



General Assembly

January Session, 2013

Governor's Bill No. 6367

LCO No. 3018



* 0 3 0 1 8 *

Referred to Committee on HUMAN SERVICES

Introduced by:

REP. SHARKEY, 88th Dist.
REP. ARESIMOWICZ, 30th Dist.
SEN. WILLIAMS, 29th Dist.
SEN. LOONEY, 11th Dist.

***AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET
RECOMMENDATIONS FOR HUMAN SERVICES PROGRAMS.***

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

1 Section 1. Subsection (b) of section 10-295 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective July*
3 *1, 2013*):

4 (b) The Commissioner of Rehabilitation Services shall expend funds
5 for the services made available pursuant to subsection (a) of this
6 section from the educational aid for blind and visually handicapped
7 children account in accordance with the provisions of this subsection.
8 The expense of such services shall be paid by the state in an amount
9 not to exceed six thousand four hundred dollars in any one fiscal year
10 for each child who is blind or visually impaired. The Commissioner of
11 Rehabilitation Services may adopt, in accordance with the provisions

12 of chapter 54, such regulations as the commissioner deems necessary
13 to carry out the purpose and intent of this subsection.

14 (1) The Commissioner of Rehabilitation Services shall provide, upon
15 written request from any interested school district, the services of
16 teachers of the visually impaired, based on the levels established in the
17 individualized education or service plan. The Commissioner of
18 Rehabilitation Services shall also make available resources, including,
19 but not limited to, the Braille and large print library, to all teachers of
20 public and nonpublic school children. The commissioner may also
21 provide vision-related professional development and training to all
22 school districts and cover the actual cost for paraprofessionals from
23 school districts to participate in agency-sponsored Braille training
24 programs. The commissioner shall utilize education consultant
25 positions, funded by moneys appropriated from the General Fund, to
26 supplement new staffing that will be made available through the
27 educational aid for the blind and visually handicapped children
28 account, which shall be governed by formal written policies
29 established by the commissioner.

30 (2) The Commissioner of Rehabilitation Services shall use funds
31 appropriated to said account, first to provide specialized books,
32 materials, equipment, supplies, adaptive technology services and
33 devices, specialist examinations and aids, preschool programs and
34 vision-related independent living services, excluding primary
35 educational placement, for eligible children without regard to a per
36 child statutory maximum.

37 (3) The Commissioner of Rehabilitation Services may, within
38 available appropriations, employ certified teachers of the visually
39 impaired in sufficient numbers to meet the requests for services
40 received from school districts. In responding to such requests, the
41 commissioner shall utilize a formula for determining the number of
42 teachers needed to serve the school districts, crediting six points for
43 each Braille-learning child and one point for each other child, with one

44 full-time certified teacher of the visually impaired assigned for every
45 twenty-five points credited. The commissioner shall exercise due
46 diligence to employ the needed number of certified teachers of the
47 visually impaired, but shall not be liable for lack of resources. Funds
48 appropriated to said account may also be utilized to employ
49 rehabilitation teachers, rehabilitation technologists and orientation and
50 mobility teachers in numbers sufficient to provide compensatory skills
51 evaluations and training to blind and visually impaired children. In
52 addition, up to five per cent of such appropriation may also be utilized
53 to employ special assistants to the blind and other support staff
54 necessary to ensure the efficient operation of service delivery. Not later
55 than October first of each year, the Commissioner of Rehabilitation
56 Services shall determine the number of teachers needed based on the
57 formula provided in this subdivision. Based on such determination,
58 the Commissioner of Rehabilitation Services shall estimate the funding
59 needed to pay such teachers' salaries, benefits and related expenses.

60 (4) In any fiscal year, when funds appropriated to cover the
61 combined costs associated with providing the services set forth in
62 subdivisions (2) and (3) of this subsection are projected to be
63 insufficient, the Commissioner of Rehabilitation Services [shall be
64 authorized to] may collect revenue from all school districts that have
65 requested such services on a per student pro rata basis, in the sums
66 necessary to cover the projected portion of these services for which
67 there are insufficient appropriations.

