 Commissioner of Social Services in accordance with criteria established
1171 by the commissioner, including, but not limited to, minimum reserve
1172 fund requirements.

1173 [(d) The commissioner shall pay all capitation claims which would
1174 otherwise be reimbursed to the health plans described in subsection (b)
1175 of this section in June, 2011, no later than July 31, 2011.]

1176 [(e)] (d) On or after May 1, 2000, the payment to the Commissioner
1177 of Social Services of (1) any monetary sanction imposed by the
1178 commissioner on a managed care organization under the provisions of
1179 a contract between the commissioner and such organization entered
1180 into pursuant to this section or sections 17b-289 to 17b-304, inclusive,
1181 as amended by this act, or (2) any sum agreed upon by the
1182 commissioner and such an organization as settlement of a claim
1183 brought by the commissioner or the state against such an organization
1184 for failure to comply with the terms of a contract with the
1185 commissioner or fraud affecting the Department of Social Services
1186 shall be deposited in an account designated for use by the department
1187 for expenditures for children's health programs and services.

1188 Sec. 42. (NEW) (*Effective from passage*) The Commissioner of Social
1189 Services, pursuant to section 17b-10 of the general statutes, may
1190 implement policies and procedures necessary to administer the
1191 provisions of this act, while in the process of adopting such policies
1192 and procedures as regulation, provided the commissioner prints notice
1193 of intent to adopt regulations in the Connecticut Law Journal not later
1194 than twenty days after the date of implementation. Policies and
1195 procedures implemented pursuant to this section shall be valid until
1196 the time final regulations are adopted.

1197 Sec. 43. (NEW) (*Effective from passage*) The Commissioner of Social
1198 Services shall amend the Medicaid state plan to provide coverage for
1199 the treatment of tuberculosis for any eligible person who has an
1200 income less than or equal to three hundred per cent of the federal
1201 poverty level, to the extent permitted by federal law.

1202 Sec. 44. Subsection (a) of section 17b-492 of the 2010 supplement to
1203 the general statutes is repealed and the following is substituted in lieu
1204 thereof (*Effective from passage*):

1205 (a) Eligibility for participation in the program shall be limited to any
1206 resident (1) who is sixty-five years of age or older or who is disabled,
1207 (2) whose current annual income at the time of application or
1208 redetermination, if unmarried, is less than twenty thousand eight
1209 hundred dollars or whose annual income, if married, when combined
1210 with that of the resident's spouse is less than twenty-eight thousand
1211 one hundred dollars, (3) who is not insured under a policy which
1212 provides full or partial coverage for prescription drugs once a
1213 deductible is met, except for a Medicare prescription drug discount
1214 card endorsed by the Secretary of Health and Human Services in
1215 accordance with Public Law 108-173, the Medicare Prescription Drug,
1216 Improvement, and Modernization Act of 2003, or coverage under
1217 Medicare Part D pursuant to said act, and (4) on and after September
1218 15, 1991, who pays an annual forty-five-dollar registration fee to the
1219 Department of Social Services. On January 1, 2012, and annually
1220 thereafter, the commissioner shall increase the income limits
1221 established under this subsection over those of the previous fiscal year
1222 to reflect the annual inflation adjustment in Social Security income, if
1223 any. Each such adjustment shall be determined to the nearest one
1224 hundred dollars. On and after October 1, 2009, new applications to
1225 participate in the ConnPACE program may be accepted only from the
1226 fifteenth day of November through the [thirtieth] thirty-first day of
1227 December each year, except that individuals may apply within thirty-
1228 one days of (A) reaching sixty-five years of age, or (B) becoming
1229 eligible for Social Security Disability Income or Supplemental Security
1230 Income.

1231 Sec. 45. (NEW) (*Effective July 1, 2010*) The Commissioner of Social
1232 Services may contract with one or more administrative services
1233 organizations to provide care coordination, utilization management,
1234 disease management, customer service and review of grievances for
1235 recipients of assistance under Medicaid, HUSKY Plan, Parts A and B,
1236 and the Charter Oak Health Plan. Such organization may also provide
1237 network management, credentialing of providers, monitoring of
1238 copayments and premiums and other services as required by the

1239 commissioner.

1240 Sec. 46. Section 17b-192 of the 2010 supplement to the general
1241 statutes is repealed and the following is substituted in lieu thereof
1242 (*Effective July 1, 2010*):

1243 (a) The Commissioner of Social Services shall implement a state
1244 medical assistance component of the state-administered general
1245 assistance program for persons who do not meet the categorical
1246 eligibility criteria for Medicaid on the basis of age, blindness,
1247 disability, pregnancy, being a parent or other caretaker relative of a
1248 dependent child, being a child under the age of twenty-one, or having
1249 been screened for breast or cervical cancer under the Centers for
1250 Disease Control and Prevention's National Breast and Cervical Cancer
1251 Early Detection Program and are found to need treatment for either
1252 breast or cervical cancer. Eligibility criteria concerning income shall be
1253 the same as the medically needy component of the Medicaid program,
1254 except that earned monthly gross income of up to one hundred fifty
1255 dollars shall be disregarded. Unearned income shall not be
1256 disregarded. No person who has family assets exceeding one thousand
1257 dollars shall be eligible. No person shall be eligible for assistance
1258 under this section if such person made, during the three months prior
1259 to the month of application, an assignment or transfer or other
1260 disposition of property for less than fair market value. The number of
1261 months of ineligibility due to such disposition shall be determined by
1262 dividing the fair market value of such property, less any consideration
1263 received in exchange for its disposition, by five hundred dollars. Such
1264 period of ineligibility shall commence in the month in which the
1265 person is otherwise eligible for benefits. Any assignment, transfer or
1266 other disposition of property, on the part of the transferor, shall be
1267 presumed to have been made for the purpose of establishing eligibility
1268 for benefits or services unless such person provides convincing
1269 evidence to establish that the transaction was exclusively for some
1270 other purpose.

1271 (b) [Each person eligible for state-administered general assistance
1272 shall be entitled to receive medical care through a federally qualified
1273 health center or other primary care provider as determined by the
1274 commissioner. The Commissioner of Social Services shall determine
1275 appropriate service areas and shall, in the commissioner's discretion,
1276 contract with community health centers, other similar clinics, and
1277 other primary care providers, if necessary, to assure access to primary
1278 care services for recipients who live farther than a reasonable distance
1279 from a federally qualified health center. The commissioner shall assign
1280 and enroll eligible persons in federally qualified health centers and
1281 with any other providers contracted for the program because of access
1282 needs. Each person eligible for state-administered general assistance
1283 shall be entitled to receive hospital services. Medical services under the
1284 program shall be limited to the services provided by a federally
1285 qualified health center, hospital, or other provider contracted for the
1286 program at the commissioner's discretion because of access needs. The
1287 commissioner shall ensure that ancillary services and specialty services
1288 are provided by a federally qualified health center, hospital, or other
1289 providers contracted for the program at the commissioner's discretion.
1290 Ancillary services include, but are not limited to, radiology, laboratory,
1291 and other diagnostic services not available from a recipient's assigned
1292 primary care provider, and durable medical equipment. Specialty
1293 services are services provided by a physician with a specialty that are
1294 not included in ancillary services. Ancillary or specialty services
1295 provided under the program shall not exceed such services provided
1296 under the state-administered general assistance program on July 1,
1297 2003,] Medical services provided under the state-administered general
1298 assistance program shall be the same as those provided under the
1299 Medicaid program, except [for] (1) nonemergency medical
1300 transportation [and vision care services which may be provided on a
1301 limited basis within available appropriations. Notwithstanding any
1302 provision of this subsection, the commissioner may provide, or require
1303 a contractor to provide,] shall be limited to transportation for radiation
1304 oncology, chemotherapy and dialysis, (2) vision care services shall

1305 exclude coverage of eyeglasses, contact lenses and services provided
1306 by an optician, and (3) home health services or skilled nursing facility
1307 coverage for state-administered general assistance recipients being
1308 discharged from a chronic disease hospital shall be provided only
1309 when the provision of such services or coverage is determined to be
1310 cost effective by the commissioner.