68 [(5) Remaining funds in said account, not expended to fund the
69 services set forth in subdivisions (2) and (3) of this subsection, shall be
70 used to cover on a pro rata basis, the actual cost with benefits of
71 retaining a teacher of the visually impaired, directly hired or
72 contracted by the school districts which opt to not seek such services
73 from the Commissioner of Rehabilitation Services, provided such
74 teacher has participated in not less than five hours of professional
75 development training on vision impairment or blindness during the
76 school year. Reimbursement shall occur at the completion of the school

77 year, using the caseload formula denoted in subdivision (3) of this
78 section, with twenty-five points allowed for the maximum
79 reimbursable amount as established by the commissioner annually.

80 (6) Remaining funds in such account, not expended to fund the
81 services set forth in subdivisions (2), (3) and (5) of this subsection, shall
82 be distributed to the school districts on a pro rata formula basis with a
83 two-to-one credit ratio for Braille-learning students to non-Braille-
84 learning students in the school district based upon the annual child
85 count data provided pursuant to subdivision (1) of this subsection,
86 provided the school district submits an annual progress report in a
87 format prescribed by the commissioner for each eligible child.]

88 Sec. 2. Section 17b-607 of the general statutes is repealed and the
89 following is substituted in lieu thereof (*Effective July 1, 2013*):

90 (a) The Commissioner of [Social] Rehabilitation Services is
91 authorized to establish and administer a fund to be known as the
92 Assistive Technology Revolving Fund. Said fund shall be used by said
93 commissioner to make loans to persons with disabilities, senior
94 citizens or their family members for the purchase of assistive
95 technology and adaptive equipment and services. Each such loan shall
96 be made for a term of not more than [five] ten years. Any loans made
97 under this section shall bear interest at a [rate to be determined in
98 accordance with subsection (t) of section 3-20] fixed rate, not to exceed
99 six per cent. Said commissioner is authorized to expend any funds
100 necessary for the reasonable direct expenses relating to the
101 administration of said fund. Said commissioner shall adopt
102 regulations, in accordance with the provisions of chapter 54, to
103 implement the purposes of this section.

104 (b) The State Bond Commission shall have power from time to time
105 to authorize the issuance of bonds of the state in one or more series in
106 accordance with section 3-20 and in a principal amount necessary to
107 carry out the purposes of this section, but not in excess of an aggregate

108 amount of one million dollars. All of said bonds shall be payable at
109 such place or places as may be determined by the Treasurer pursuant
110 to section 3-19 and shall bear such date or dates, mature at such time or
111 times, not exceeding five years from their respective dates, bear
112 interest at such rate or different or varying rates and payable at such
113 time or times, be in such denominations, be in such form with or
114 without interest coupons attached, carry such registration and transfer
115 privileges, be payable in such medium of payment and be subject to
116 such terms of redemption with or without premium as, irrespective of
117 the provisions of said section 3-20, may be provided by the
118 authorization of the State Bond Commission or fixed in accordance
119 therewith. The proceeds of the sale of such bonds shall be deposited in
120 the Assistive Technology Revolving Fund created by this section. Such
121 bonds shall be general obligations of the state and the full faith and
122 credit of the state of Connecticut are pledged for the payment of the
123 principal of and interest on such bonds as the same become due.
124 Accordingly, and as part of the contract of the state with the holders of
125 such bonds, appropriation of all amounts necessary for punctual
126 payment of such principal and interest is hereby made and the
127 Treasurer shall pay such principal and interest as the same become
128 due. Net earnings on investments or reinvestments of proceeds,
129 accrued interest and premiums on the issuance of such bonds, after
130 payment therefrom of expenses incurred by the Treasurer or State
131 Bond Commission in connection with their issuance, shall be deposited
132 in the General Fund of the state.

133 (c) The Connecticut Tech Act Project, within the Department of
134 Rehabilitation Services and as authorized by 29 USC 3001, may
135 provide assistive technology evaluation and training services upon the
136 request of any person or any public or private entity, to the extent
137 persons who provide assistive technology services are available. The
138 project may charge a fee to any person or entity receiving such
139 assistive technology evaluation and training services to reimburse the
140 department for its costs. The Commissioner of Rehabilitation Services

141 shall establish fees at reasonable rates that will cover the department's
142 direct and indirect costs.

143 Sec. 3. Subdivision (5) of section 17a-1 of the general statutes is
144 repealed and the following is substituted in lieu thereof (*Effective July*
145 *1, 2013*):

146 (5) "Child" means [a child, as defined in section 46b-120] any person
147 (A) under eighteen years of age, or (B) eighteen years of age or older
148 but under twenty-one years of age who was committed to the
149 commissioner before attaining his or her eighteenth birthday and is: (i)
150 Enrolled full time, or in the commissioner's discretion part time, in an
151 approved secondary education program or an approved program
152 leading to an equivalent credential; (ii) enrolled full time, or in the
153 commissioner's discretion part time, in an institution which provides
154 post-secondary or vocational education; or (iii) participating in a
155 program or activity approved by the commissioner that is designed to
156 promote or remove barriers to employment;

157 Sec. 4. Subsection (a) of section 17a-93 of the general statutes is
158 repealed and the following is substituted in lieu thereof (*Effective July*
159 *1, 2013*):

160 (a) "Child" means any person under eighteen years of age, [except as
161 otherwise specified,] or any person [under twenty-one years of age
162 who is in full-time attendance in a secondary school, a technical school,
163 a college or a state-accredited job training program] eighteen years of
164 age or older but under twenty-one years of age who was committed to
165 the commissioner before attaining his or her eighteenth birthday and
166 is: (1) Enrolled full time, or in the commissioner's discretion part time,
167 in an approved secondary education program or an approved program
168 leading to an equivalent credential; (2) enrolled full time, or in the
169 commissioner's discretion part time, in an institution which provides
170 post-secondary or vocational education; or (3) participating in a
171 program or activity approved by the commissioner that is designed to

172 promote or remove barriers to employment;

173 Sec. 5. Subdivision (1) of section 46b-120 of the general statutes is
174 repealed and the following is substituted in lieu thereof (*Effective July*
175 *1, 2013*):

176 (1) "Child" means any person under eighteen years of age who has
177 not been legally emancipated, except that (A) for purposes of
178 delinquency matters and proceedings, "child" means any person who
179 (i) is at least seven years of age at the time of the alleged commission of
180 a delinquent act and who is (I) under eighteen years of age and has not
181 been legally emancipated, or (II) eighteen years of age or older and
182 committed a delinquent act prior to attaining eighteen years of age, or
183 (ii) is subsequent to attaining eighteen years of age, (I) violates any
184 order of the Superior Court or any condition of probation ordered by
185 the Superior Court with respect to a delinquency proceeding, or (II)
186 wilfully fails to appear in response to a summons under section 46b-
187 133 or at any other court hearing in a delinquency proceeding of which
188 the child had notice, [and] (B) for purposes of family with service
189 needs matters and proceedings, child means a person who is at least
190 seven years of age and is under eighteen years of age, and (C) for
191 purposes of providing post-majority services, any person eighteen
192 years of age or older but under twenty-one years of age who was
193 committed to the Commissioner of Children and Families before
194 attaining his or her eighteenth birthday and is: (i) Enrolled full time, or
195 in said commissioner's discretion part time, in an approved secondary
196 education program or an approved program leading to an equivalent
197 credential; (ii) enrolled full time, or in said commissioner's discretion
198 part time, in an institution which provides post-secondary or
199 vocational education; or (iii) participating in a program or activity
200 approved by said commissioner that is designed to promote or remove
201 barriers to employment;

202 Sec. 6. Subdivision (4) of subsection (f) of section 17b-340 of the
203 general statutes is repealed and the following is substituted in lieu

204 thereof (*Effective July 1, 2013*):