1311 [(c) Pharmacy services shall be provided to recipients of state-
1312 administered general assistance through the federally qualified health
1313 center to which they are assigned or through a pharmacy with which
1314 the health center contracts. Recipients who are assigned to a
1315 community health center or similar clinic or primary care provider
1316 other than a federally qualified health center or to a federally qualified
1317 health center that does not have a contract for pharmacy services shall
1318 receive pharmacy services at pharmacies designated by the
1319 commissioner. The Commissioner of Social Services or the managed
1320 care organization or other entity performing administrative functions
1321 for the program as permitted in subsection (d) of this section, shall
1322 require prior authorization for coverage of drugs for the treatment of
1323 erectile dysfunction. The commissioner or the managed care
1324 organization or other entity performing administrative functions for
1325 the program may limit or exclude coverage for drugs for the treatment
1326 of erectile dysfunction for persons who have been convicted of a sexual
1327 offense who are required to register with the Commissioner of Public
1328 Safety pursuant to chapter 969.

1329 (d) The Commissioner of Social Services shall contract with
1330 federally qualified health centers or other primary care providers as
1331 necessary to provide medical services to eligible state-administered
1332 general assistance recipients pursuant to this section. The
1333 commissioner shall, within available appropriations, make payments
1334 to such centers based on their pro rata share of the cost of services
1335 provided or the number of clients served, or both. The Commissioner
1336 of Social Services shall, within available appropriations, make
1337 payments to other providers based on a methodology determined by

1338 the commissioner. The Commissioner of Social Services may reimburse
1339 for extraordinary medical services, provided such services are
1340 documented to the satisfaction of the commissioner. For purposes of
1341 this section, the commissioner may contract with a managed care
1342 organization or other entity to perform administrative functions,
1343 including a grievance process for recipients to access review of a denial
1344 of coverage for a specific medical service, and to operate the program
1345 in whole or in part. Provisions of a contract for medical services
1346 entered into by the commissioner pursuant to this section shall
1347 supersede any inconsistent provision in the regulations of Connecticut
1348 state agencies. A recipient who has exhausted the grievance process
1349 established through such contract and wishes to seek further review of
1350 the denial of coverage for a specific medical service may request a
1351 hearing in accordance with the provisions of section 17b-60.

1352 (e) Each federally qualified health center participating in the
1353 program shall enroll in the federal Office of Pharmacy Affairs Section
1354 340B drug discount program established pursuant to 42 USC 256b to
1355 provide pharmacy services to recipients at Federal Supply Schedule
1356 costs. Each such health center may establish an on-site pharmacy or
1357 contract with a commercial pharmacy to provide such pharmacy
1358 services.]

1359 [(f)] (c) The Commissioner of Social Services shall, within available
1360 appropriations, make payments to hospitals for inpatient services
1361 based on their pro rata share of the cost of services provided or the
1362 number of clients served, or both. [The Commissioner of Social
1363 Services shall, within available appropriations, make payments for any
1364 ancillary or specialty services provided to state-administered general
1365 assistance recipients under this section based on a methodology
1366 determined by the commissioner.]

1367 (d) The Commissioner of Social Services may contract with one or
1368 more administrative services organizations to provide care
1369 coordination, utilization management, disease management, customer

1370 service and review of grievances for recipients of assistance under the
1371 state-administered general assistance program.

1372 [(g)] (e) The Commissioner of Social Services shall seek a waiver of
1373 federal law for the purpose of extending health insurance coverage
1374 under Medicaid to persons who otherwise qualify for medical
1375 assistance under the state-administered general assistance program.
1376 The provisions of section 17b-8 shall apply to this section. If the
1377 commissioner fails to submit the application for the waiver to the joint
1378 standing committees of the General Assembly having cognizance of
1379 matters relating to human services and appropriations by February 1,
1380 2010, the commissioner shall submit a written report to said
1381 committees not later than February 2, 2010. The report shall include,
1382 but not be limited to: (1) An explanation of the reasons for failing to
1383 seek the waiver; and (2) an estimate of the fiscal impact that would
1384 result from the approval of the waiver in one calendar year.

1385 [(h)] (f) Upon approval of the waiver submitted pursuant to
1386 subsection [(g)] (e) of this section, the commissioner may provide [, or
1387 require a contractor, federally qualified health center or other provider
1388 to provide] coverage for home care services, school-based services or
1389 other outpatient community-based services for state-administered
1390 general assistance recipients when the provision of such services or
1391 coverage is determined to be cost effective by the commissioner. [The
1392 commissioner shall contract with federally qualified health centers or
1393 other primary care providers as necessary to provide such services to
1394 eligible state-administered general assistance recipients pursuant to
1395 this section. The commissioner shall, within available appropriations,
1396 make payments to such centers for any home based services, school-
1397 based services or other outpatient community-based services provided
1398 by such centers.]

1399 [(i)] (g) The commissioner, pursuant to section 17b-10, may
1400 implement policies and procedures to administer the provisions of this
1401 section while in the process of adopting such policies and procedures

1402 as regulation, provided the commissioner prints notice of the intent to
1403 adopt the regulation in the Connecticut Law Journal not later than
1404 twenty days after the date of implementation. Such policy shall be
1405 valid until the time final regulations are adopted.

1406 Sec. 47. Section 17b-193 of the general statutes is repealed and the
1407 following is substituted in lieu thereof (*Effective July 1, 2010*):

1408 A person whose application for state-administered general
1409 assistance cash or medical benefits is denied or whose receipt of such
1410 assistance is terminated or modified may request a hearing pursuant to
1411 section 17b-60. [, provided a recipient of medical benefits who seeks
1412 review of a denial of coverage for a specific medical service shall
1413 exhaust the grievance process available pursuant to section 17b-192
1414 prior to requesting such a hearing.]

1415 Sec. 48. Section 17b-290 of the general statutes is repealed and the
1416 following is substituted in lieu thereof (*Effective July 1, 2010*):

1417 As used in sections 17b-289 to 17b-303, inclusive, as amended by
1418 this act, and section 16 of public act 97-1 of the October 29 special
1419 session*:

1420 (1) "Applicant" means an individual over the age of eighteen years
1421 who is a natural or adoptive parent or a legal guardian; a caretaker
1422 relative, foster parent or stepparent with whom the child resides; or a
1423 noncustodial parent under order of a court or family support
1424 magistrate to provide health insurance, who applies for coverage
1425 under the HUSKY Plan, Part B on behalf of a child and shall include a
1426 child who is eighteen years of age or emancipated in accordance with
1427 the provisions of sections 46b-150 to 46b-150e, inclusive, and who is
1428 applying on his own behalf or on behalf of a minor dependent for
1429 coverage under such plan;

1430 (2) "Child" means an individual under nineteen years of age;

1431 (3) "Coinsurance" means the sharing of health care expenses by the

1432 insured and an insurer in a specified ratio;

1433 (4) "Commissioner" means the Commissioner of Social Services;

1434 (5) "Copayment" means a payment made on behalf of an enrollee for
1435 a specified service under the HUSKY Plan, Part B;

1436 (6) "Cost sharing" means arrangements made on behalf of an
1437 enrollee whereby an applicant pays a portion of the cost of health
1438 services, sharing costs with the state and includes copayments,
1439 premiums, deductibles and coinsurance;

1440 (7) "Deductible" means the amount of out-of-pocket expenses that
1441 would be paid for health services on behalf of an enrollee before
1442 becoming payable by the insurer;

1443 (8) "Department" means the Department of Social Services;

1444 (9) "Durable medical equipment" means durable medical
1445 equipment, as defined in Section 1395x(n) of the Social Security Act;

1446 (10) "Eligible beneficiary" means a child who meets the
1447 requirements specified in section 17b-292, as amended by this act,
1448 except a child excluded under the provisions of Subtitle J of Public
1449 Law 105-33 or a child of any municipal employee eligible for
1450 employer-sponsored insurance on or after October 30, 1997, provided a
1451 child of such a municipal employee may be eligible for coverage under
1452 the HUSKY Plan, Part B if dependent coverage was terminated due to
1453 an extreme economic hardship on the part of the employee, as
1454 determined by the commissioner;

1455 (11) "Enrollee" means an eligible beneficiary who receives services
1456 [from a managed care plan] under the HUSKY Plan, Part B;

1457 (12) "Family" means any combination of the following: (A) An
1458 individual; (B) the individual's spouse; (C) any child of the individual
1459 or such spouse; or (D) the legal guardian of any such child if the

1460 guardian resides with the child;

1461 (13) "HUSKY Plan, Part A" means assistance provided to children,
1462 caretaker relatives and pregnant women pursuant to section 17b-261,
1463 as amended by this act, or 17b-277, as amended by this act;

1464 (14) "HUSKY Plan, Part B" means the health insurance plan for
1465 children established pursuant to the provisions of sections 17b-289 to
1466 17b-303, inclusive, as amended by this act, and section 16 of public act
1467 97-1 of the October 29 special session*;

1468 [(15) "HUSKY Plus programs" means two supplemental health
1469 insurance programs established pursuant to section 17b-294 for
1470 medically eligible enrollees of the HUSKY Plan, Part B whose medical
1471 needs cannot be accommodated within the basic benefit package
1472 offered to enrollees. One program shall supplement coverage for those
1473 medically eligible enrollees with intensive physical health needs and
1474 the other program shall supplement coverage for those medically
1475 eligible enrollees with intensive behavioral health needs;]

1476 [(16)] (15) "Income" means income as calculated in the same manner
1477 as under the Medicaid program pursuant to section 17b-261, as
1478 amended by this act;

1479 [(17) "Managed care plan" means a plan offered by an entity that
1480 contracts with the department to provide benefits to enrollees on a
1481 prepaid basis;]

1482 [(18)] (16) "Parent" means a natural parent, stepparent, adoptive
1483 parent, guardian or custodian of a child;

1484 [(19)] (17) "Premium" means any required payment made by an
1485 individual to offset or pay in full the [capitation rate] cost under the
1486 HUSKY Plan, Part B;

1487 [(20)] (18) "Preventive care and services" means: (A) Child
1488 preventive care, including periodic and interperiodic well-child visits,

1489 routine immunizations, health screenings and routine laboratory tests;
1490 (B) prenatal care, including care of all complications of pregnancy; (C)
1491 care of newborn infants, including attendance at high-risk deliveries
1492 and normal newborn care; (D) WIC evaluations; (E) child abuse
1493 assessment required under sections 17a-106a and 46b-129a; (F)
1494 preventive dental care for children; and (G) periodicity schedules and
1495 reporting based on the standards specified by the American Academy
1496 of Pediatrics;

1497 [(21)] (19) "Primary and preventive health care services" means the
1498 services of licensed physicians, optometrists, nurses, nurse
1499 practitioners, midwives and other related health care professionals
1500 which are provided on an outpatient basis, including routine well-
1501 child visits, diagnosis and treatment of illness and injury, laboratory
1502 tests, diagnostic x-rays, prescription drugs, radiation therapy,
1503 chemotherapy, hemodialysis, emergency room services, and outpatient
1504 alcohol and substance abuse services, as defined by the commissioner;

1505 [(22)] (20) "Qualified entity" means any entity: (A) Eligible for
1506 payments under a state plan approved under Medicaid and which
1507 provides medical services under the HUSKY Plan, Part A, or (B) that is
1508 a qualified entity, as defined in 42 USC 1396r-1a, as amended by
1509 Section 708 of Public Law 106-554 and that is determined by the
1510 commissioner to be capable of making the determination of eligibility.
1511 The commissioner shall provide qualified entities with such forms as
1512 are necessary for an application to be made on behalf of a child under
1513 the HUSKY Plan, Part A and information on how to assist parents,
1514 guardians and other persons in completing and filing such forms;

1515 [(23)] (21) "WIC" means the federal Special Supplemental Food
1516 Program for Women, Infants and Children administered by the
1517 Department of Public Health pursuant to section 19a-59c.

1518 Sec. 49. Section 17b-292 of the 2010 supplement to the general
1519 statutes is repealed and the following is substituted in lieu thereof
1520 (*Effective July 1, 2010*):

1521 (a) A child who resides in a household with a family income which
1522 exceeds one hundred eighty-five per cent of the federal poverty level
1523 and does not exceed three hundred per cent of the federal poverty
1524 level may be eligible for subsidized benefits under the HUSKY Plan,
1525 Part B.

1526 (b) A child who resides in a household with a family income over
1527 three hundred per cent of the federal poverty level may be eligible for
1528 unsubsidized benefits under the HUSKY Plan, Part B.

1529 (c) Whenever a court or family support magistrate orders a
1530 noncustodial parent to provide health insurance for a child, such
1531 parent may provide for coverage under the HUSKY Plan, Part B.

1532 (d) To the extent allowed under federal law, the commissioner shall
1533 not pay for services or durable medical equipment under the HUSKY
1534 Plan, Part B if the enrollee has other insurance coverage for the services
1535 or such equipment.

1536 (e) A newborn child who otherwise meets the eligibility criteria for
1537 the HUSKY Plan, Part B shall be eligible for benefits retroactive to his
1538 or her date of birth, provided an application is filed on behalf of the
1539 child not later than thirty days after such date. Any uninsured child
1540 born in a hospital in this state or in a border state hospital shall be
1541 enrolled on an expedited basis in the HUSKY Plan, Part B, provided (1)
1542 the parent or caretaker relative of such child resides in this state, and
1543 (2) the parent or caretaker relative of such child authorizes enrollment
1544 in the program. The commissioner shall pay any premium cost such
1545 family would otherwise incur for the first four months of coverage. [to
1546 the managed care organization selected by the parent or caretaker
1547 relative to provide coverage for such child.]

1548 (f) The commissioner shall implement presumptive eligibility for
1549 children applying for Medicaid. Such presumptive eligibility
1550 determinations shall be in accordance with applicable federal law and
1551 regulations. The commissioner shall adopt regulations, in accordance

1552 with chapter 54, to establish standards and procedures for the
1553 designation of organizations as qualified entities to grant presumptive
1554 eligibility. Qualified entities shall ensure that, at the time a
1555 presumptive eligibility determination is made, a completed application
1556 for Medicaid is submitted to the department for a full eligibility
1557 determination. In establishing such standards and procedures, the
1558 commissioner shall ensure the representation of state-wide and local
1559 organizations that provide services to children of all ages in each
1560 region of the state.

1561 (g) The commissioner shall provide for a single point of entry
1562 servicer for applicants and enrollees under the HUSKY Plan, Part A
1563 and Part B. The commissioner, in consultation with the servicer, shall
1564 establish a centralized unit to be responsible for processing all
1565 applications for assistance under the HUSKY Plan, Part A and Part B.
1566 The department, through its servicer, shall ensure that a child who is
1567 determined to be eligible for benefits under the HUSKY Plan, Part A,
1568 or the HUSKY Plan, Part B has uninterrupted health insurance
1569 coverage for as long as the parent or guardian elects to enroll or re-
1570 enroll such child in the HUSKY Plan, Part A or Part B. The
1571 commissioner, in consultation with the servicer, and in accordance
1572 with the provisions of section 17b-297, as amended by this act, shall
1573 jointly market both Part A and Part B together as the HUSKY Plan and
1574 shall develop and implement public information and outreach
1575 activities with community programs. Such servicer shall electronically
1576 transmit data with respect to enrollment and disenrollment in the
1577 HUSKY Plan, Part A and Part B to the commissioner.

1578 (h) Upon the expiration of any contractual provisions entered into
1579 pursuant to subsection (g) of this section, the commissioner shall
1580 develop a new contract for single point of entry services. [and
1581 managed care enrollment brokerage services.] The commissioner may
1582 enter into one or more contractual arrangements for such services for a
1583 contract period not to exceed seven years. Such contracts shall include
1584 performance measures, including, but not limited to, specified time

1585 limits for the processing of applications, parameters setting forth the
1586 requirements for a completed and reviewable application and the
1587 percentage of applications forwarded to the department in a complete
1588 and timely fashion. Such contracts shall also include a process for
1589 identifying and correcting noncompliance with established
1590 performance measures, including sanctions applicable for instances of
1591 continued noncompliance with performance measures.