205 (4) For the fiscal year ending June 30, 1992, (A) no facility shall
206 receive a rate that is less than the rate it received for the rate year
207 ending June 30, 1991; (B) no facility whose rate, if determined pursuant
208 to this subsection, would exceed one hundred twenty per cent of the
209 state-wide median rate, as determined pursuant to this subsection,
210 shall receive a rate which is five and one-half per cent more than the
211 rate it received for the rate year ending June 30, 1991; and (C) no
212 facility whose rate, if determined pursuant to this subsection, would be
213 less than one hundred twenty per cent of the state-wide median rate,
214 as determined pursuant to this subsection, shall receive a rate which is
215 six and one-half per cent more than the rate it received for the rate year
216 ending June 30, 1991. For the fiscal year ending June 30, 1993, no
217 facility shall receive a rate that is less than the rate it received for the
218 rate year ending June 30, 1992, or six per cent more than the rate it
219 received for the rate year ending June 30, 1992. For the fiscal year
220 ending June 30, 1994, no facility shall receive a rate that is less than the
221 rate it received for the rate year ending June 30, 1993, or six per cent
222 more than the rate it received for the rate year ending June 30, 1993.
223 For the fiscal year ending June 30, 1995, no facility shall receive a rate
224 that is more than five per cent less than the rate it received for the rate
225 year ending June 30, 1994, or six per cent more than the rate it received
226 for the rate year ending June 30, 1994. For the fiscal years ending June
227 30, 1996, and June 30, 1997, no facility shall receive a rate that is more
228 than three per cent more than the rate it received for the prior rate
229 year. For the fiscal year ending June 30, 1998, a facility shall receive a
230 rate increase that is not more than two per cent more than the rate that
231 the facility received in the prior year. For the fiscal year ending June
232 30, 1999, a facility shall receive a rate increase that is not more than
233 three per cent more than the rate that the facility received in the prior
234 year and that is not less than one per cent more than the rate that the
235 facility received in the prior year, exclusive of rate increases associated
236 with a wage, benefit and staffing enhancement rate adjustment added

237 for the period from April 1, 1999, to June 30, 1999, inclusive. For the
238 fiscal year ending June 30, 2000, each facility, except a facility with an
239 interim rate or replaced interim rate for the fiscal year ending June 30,
240 1999, and a facility having a certificate of need or other agreement
241 specifying rate adjustments for the fiscal year ending June 30, 2000,
242 shall receive a rate increase equal to one per cent applied to the rate the
243 facility received for the fiscal year ending June 30, 1999, exclusive of
244 the facility's wage, benefit and staffing enhancement rate adjustment.
245 For the fiscal year ending June 30, 2000, no facility with an interim rate,
246 replaced interim rate or scheduled rate adjustment specified in a
247 certificate of need or other agreement for the fiscal year ending June
248 30, 2000, shall receive a rate increase that is more than one per cent
249 more than the rate the facility received in the fiscal year ending June
250 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a
251 facility with an interim rate or replaced interim rate for the fiscal year
252 ending June 30, 2000, and a facility having a certificate of need or other
253 agreement specifying rate adjustments for the fiscal year ending June
254 30, 2001, shall receive a rate increase equal to two per cent applied to
255 the rate the facility received for the fiscal year ending June 30, 2000,
256 subject to verification of wage enhancement adjustments pursuant to
257 subdivision (14) of this subsection. For the fiscal year ending June 30,
258 2001, no facility with an interim rate, replaced interim rate or
259 scheduled rate adjustment specified in a certificate of need or other
260 agreement for the fiscal year ending June 30, 2001, shall receive a rate
261 increase that is more than two per cent more than the rate the facility
262 received for the fiscal year ending June 30, 2000. For the fiscal year
263 ending June 30, 2002, each facility shall receive a rate that is two and
264 one-half per cent more than the rate the facility received in the prior
265 fiscal year. For the fiscal year ending June 30, 2003, each facility shall
266 receive a rate that is two per cent more than the rate the facility
267 received in the prior fiscal year, except that such increase shall be
268 effective January 1, 2003, and such facility rate in effect for the fiscal
269 year ending June 30, 2002, shall be paid for services provided until
270 December 31, 2002, except any facility that would have been issued a