1592 (i) The single point of entry servicer shall send all applications and
1593 supporting documents to the commissioner for determination of
1594 eligibility. The servicer shall enroll eligible beneficiaries in the
1595 applicant's choice of [managed care plan. Upon] an administrative
1596 services organization. If there is more than one administrative services
1597 organization, upon enrollment in [a managed care plan] an
1598 administrative services organization, an eligible HUSKY Plan Part A or
1599 Part B beneficiary shall remain enrolled in such [managed care plan]
1600 organization for twelve months from the date of such enrollment
1601 unless (1) an eligible beneficiary demonstrates good cause to the
1602 satisfaction of the commissioner of the need to enroll in a different
1603 [managed care plan] organization, or (2) the beneficiary no longer
1604 meets program eligibility requirements.

1605 (j) Not later than ten months after the determination of eligibility for
1606 benefits under the HUSKY Plan, Part A and Part B and annually
1607 thereafter, the commissioner or the servicer, as the case may be, shall,
1608 within existing budgetary resources, mail or, upon request of a
1609 participant, electronically transmit an application form to each
1610 participant in the plan for the purposes of obtaining information to
1611 make a determination on continued eligibility beyond the twelve
1612 months of initial eligibility. To the extent permitted by federal law, in
1613 determining eligibility for benefits under the HUSKY Plan, Part A or
1614 Part B with respect to family income, the commissioner or the servicer
1615 shall rely upon information provided in such form by the participant
1616 unless the commissioner or the servicer has reason to believe that such
1617 information is inaccurate or incomplete. The Department of Social

1618 Services shall annually review a random sample of cases to confirm
1619 that, based on the statistical sample, relying on such information is not
1620 resulting in ineligible clients receiving benefits under HUSKY Plan
1621 Part A or Part B. The determination of eligibility shall be coordinated
1622 with health plan open enrollment periods.

1623 (k) The commissioner shall implement the HUSKY Plan, Part B
1624 while in the process of adopting necessary policies and procedures in
1625 regulation form in accordance with the provisions of section 17b-10.

1626 (l) The commissioner shall adopt regulations, in accordance with
1627 chapter 54, to establish residency requirements and income eligibility
1628 for participation in the HUSKY Plan, Part B and procedures for a
1629 simplified mail-in application process. Notwithstanding the provisions
1630 of section 17b-257b, such regulations shall provide that any child
1631 adopted from another country by an individual who is a citizen of the
1632 United States and a resident of this state shall be eligible for benefits
1633 under the HUSKY Plan, Part B upon arrival in this state.

1634 Sec. 50. Section 17b-300 of the general statutes is repealed and the
1635 following is substituted in lieu thereof (*Effective July 1, 2010*):

1636 The applicant for an enrollee shall notify the [enrollee's managed
1637 care plan] Department of Social Services of any change in circumstance
1638 that could affect the enrollee's continued eligibility for coverage under
1639 the HUSKY Plan, Part B within thirty days of such change. An enrollee
1640 shall be disenrolled if the commissioner determines the enrollee is no
1641 longer eligible for participation in such plan for reasons including, but
1642 not limited to, those specified in section 17b-301 and the nonpayment
1643 of premiums.

1644 Sec. 51. Section 17b-311 of the general statutes is repealed and the
1645 following is substituted in lieu thereof (*Effective July 1, 2010*):

1646 (a) There is established the Charter Oak Health Plan for the purpose
1647 of providing access to health insurance coverage for state residents

1648 who have been uninsured for at least six months and who are
1649 ineligible for other publicly funded health insurance plans. The
1650 Commissioner of Social Services may enter into contracts for the
1651 provision of comprehensive health care for such uninsured state
1652 residents. [The commissioner shall conduct outreach to facilitate
1653 enrollment in the plan.]

1654 (b) The commissioner shall impose cost-sharing requirements in
1655 connection with services provided under the Charter Oak Health Plan.
1656 Such requirements may include, but not be limited to: (1) A monthly
1657 premium; (2) an annual deductible not to exceed one thousand dollars;
1658 (3) a coinsurance payment not to exceed twenty per cent after the
1659 deductible amount is met; (4) tiered copayments for prescription drugs
1660 determined by whether the drug is generic or brand name, formulary
1661 or nonformulary and whether purchased through mail order; (5) no fee
1662 for emergency visits to hospital emergency rooms; (6) a copayment not
1663 to exceed one hundred fifty dollars for nonemergency visits to hospital
1664 emergency rooms; and (7) a lifetime benefit not to exceed one million
1665 dollars.

1666 (c) (1) The Commissioner of Social Services shall provide premium
1667 assistance to eligible state residents whose gross annual income does
1668 not exceed three hundred per cent of the federal poverty level. Such
1669 premium assistance shall be limited to: [(1)] (A) One hundred seventy-
1670 five dollars per month for individuals whose gross annual income is
1671 below one hundred fifty per cent of the federal poverty level; [(2)] (B)
1672 one hundred fifty dollars per month for individuals whose gross
1673 annual income is at or above one hundred fifty per cent of the federal
1674 poverty level but not more than one hundred eighty-five per cent of
1675 the federal poverty level; [(3)] (C) seventy-five dollars per month for
1676 individuals whose gross annual income is above one hundred eighty-
1677 five per cent of the federal poverty level but not more than two
1678 hundred thirty-five per cent of the federal poverty level; and [(4)] (D)
1679 fifty dollars per month for individuals whose gross annual income is
1680 above two hundred thirty-five per cent of the federal poverty level but

1681 not more than three hundred per cent of the federal poverty level.
1682 [Individuals insured under the Charter Oak Health Plan shall pay their
1683 share of payment for coverage in the plan directly to the insurer.]

1684 (2) Notwithstanding the provisions of this subsection, for the fiscal
1685 year ending June 30, 2011, the Commissioner of Social Services shall
1686 only provide premium assistance to state residents who are eligible for
1687 such assistance and who are enrolled in the Charter Oak Health Plan
1688 on June 30, 2010.

1689 (d) The Commissioner of Social Services shall determine minimum
1690 requirements on the amount, duration and scope of benefits under the
1691 Charter Oak Health Plan, except that there shall be no preexisting
1692 condition exclusion. Each participating insurer or administrative
1693 services organization shall provide an internal grievance process by
1694 which an [insured] enrollee in the Charter Oak Health Plan may
1695 request and be provided a review of a denial of coverage under the
1696 plan.

1697 [(e) The Commissioner of Social Services may contract with the
1698 following entities for the purposes of this section: (1) A health care
1699 center subject to the provisions of chapter 698a; (2) a consortium of
1700 federally qualified health centers and other community-based
1701 providers of health services which are funded by the state; or (3) other
1702 consortia of providers of health care services established for the
1703 purposes of this section. Providers of comprehensive health care
1704 services as described in subdivisions (2) and (3) of this subsection shall
1705 not be subject to the provisions of chapter 698a. Any such provider
1706 shall be certified by the commissioner to participate in the Charter Oak
1707 Health Plan in accordance with criteria established by the
1708 commissioner, including, but not limited to, minimum reserve fund
1709 requirements.]

1710 [(f)] (e) The Commissioner of Social Services shall seek proposals
1711 from entities [described in subsection (e) of this section] based on the
1712 cost sharing and benefits described in subsections (b) and (c) of this

1713 section. The commissioner may approve an alternative plan in order to
1714 make coverage options available to those eligible to be insured under
1715 the plan.

1716 [(g)] (f) The Commissioner of Social Services, pursuant to section
1717 17b-10, may implement policies and procedures to administer the
1718 provisions of this section while in the process of adopting such policies
1719 and procedures as regulation, provided the commissioner prints notice
1720 of the intent to adopt the regulation in the Connecticut Law Journal
1721 not later than twenty days after the date of implementation. Such
1722 policies shall be valid until the time final regulations are adopted and
1723 may include: (1) Exceptions to the requirement that a resident be
1724 uninsured for at least six months to be eligible for the Charter Oak
1725 Health Plan; and (2) requirements for open enrollment and limitations
1726 on the ability of enrollees to change plans between such open
1727 enrollment periods.

1728 Sec. 52. Subsection (b) of section 17b-29 of the general statutes is
1729 repealed and the following is substituted in lieu thereof (*Effective July*
1730 *1, 2010*):

1731 (b) Beginning September 1, 1997, at meetings scheduled by the
1732 council, the Commissioner of Social Services and the Labor
1733 Commissioner shall update the council on the implementation of the
1734 temporary family assistance program and the employment services
1735 program. The council shall submit recommendations to the
1736 department regarding, but not limited to, the availability of quality
1737 child care and the provision of seamless child care services, procedures
1738 for informing parents and teenagers about family planning and
1739 pregnancy prevention, client education regarding their rights and
1740 responsibilities, the effectiveness of child support enforcement, the
1741 effect of reduced exemptions, time limits and increased sanctions, the
1742 coordination with Medicaid [managed care] and health care reform
1743 measures and the fiscal impact of these program changes.

1744 Sec. 53. Subsection (a) of section 17b-261 of the 2010 supplement to

1745 the general statutes is repealed and the following is substituted in lieu
1746 thereof (*Effective July 1, 2010*):

1747 (a) Medical assistance shall be provided for any otherwise eligible
1748 person whose income, including any available support from legally
1749 liable relatives and the income of the person's spouse or dependent
1750 child, is not more than one hundred forty-three per cent, pending
1751 approval of a federal waiver applied for pursuant to subsection (e) of
1752 this section, of the benefit amount paid to a person with no income
1753 under the temporary family assistance program in the appropriate
1754 region of residence and if such person is an institutionalized
1755 individual as defined in Section 1917(c) of the Social Security Act, 42
1756 USC 1396p(c), and has not made an assignment or transfer or other
1757 disposition of property for less than fair market value for the purpose
1758 of establishing eligibility for benefits or assistance under this section.
1759 Any such disposition shall be treated in accordance with Section
1760 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
1761 property made on behalf of an applicant or recipient or the spouse of
1762 an applicant or recipient by a guardian, conservator, person
1763 authorized to make such disposition pursuant to a power of attorney
1764 or other person so authorized by law shall be attributed to such
1765 applicant, recipient or spouse. A disposition of property ordered by a
1766 court shall be evaluated in accordance with the standards applied to
1767 any other such disposition for the purpose of determining eligibility.
1768 The commissioner shall establish the standards for eligibility for
1769 medical assistance at one hundred forty-three per cent of the benefit
1770 amount paid to a family unit of equal size with no income under the
1771 temporary family assistance program in the appropriate region of
1772 residence. Except as provided in section 17b-277, as amended by this
1773 act, the medical assistance program shall provide coverage to persons
1774 under the age of nineteen with family income up to one hundred
1775 eighty-five per cent of the federal poverty level without an asset limit
1776 and to persons under the age of nineteen and their parents and needy
1777 caretaker relatives, who qualify for coverage under Section 1931 of the
1778 Social Security Act, with family income up to one hundred eighty-five

1779 per cent of the federal poverty level without an asset limit. Such levels
1780 shall be based on the regional differences in such benefit amount, if
1781 applicable, unless such levels based on regional differences are not in
1782 conformance with federal law. Any income in excess of the applicable
1783 amounts shall be applied as may be required by said federal law, and
1784 assistance shall be granted for the balance of the cost of authorized
1785 medical assistance. [All contracts entered into on and after July 1, 1997,
1786 pursuant to this section shall include provisions for collaboration of
1787 managed care organizations with the Nurturing Families Network
1788 established pursuant to section 17b-751b.] The Commissioner of Social
1789 Services shall provide applicants for assistance under this section, at
1790 the time of application, with a written statement advising them of (1)
1791 the effect of an assignment or transfer or other disposition of property
1792 on eligibility for benefits or assistance, (2) the effect that having income
1793 that exceeds the limits prescribed in this subsection will have with
1794 respect to program eligibility, and (3) the availability of, and eligibility
1795 for, services provided by the Nurturing Families Network established
1796 pursuant to section 17b-751b. Persons who are determined ineligible
1797 for assistance pursuant to this section shall be provided a written
1798 statement notifying such persons of their ineligibility and advising
1799 such persons of the availability of HUSKY Plan, Part B health
1800 insurance benefits.

1801 Sec. 54. Subsection (e) of section 17b-274d of the 2010 supplement to
1802 the general statutes is repealed and the following is substituted in lieu
1803 thereof (*Effective July 1, 2010*):

1804 (e) The Department of Social Services, in consultation with the
1805 Pharmaceutical and Therapeutics Committee, may adopt preferred
1806 drug lists for use in the Medicaid, state-administered general
1807 assistance and ConnPACE programs. [The Department of Social
1808 Services, upon entering into a contract for the provision of prescription
1809 drug coverage to medical assistance recipients receiving services in a
1810 managed care setting as provided by section 17b-266a, shall in
1811 consultation with the Pharmaceutical and Therapeutics Committee,

1812 expand the preferred drug list for use in the HUSKY Plan, Part A and
1813 Part B.] To the extent feasible, the department shall review all drugs
1814 included on the preferred drug lists at least every twelve months, and
1815 may recommend additions to, and deletions from, the preferred drug
1816 lists, to ensure that the preferred drug lists provide for medically
1817 appropriate drug therapies for Medicaid, state-administered general
1818 assistance and ConnPACE patients. For the fiscal year ending June 30,
1819 2004, such drug lists shall be limited to use in the Medicaid and
1820 ConnPACE programs and cover three classes of drugs, including
1821 proton pump inhibitors and two other classes of drugs determined by
1822 the Commissioner of Social Services. Not later than June 30, 2005, the
1823 Department of Social Services, in consultation with the Pharmaceutical
1824 and Therapeutic Committee shall expand such drug lists to include
1825 other classes of drugs, except as provided in subsection (f) of this
1826 section, in order to achieve savings reflected in the amounts
1827 appropriated to the department, for the various components of the
1828 program, in the state budget act.

1829 Sec. 55. Subsection (a) of section 17b-297 of the general statutes is
1830 repealed and the following is substituted in lieu thereof (*Effective July*
1831 *1, 2010*):

1832 (a) The commissioner, in consultation with the Children's Health
1833 Council [, the Medicaid Managed Care Council] and the 2-1-1 Infoline
1834 program, shall develop mechanisms to increase outreach and
1835 maximize enrollment of eligible children and adults in the HUSKY
1836 Plan, Part A or Part B, including, but not limited to, development of
1837 mail-in applications and appropriate outreach materials through the
1838 Department of Revenue Services, the Labor Department, the
1839 Department of Social Services, the Department of Public Health, the
1840 Department of Children and Families and the Office of Protection and
1841 Advocacy for Persons with Disabilities. Such mechanisms shall seek to
1842 maximize federal funds where appropriate for such outreach activities.

1843 Sec. 56. Section 17b-306a of the 2010 supplement to the general

1844 statutes is repealed and the following is substituted in lieu thereof
1845 (*Effective July 1, 2010*):

1846 (a) The Commissioner of Social Services, in collaboration with the
1847 Commissioners of Public Health and Children and Families, shall
1848 establish a child health quality improvement program for the purpose
1849 of promoting the implementation of evidence-based strategies by
1850 providers participating in the HUSKY Plan, Part A and Part B to
1851 improve the delivery of and access to children's health services. Such
1852 strategies shall focus on physical, dental and mental health services
1853 and shall include, but need not be limited to: (1) Methods for early
1854 identification of children with special health care needs; (2) integration
1855 of care coordination and care planning into children's health services;
1856 (3) implementation of standardized data collection to measure
1857 performance improvement; and (4) implementation of family-centered
1858 services in patient care, including, but not limited to, the development
1859 of parent-provider partnerships. The Commissioner of Social Services
1860 shall seek the participation of public and private entities that are
1861 dedicated to improving the delivery of health services, including
1862 medical, dental and mental health providers, academic professionals
1863 with experience in health services research and performance
1864 measurement and improvement, and any other entity deemed
1865 appropriate by the Commissioner of Social Services, to promote such
1866 strategies. The commissioner shall ensure that such strategies reflect
1867 new developments and best practices in the field of children's health
1868 services. As used in this section, "evidence-based strategies" means
1869 policies, procedures and tools that are informed by research and
1870 supported by empirical evidence, including, but not limited to,
1871 research developed by organizations such as the American Academy
1872 of Pediatrics, the American Academy of Family Physicians, the
1873 National Association of Pediatric Nurse Practitioners and the Institute
1874 of Medicine.