271 lower rate effective July 1, 2002, than for the fiscal year ending June 30,
272 2002, due to interim rate status or agreement with the department shall
273 be issued such lower rate effective July 1, 2002, and have such rate
274 increased two per cent effective June 1, 2003. For the fiscal year ending
275 June 30, 2004, rates in effect for the period ending June 30, 2003, shall
276 remain in effect, except any facility that would have been issued a
277 lower rate effective July 1, 2003, than for the fiscal year ending June 30,
278 2003, due to interim rate status or agreement with the department shall
279 be issued such lower rate effective July 1, 2003. For the fiscal year
280 ending June 30, 2005, rates in effect for the period ending June 30, 2004,
281 shall remain in effect until December 31, 2004, except any facility that
282 would have been issued a lower rate effective July 1, 2004, than for the
283 fiscal year ending June 30, 2004, due to interim rate status or
284 agreement with the department shall be issued such lower rate
285 effective July 1, 2004. Effective January 1, 2005, each facility shall
286 receive a rate that is one per cent greater than the rate in effect
287 December 31, 2004. Effective upon receipt of all the necessary federal
288 approvals to secure federal financial participation matching funds
289 associated with the rate increase provided in this subdivision, but in
290 no event earlier than July 1, 2005, and provided the user fee imposed
291 under section 17b-320 is required to be collected, for the fiscal year
292 ending June 30, 2006, the department shall compute the rate for each
293 facility based upon its 2003 cost report filing or a subsequent cost year
294 filing for facilities having an interim rate for the period ending June 30,
295 2005, as provided under section 17-311-55 of the regulations of
296 Connecticut state agencies. For each facility not having an interim rate
297 for the period ending June 30, 2005, the rate for the period ending June
298 30, 2006, shall be determined beginning with the higher of the
299 computed rate based upon its 2003 cost report filing or the rate in
300 effect for the period ending June 30, 2005. Such rate shall then be
301 increased by eleven dollars and eighty cents per day except that in no
302 event shall the rate for the period ending June 30, 2006, be thirty-two
303 dollars more than the rate in effect for the period ending June 30, 2005,
304 and for any facility with a rate below one hundred ninety-five dollars

305 per day for the period ending June 30, 2005, such rate for the period
306 ending June 30, 2006, shall not be greater than two hundred seventeen
307 dollars and forty-three cents per day and for any facility with a rate
308 equal to or greater than one hundred ninety-five dollars per day for
309 the period ending June 30, 2005, such rate for the period ending June
310 30, 2006, shall not exceed the rate in effect for the period ending June
311 30, 2005, increased by eleven and one-half per cent. For each facility
312 with an interim rate for the period ending June 30, 2005, the interim
313 replacement rate for the period ending June 30, 2006, shall not exceed
314 the rate in effect for the period ending June 30, 2005, increased by
315 eleven dollars and eighty cents per day plus the per day cost of the
316 user fee payments made pursuant to section 17b-320 divided by
317 annual resident service days, except for any facility with an interim
318 rate below one hundred ninety-five dollars per day for the period
319 ending June 30, 2005, the interim replacement rate for the period
320 ending June 30, 2006, shall not be greater than two hundred seventeen
321 dollars and forty-three cents per day and for any facility with an
322 interim rate equal to or greater than one hundred ninety-five dollars
323 per day for the period ending June 30, 2005, the interim replacement
324 rate for the period ending June 30, 2006, shall not exceed the rate in
325 effect for the period ending June 30, 2005, increased by eleven and one-
326 half per cent. Such July 1, 2005, rate adjustments shall remain in effect
327 unless (i) the federal financial participation matching funds associated
328 with the rate increase are no longer available; or (ii) the user fee
329 created pursuant to section 17b-320 is not in effect. For the fiscal year
330 ending June 30, 2007, each facility shall receive a rate that is three per
331 cent greater than the rate in effect for the period ending June 30, 2006,
332 except any facility that would have been issued a lower rate effective
333 July 1, 2006, than for the rate period ending June 30, 2006, due to
334 interim rate status or agreement with the department, shall be issued
335 such lower rate effective July 1, 2006. For the fiscal year ending June
336 30, 2008, each facility shall receive a rate that is two and nine-tenths
337 per cent greater than the rate in effect for the period ending June 30,
338 2007, except any facility that would have been issued a lower rate