1875 (b) Not later than July 1, 2008, and annually thereafter, the
1876 Commissioner of Social Services shall report, in accordance with

1877 section 11-4a, to the joint standing committees of the General
1878 Assembly having cognizance of matters relating to human services,
1879 public health and appropriations [, and to the Medicaid Managed Care
1880 Council] on (1) the implementation of any strategies developed
1881 pursuant to subsection (a) of this section, and (2) the efficacy of such
1882 strategies in improving the delivery of and access to health services for
1883 children enrolled in the HUSKY Plan.

1884 [(c) The Commissioner of Social Services, in collaboration with the
1885 Medicaid Managed Care Council, shall, subject to available
1886 appropriations, prepare, annually, a report concerning health care
1887 choices under the HUSKY Plan, Part A. Such report shall include, but
1888 not be limited to, a comparison of the performance of each managed
1889 care organization, the primary care case management program and
1890 other member service delivery choices. The commissioner shall
1891 provide a copy of each report to all HUSKY Plan, Part A members.]

1892 Sec. 57. Section 19a-45b of the general statutes is repealed and the
1893 following is substituted in lieu thereof (*Effective July 1, 2010*):

1894 On or after January 1, 2007, and within any available federal or
1895 private funds, the Commissioner of Public Health, in consultation with
1896 the [Medicaid managed care organizations administering the HUSKY
1897 Plan, Part A, as defined in section 17b-290] Commissioner of Social
1898 Services, may establish a medical home pilot program in one region of
1899 the state to be determined by said commissioner in order to enhance
1900 health outcomes for children, including children with special health
1901 care needs, by ensuring that each child has a primary care physician
1902 who will provide continuous comprehensive health care for such child.
1903 Said commissioner may solicit and accept private funds to implement
1904 such pilot program.

1905 Sec. 58. Section 17a-22j of the general statutes is repealed and the
1906 following is substituted in lieu thereof (*Effective July 1, 2010*):

1907 (a) There is established a Behavioral Health Partnership Oversight

1908 Council which shall advise the Commissioners of Children and
1909 Families and Social Services on the planning and implementation of
1910 the Behavioral Health Partnership.

1911 (b) The council shall consist of the following members:

1912 (1) Four appointed by the speaker of the House of Representatives;
1913 two of whom are representatives of general or specialty psychiatric
1914 hospitals; one of whom is an adult with a psychiatric disability; and
1915 one of whom is an advocate for adults with psychiatric disabilities;

1916 (2) Four appointed by the president pro tempore of the Senate, two
1917 of whom are parents of children who have a behavioral health
1918 disorder or have received child protection or juvenile justice services
1919 from the Department of Children and Families; one of whom has
1920 expertise in health policy and evaluation; and one of whom is an
1921 advocate for children with behavioral health disorders;

1922 (3) Two appointed by the majority leader of the House of
1923 Representatives; one of whom is a primary care provider serving
1924 children pursuant to the HUSKY Plan; and one of whom is a child
1925 psychiatrist serving children pursuant to the HUSKY Plan;

1926 (4) Two appointed by the majority leader of the Senate; one of
1927 whom is either an adult with a substance use disorder or an advocate
1928 for adults with substance use disorders; and one of whom is a
1929 representative of school-based health clinics;

1930 (5) Two appointed by the minority leader of the House of
1931 Representatives; one of whom is a provider of community-based
1932 behavioral health services for adults; and one of whom is a provider of
1933 residential treatment for children;

1934 (6) [Two] One appointed by the minority leader of the Senate [; one
1935 of whom] who is a provider of community-based services for children
1936 with behavioral health problems; [and one of whom is a member of the
1937 advisory council on Medicaid managed care;]

1938 (7) Four appointed by the Governor; two of whom are
1939 representatives of general or specialty psychiatric hospitals and two of
1940 whom are parents of children who have a behavioral health disorder
1941 or have received child protection or juvenile justice services from the
1942 Department of Children and Families;

1943 (8) The chairpersons and ranking members of the joint standing
1944 committees of the General Assembly having cognizance of matters
1945 relating to human services, public health, appropriations and the
1946 budgets of state agencies, or their designees;

1947 (9) A member of the Community Mental Health Strategy Board,
1948 established pursuant to section 17a-485b, as selected by said board;

1949 (10) The Commissioner of Mental Health and Addiction Services, or
1950 said commissioner's designee;

1951 (11) Seven nonvoting ex-officio members, one each appointed by the
1952 Commissioners of Social Services, Children and Families, Mental
1953 Health and Addiction Services and Education to represent his or her
1954 department and one appointed by the State Comptroller, the Secretary
1955 of the Office of Policy and Management and the Office of Health Care
1956 Access to represent said offices;

1957 (12) One or more consumers appointed by the chairpersons of the
1958 council, to be nonvoting ex-officio members; and

1959 (13) One representative from [the] each administrative services
1960 organization [and from each Medicaid managed care organization]
1961 under contract with the Department of Social Services to provide such
1962 services for recipients of assistance under Medicaid, HUSKY Plans Part
1963 A and Part B and the Charter Oak Health Plan, to be nonvoting ex-
1964 officio members.

1965 (c) All appointments to the council shall be made no later than July
1966 1, 2005, except that the chairpersons of the council may appoint
1967 additional consumers to the council as nonvoting ex-officio members.

1968 Any vacancy shall be filled by the appointing authority.

1969 (d) [The chairpersons of the advisory council on Medicaid managed
1970 care] On or after July 1, 2010, the members of the Behavioral Health
1971 Partnership Oversight Council shall select the chairpersons of the
1972 [Behavioral Health Partnership Oversight Council] council from
1973 among the members of [such oversight] the council. Such chairpersons
1974 shall convene the first meeting of the council, which shall be held not
1975 later than August 1, 2005. The council shall meet at least monthly
1976 thereafter.

1977 (e) The Joint Committee on Legislative Management shall provide
1978 administrative support to the chairpersons and assistance in convening
1979 the council's meetings.

1980 (f) The council shall make specific recommendations on matters
1981 related to the planning and implementation of the Behavioral Health
1982 Partnership which shall include, but not be limited to: (1) Review of
1983 any contract entered into by the Departments of Children and Families
1984 and Social Services with an administrative services organization, to
1985 assure that the administrative services organization's decisions are
1986 based solely on clinical management criteria developed by the clinical
1987 management committee established in section 17a-22k; (2) review of
1988 behavioral health services pursuant to Title XIX and Title XXI of the
1989 Social Security Act to assure that federal revenue is being maximized;
1990 and (3) review of periodic reports on the program activities, finances
1991 and outcomes, including reports from the director of the Behavioral
1992 Health Partnership on achievement of service delivery system goals,
1993 pursuant to section 17a-22i. The council may conduct or cause to be
1994 conducted an external, independent evaluation of the Behavioral
1995 Health Partnership.

1996 (g) On or before March 1, 2006, and annually thereafter, the council
1997 shall submit a report to the Governor and, in accordance with section
1998 11-4a, to the joint standing committees of the General Assembly having
1999 cognizance of matters relating to human services, public health and

2000 appropriations and the budgets of state agencies, on the council's
2001 activities and progress.

2002 Sec. 59. Subsection (f) of section 17a-22p of the general statutes is
2003 repealed and the following is substituted in lieu thereof (*Effective July*
2004 *1, 2010*):

2005 (f) The Behavioral Health Partnership shall establish policies to
2006 coordinate benefits received under the partnership with [those] other
2007 benefits received [through] under Medicaid, [managed care
2008 organizations for persons covered by both a Medicaid managed care
2009 organization and the Behavioral Health Partnership.] Such policies
2010 shall specify a coordinated delivery of both physical and behavioral
2011 health care. The policies shall be submitted to the Behavioral Health
2012 Partnership Oversight Council for review and comment.