339 effective July 1, 2007, than for the rate period ending June 30, 2007, due
340 to interim rate status or agreement with the department, shall be
341 issued such lower rate effective July 1, 2007. For the fiscal year ending
342 June 30, 2009, rates in effect for the period ending June 30, 2008, shall
343 remain in effect until June 30, 2009, except any facility that would have
344 been issued a lower rate for the fiscal year ending June 30, 2009, due to
345 interim rate status or agreement with the department shall be issued
346 such lower rate. For the fiscal years ending June 30, 2010, and June 30,
347 2011, rates in effect for the period ending June 30, 2009, shall remain in
348 effect until June 30, 2011, except any facility that would have been
349 issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal
350 year ending June 30, 2011, due to interim rate status or agreement with
351 the department, shall be issued such lower rate. For the fiscal years
352 ending June 30, 2012, and June 30, 2013, rates in effect for the period
353 ending June 30, 2011, shall remain in effect until June 30, 2013, except
354 any facility that would have been issued a lower rate for the fiscal year
355 ending June 30, 2012, or the fiscal year ending June 30, 2013, due to
356 interim rate status or agreement with the department, shall be issued
357 such lower rate. For the fiscal years ending June 30, 2014, and June 30,
358 2015, rates shall not exceed those in effect for the period ending June
359 30, 2013. Any facility that would have been issued a lower rate for the
360 fiscal year ending June 30, 2014, or the fiscal year ending June 30, 2015,
361 due to rebasing, available appropriations, interim rate status or
362 agreement with the department, shall be issued such lower rate. The
363 Commissioner of Social Services shall add fair rent increases to any
364 other rate increases established pursuant to this subdivision for a
365 facility which has undergone a material change in circumstances
366 related to fair rent, except for the fiscal years ending June 30, 2010, June
367 30, 2011, and June 30, 2012, such fair rent increases shall only be
368 provided to facilities with an approved certificate of need pursuant to
369 section 17b-352, 17b-353, 17b-354 or 17b-355. For the fiscal year ending
370 June 30, 2013, the commissioner may, within available appropriations,
371 provide pro rata fair rent increases for facilities which have undergone
372 a material change in circumstances related to fair rent additions placed

373 in service in cost report years ending September 30, 2008, to September
374 30, 2011, inclusive, and not otherwise included in rates issued. For the
375 fiscal year ending June 30, 2013, the commissioner shall add fair rent
376 increases associated with an approved certificate of need pursuant to
377 section 17b-352, 17b-353, 17b-354 or 17b-355. Interim rates may take
378 into account reasonable costs incurred by a facility, including wages
379 and benefits. Notwithstanding the provisions of this section, the
380 Commissioner of Social Services may, [within] subject to available
381 appropriations, increase or decrease rates issued to licensed chronic
382 and convalescent nursing homes and licensed rest homes with nursing
383 supervision.

384 Sec. 7. Subsection (g) of section 17b-340 of the general statutes is
385 repealed and the following is substituted in lieu thereof (*Effective July*
386 *1, 2013*):

387 (g) For the fiscal year ending June 30, 1993, any intermediate care
388 facility for the mentally retarded with an operating cost component of
389 its rate in excess of one hundred forty per cent of the median of
390 operating cost components of rates in effect January 1, 1992, shall not
391 receive an operating cost component increase. For the fiscal year
392 ending June 30, 1993, any intermediate care facility for the mentally
393 retarded with an operating cost component of its rate that is less than
394 one hundred forty per cent of the median of operating cost
395 components of rates in effect January 1, 1992, shall have an allowance
396 for real wage growth equal to thirty per cent of the increase
397 determined in accordance with subsection (q) of section 17-311-52 of
398 the regulations of Connecticut state agencies, provided such operating
399 cost component shall not exceed one hundred forty per cent of the
400 median of operating cost components in effect January 1, 1992. Any
401 facility with real property other than land placed in service prior to
402 October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a
403 rate of return on real property equal to the average of the rates of
404 return applied to real property other than land placed in service for the
405 five years preceding October 1, 1993. For the fiscal year ending June 30,