2013 Sec. 60. Subsection (b) of section 12-202a of the general statutes is
2014 repealed and the following is substituted in lieu thereof (*Effective from*
2015 *passage*):

2016 (b) Notwithstanding the provisions of subsection (a) of this section,
2017 the tax shall not apply to:

2018 (1) Any new or renewal contract or policy entered into with the state
2019 on or after July 1, 1997, to provide health care coverage to state
2020 employees, retirees and their dependents;

2021 (2) Any subscriber charges received from the federal government to
2022 provide coverage for Medicare patients;

2023 (3) Any subscriber charges received under a contract or policy
2024 entered into with the state to provide health care coverage to Medicaid
2025 recipients, [under the Medicaid managed care program established
2026 pursuant to section 17b-28,] which charges are attributable to a period
2027 on or after January 1, 1998;

2028 (4) Any new or renewal contract or policy entered into with the state

2029 on or after April 1, 1998, to provide health care coverage to eligible
2030 beneficiaries under the HUSKY Medicaid Plan Part A [.] or HUSKY
2031 Part B, [or the HUSKY Plus programs,] each as defined in section 17b-
2032 290, as amended by this act;

2033 (5) Any new or renewal contract or policy entered into with the state
2034 on or after April 1, 1998, to provide health care coverage to recipients
2035 of state-administered general assistance pursuant to section 17b-192, as
2036 amended by this act;

2037 (6) Any new or renewal contract or policy entered into with the state
2038 on or after February 1, 2000, to provide health care coverage to retired
2039 teachers, spouses or surviving spouses covered by plans offered by the
2040 state teachers' retirement system;

2041 (7) Any new or renewal contract or policy entered into on or after
2042 July 1, 2001, to provide health care coverage to employees of a
2043 municipality and their dependents under a plan procured pursuant to
2044 section 5-259;

2045 (8) Any new or renewal contract or policy entered into on or after
2046 July 1, 2001, to provide health care coverage to employees of nonprofit
2047 organizations and their dependents under a plan procured pursuant to
2048 section 5-259;

2049 (9) Any new or renewal contract or policy entered into on or after
2050 July 1, 2003, to provide health care coverage to individuals eligible for
2051 a health coverage tax credit and their dependents under a plan
2052 procured pursuant to section 5-259;

2053 (10) Any new or renewal contract or policy entered into on or after
2054 July 1, 2005, to provide health care coverage to employees of
2055 community action agencies and their dependents under a plan
2056 procured pursuant to section 5-259; or

2057 (11) Any new or renewal contract or policy entered into on or after
2058 July 1, 2005, to provide health care coverage to retired members and

2059 their dependents under a plan procured pursuant to section 5-259.

2060 Sec. 61. Subsection (a) of section 17a-450a of the 2010 supplement to
2061 the general statutes is repealed and the following is substituted in lieu
2062 thereof (*Effective from passage*):

2063 (a) The Department of Mental Health and Addiction Services shall
2064 constitute a successor department to the Department of Mental Health.
2065 Whenever the words "Commissioner of Mental Health" are used or
2066 referred to in the following general statutes, the words "Commissioner
2067 of Mental Health and Addiction Services" shall be substituted in lieu
2068 thereof and whenever the words "Department of Mental Health" are
2069 used or referred to in the following general statutes, the words
2070 "Department of Mental Health and Addiction Services" shall be
2071 substituted in lieu thereof: 2c-2b, 4-5, 4-38c, 4-60i, 4-77a, 4a-12, 4a-16, 5-
2072 142, 8-206d, 10-19, 10-71, 10-76d, 17a-14, 17a-26, 17a-31, 17a-33, 17a-218,
2073 17a-246, 17a-450, 17a-451, 17a-452, 17a-453, 17a-454, 17a-455, 17a-456,
2074 17a-457, 17a-458, 17a-459, 17a-460, 17a-464, 17a-465, 17a-466, 17a-467,
2075 17a-468, 17a-470, 17a-471, 17a-472, 17a-473, 17a-474, 17a-476, 17a-478,
2076 17a-479, 17a-480, 17a-481, 17a-482, 17a-483, 17a-484, 17a-498, 17a-499,
2077 17a-502, 17a-506, 17a-510, 17a-511, 17a-512, 17a-513, 17a-519, 17a-528,
2078 17a-560, 17a-561, 17a-562, 17a-565, 17a-576, 17a-581, 17a-582, 17a-675,
2079 [17b-28,] 17b-222, 17b-223, 17b-225, 17b-359, 17b-420, 17b-694, 19a-82,
2080 19a-495, 19a-498, 19a-507a, 19a-507c, 19a-576, 19a-583, 20-14i, 20-14j,
2081 21a-240, 21a-301, 27-122a, 31-222, 38a-514, 46a-28, as amended by this
2082 act, 51-51o, 52-146h and 54-56d.

2083 Sec. 62. Subsection (b) of section 17b-28a of the general statutes is
2084 repealed and the following is substituted in lieu thereof (*Effective from*
2085 *passage*):

2086 (b) There is established a Medicaid waiver unit within the
2087 Department of Social Services for the purposes of developing the
2088 waiver under subsection (a) of this section. The Medicaid waiver unit's
2089 responsibilities shall include, but not be limited to, the following: (1)
2090 [Administrating the Medicaid managed care program, established

2091 pursuant to section 17b-28; (2) contracting] Contracting with and
2092 evaluating prepaid health plans providing Medicaid services,
2093 including negotiation and establishment of capitated rates; [(3)] (2)
2094 assessing quality assurance information compiled by the federally
2095 required independent quality assurance contractor; [(4)] (3) monitoring
2096 contractual compliance; [(5)] (4) evaluating enrollment broker
2097 performance; [(6)] (5) providing assistance to the Insurance
2098 Department for the regulation of Medicaid managed care health plans;
2099 and [(7)] (6) developing a system to compare performance levels
2100 among prepaid health plans providing Medicaid services.

2101 Sec. 63. Section 17b-277 of the 2010 supplement to the general
2102 statutes is repealed and the following is substituted in lieu thereof
2103 (*Effective from passage*):

2104 (a) The Commissioner of Social Services shall provide, in accordance
2105 with federal law and regulations, medical assistance under the
2106 Medicaid program to needy pregnant women whose families have an
2107 income not exceeding two hundred fifty per cent of the federal poverty
2108 level.

2109 (b) The commissioner shall implement presumptive eligibility for
2110 appropriate pregnant women applicants for the Medicaid program in
2111 accordance with Section 1920 of the Social Security Act. The
2112 commissioner shall designate qualified entities to receive and
2113 determine presumptive eligibility under this section consistent with
2114 the provisions of federal law and regulations.

2115 (c) On or before September 30, 2007, the Commissioner of Social
2116 Services shall submit a state plan amendment or, if required by the
2117 federal government, seek a waiver under federal law to provide health
2118 insurance coverage to pregnant women, who do not otherwise have
2119 creditable coverage, as defined in 42 USC 300gg(c), and who have
2120 income above one hundred eighty-five per cent of the federal poverty
2121 level but not in excess of two hundred fifty per cent of the federal
2122 poverty level. Following approval of such state plan amendment or

2123 approval of such waiver application, the commissioner, on or before
2124 January 1, 2008, shall implement the provisions of subsections (a) and
2125 (b) of this section.

2126 (d) Presumptive eligibility for medical assistance shall be
2127 implemented for any uninsured newborn child born in a hospital in
2128 this state or a border state hospital, provided (1) the parent or
2129 caretaker relative of such child resides in this state, and (2) the parent
2130 or caretaker relative of such child authorizes enrollment in the
2131 program.

2132 [(e) The commissioner shall submit biannual reports to the council,
2133 established pursuant to section 17b-28, on the department's compliance
2134 with the administrative processing requirements set forth in subsection
2135 (b) of this section.]

2136 Sec. 64. Section 19a-523 of the general statutes is repealed and the
2137 following is substituted in lieu thereof (*Effective from passage*):

2138 (a) If, from the results of an inspection and investigation in
2139 accordance with section 19a-498, or upon receipt of a report or
2140 complaint from the Commissioner [of Social Services] on Aging,
2141 pursuant to section 17b-408, and upon such review and further
2142 investigation, as the Commissioner of Public Health deems necessary,
2143 the Commissioner of Public Health determines that such nursing home
2144 facility has violated any provision of the Public Health Code relating to
2145 the operation or maintenance of a nursing home facility, the
2146 Commissioner of Public Health may, notwithstanding the provisions
2147 of chapter 54, request the Attorney General to seek a temporary or
2148 permanent injunction and such other relief as may be appropriate to
2149 enjoin such nursing home facility from continuing such violation or
2150 violations. If the court determines such violation or violations exist, it
2151 may grant such injunctive relief and such other relief as justice may
2152 require and may set a time period within which such nursing home
2153 facility shall comply with any such order.

2154 (b) Any appeal taken from any permanent injunction granted under
2155 subsection (a) of this section shall not stay the operation of such
2156 injunction unless the court is of the opinion that great and irreparable
2157 injury will be done by not staying the operation of such injunction.

2158 Sec. 65. Subdivision (9) of section 17a-248 of the general statutes is
2159 repealed and the following is substituted in lieu thereof (*Effective from*
2160 *passage*):

2161 (9) "Participating agencies" includes, but is not limited to, the
2162 Departments of Education, Social Services, Public Health, Children
2163 and Families and Developmental Services, the Insurance Department,
2164 the Board of Education and Services for the Blind [, the Commission on
2165 the Deaf and Hearing Impaired] and the Office of Protection and
2166 Advocacy for Persons with Disabilities.

2167 Sec. 66. Subsection (e) of section 2c-2b of the 2010 supplement to the
2168 general statutes is repealed and the following is substituted in lieu
2169 thereof (*Effective from passage*):

2170 (e) The following governmental entities and programs are
2171 terminated, effective July 1, 2016, unless reestablished in accordance
2172 with the provisions of section 2c-10:

2173 (1) Regional advisory councils for children and youth center
2174 facilities, established under section 17a-30;

2175 (2) Repealed by P.A. 93-262, S. 86, 87;

2176 (3) Advisory Council on Children and Families, established under
2177 section 17a-4;

2178 (4) Board of Education and Services for the Blind, established under
2179 section 10-293;

2180 (5) Repealed by P.A. 84-361, S. 6, 7;

2181 (6) Commission on the Deaf and Hearing Impaired, established

- 2182 under section [46a-27] ~~46a-28~~;
- 2183 (7) Advisory and planning councils for regional centers for the
2184 mentally retarded, established under section 17a-273;
- 2185 (8) Repealed by P.A. 01-141, S. 15, 16;
- 2186 (9) Repealed by P.A. 94-245, S. 45, 46;
- 2187 (10) Repealed by P.A. 85-613, S. 153, 154;
- 2188 (11) State Library Board, established under section 11-1;
- 2189 (12) Advisory Council for Special Education, established under
2190 section 10-76i;
- 2191 (13) Repealed by June 30 Sp. Sess. P.A. 03-6, S. 248;
- 2192 (14) Repealed by June 30 Sp. Sess. P.A. 03-6, S. 248;
- 2193 (15) Repealed by P.A. 89-362, S. 4, 5;
- 2194 (16) Repealed by June Sp. Sess. P.A. 91-14, S. 28, 30;
- 2195 (17) Repealed by P.A. 90-230, S. 100, 101;
- 2196 (18) State Commission on Capitol Preservation and Restoration,
2197 established under section 4b-60;
- 2198 (19) Repealed by P.A. 90-230, S. 100, 101; and
- 2199 (20) Examining Board for Crane Operators, established under
2200 section 29-222.
- 2201 Sec. 67. Section 81 of public act 09-3 of the June special session and
2202 section 107 of public act 09-7 of the September special session are
2203 repealed. (*Effective from passage*)
- 2204 Sec. 68. Sections 17b-28, 17b-266a, 17b-294, 17b-296, 17b-298, 17b-
2205 302, 17b-423, 46a-27, 46a-29, 46a-30 and 46a-32 of the general statutes

2206 are repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2010</i>	17a-317
Sec. 2	<i>July 1, 2010</i>	17b-421
Sec. 3	<i>July 1, 2010</i>	17b-422
Sec. 4	<i>July 1, 2010</i>	17b-424
Sec. 5	<i>July 1, 2010</i>	17b-425
Sec. 6	<i>July 1, 2010</i>	17b-426
Sec. 7	<i>July 1, 2010</i>	17b-427
Sec. 8	<i>July 1, 2010</i>	17b-429
Sec. 9	<i>July 1, 2010</i>	17b-349e
Sec. 10	<i>July 1, 2010</i>	17b-792(a)
Sec. 11	<i>July 1, 2010</i>	17b-400
Sec. 12	<i>July 1, 2010</i>	17b-405
Sec. 13	<i>July 1, 2010</i>	17b-406
Sec. 14	<i>July 1, 2010</i>	17b-407
Sec. 15	<i>July 1, 2010</i>	17b-411
Sec. 16	<i>July 1, 2010</i>	19a-530
Sec. 17	<i>July 1, 2010</i>	19a-531
Sec. 18	<i>July 1, 2010</i>	17b-412
Sec. 19	<i>July 1, 2010</i>	17b-413
Sec. 20	<i>July 1, 2010</i>	New section
Sec. 21	<i>July 1, 2010</i>	46a-28
Sec. 22	<i>July 1, 2010</i>	46a-33a
Sec. 23	<i>July 1, 2010</i>	46a-33b
Sec. 24	<i>July 1, 2010</i>	4-89(g)
Sec. 25	<i>July 1, 2010</i>	51-245(d)
Sec. 26	<i>July 1, 2010</i>	16-256b
Sec. 27	<i>July 1, 2010</i>	9-20(c)
Sec. 28	<i>July 1, 2010</i>	New section
Sec. 29	<i>July 1, 2010</i>	17b-295(a)
Sec. 30	<i>July 1, 2010</i>	New section
Sec. 31	<i>July 1, 2010</i>	New section
Sec. 32	<i>July 1, 2010</i>	17b-197
Sec. 33	<i>July 1, 2010</i>	17b-274d(f)
Sec. 34	<i>July 1, 2010</i>	New section
Sec. 35	<i>July 1, 2010</i>	17b-265d(c)

Sec. 36	<i>from passage</i>	New section
Sec. 37	<i>July 1, 2010</i>	17b-28e
Sec. 38	<i>July 1, 2010</i>	New section
Sec. 39	<i>July 1, 2010</i>	19a-180(a)
Sec. 40	<i>July 1, 2010</i>	19a-175(11)
Sec. 41	<i>July 1, 2010</i>	17b-266
Sec. 42	<i>from passage</i>	New section
Sec. 43	<i>from passage</i>	New section
Sec. 44	<i>from passage</i>	17b-492(a)
Sec. 45	<i>July 1, 2010</i>	New section
Sec. 46	<i>July 1, 2010</i>	17b-192
Sec. 47	<i>July 1, 2010</i>	17b-193
Sec. 48	<i>July 1, 2010</i>	17b-290
Sec. 49	<i>July 1, 2010</i>	17b-292
Sec. 50	<i>July 1, 2010</i>	17b-300
Sec. 51	<i>July 1, 2010</i>	17b-311
Sec. 52	<i>July 1, 2010</i>	17b-29(b)
Sec. 53	<i>July 1, 2010</i>	17b-261(a)
Sec. 54	<i>July 1, 2010</i>	17b-274d(e)
Sec. 55	<i>July 1, 2010</i>	17b-297(a)
Sec. 56	<i>July 1, 2010</i>	17b-306a
Sec. 57	<i>July 1, 2010</i>	19a-45b
Sec. 58	<i>July 1, 2010</i>	17a-22j
Sec. 59	<i>July 1, 2010</i>	17a-22p(f)
Sec. 60	<i>from passage</i>	12-202a(b)
Sec. 61	<i>from passage</i>	17a-450a(a)
Sec. 62	<i>from passage</i>	17b-28a(b)
Sec. 63	<i>from passage</i>	17b-277
Sec. 64	<i>from passage</i>	19a-523
Sec. 65	<i>from passage</i>	17a-248(9)
Sec. 66	<i>from passage</i>	2c-2b(e)
Sec. 67	<i>from passage</i>	Repealer section
Sec. 68	<i>from passage</i>	Repealer section

Statement of Purpose:

To implement the Governor's budget recommendations.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]