406 1996, and any succeeding fiscal year, the rate of return on real property
407 for property items shall be revised every five years. The commissioner
408 shall, upon submission of a request, allow actual debt service,
409 comprised of principal and interest, in excess of property costs allowed
410 pursuant to section 17-311-52 of the regulations of Connecticut state
411 agencies, provided such debt service terms and amounts are
412 reasonable in relation to the useful life and the base value of the
413 property. For the fiscal year ending June 30, 1995, and any succeeding
414 fiscal year, the inflation adjustment made in accordance with
415 subsection (p) of section 17-311-52 of the regulations of Connecticut
416 state agencies shall not be applied to real property costs. For the fiscal
417 year ending June 30, 1996, and any succeeding fiscal year, the
418 allowance for real wage growth, as determined in accordance with
419 subsection (q) of section 17-311-52 of the regulations of Connecticut
420 state agencies, shall not be applied. For the fiscal year ending June 30,
421 1996, and any succeeding fiscal year, no rate shall exceed three
422 hundred seventy-five dollars per day unless the commissioner, in
423 consultation with the Commissioner of Developmental Services,
424 determines after a review of program and management costs, that a
425 rate in excess of this amount is necessary for care and treatment of
426 facility residents. For the fiscal year ending June 30, 2002, rate period,
427 the Commissioner of Social Services shall increase the inflation
428 adjustment for rates made in accordance with subsection (p) of section
429 17-311-52 of the regulations of Connecticut state agencies to update
430 allowable fiscal year 2000 costs to include a three and one-half per cent
431 inflation factor. For the fiscal year ending June 30, 2003, rate period, the
432 commissioner shall increase the inflation adjustment for rates made in
433 accordance with subsection (p) of section 17-311-52 of the regulations
434 of Connecticut state agencies to update allowable fiscal year 2001 costs
435 to include a one and one-half per cent inflation factor, except that such
436 increase shall be effective November 1, 2002, and such facility rate in
437 effect for the fiscal year ending June 30, 2002, shall be paid for services
438 provided until October 31, 2002, except any facility that would have
439 been issued a lower rate effective July 1, 2002, than for the fiscal year

440 ending June 30, 2002, due to interim rate status or agreement with the
441 department shall be issued such lower rate effective July 1, 2002, and
442 have such rate updated effective November 1, 2002, in accordance with
443 applicable statutes and regulations. For the fiscal year ending June 30,
444 2004, rates in effect for the period ending June 30, 2003, shall remain in
445 effect, except any facility that would have been issued a lower rate
446 effective July 1, 2003, than for the fiscal year ending June 30, 2003, due
447 to interim rate status or agreement with the department shall be issued
448 such lower rate effective July 1, 2003. For the fiscal year ending June
449 30, 2005, rates in effect for the period ending June 30, 2004, shall
450 remain in effect until September 30, 2004. Effective October 1, 2004,
451 each facility shall receive a rate that is five per cent greater than the
452 rate in effect September 30, 2004. Effective upon receipt of all the
453 necessary federal approvals to secure federal financial participation
454 matching funds associated with the rate increase provided in
455 subdivision (4) of subsection (f) of this section, but in no event earlier
456 than October 1, 2005, and provided the user fee imposed under section
457 17b-320 is required to be collected, each facility shall receive a rate that
458 is four per cent more than the rate the facility received in the prior
459 fiscal year, except any facility that would have been issued a lower rate
460 effective October 1, 2005, than for the fiscal year ending June 30, 2005,
461 due to interim rate status or agreement with the department, shall be
462 issued such lower rate effective October 1, 2005. Such rate increase
463 shall remain in effect unless: (1) The federal financial participation
464 matching funds associated with the rate increase are no longer
465 available; or (2) the user fee created pursuant to section 17b-320 is not
466 in effect. For the fiscal year ending June 30, 2007, rates in effect for the
467 period ending June 30, 2006, shall remain in effect until September 30,
468 2006, except any facility that would have been issued a lower rate
469 effective July 1, 2006, than for the fiscal year ending June 30, 2006, due
470 to interim rate status or agreement with the department, shall be
471 issued such lower rate effective July 1, 2006. Effective October 1, 2006,
472 no facility shall receive a rate that is more than three per cent greater
473 than the rate in effect for the facility on September 30, 2006, except any

474 facility that would have been issued a lower rate effective October 1,
475 2006, due to interim rate status or agreement with the department,
476 shall be issued such lower rate effective October 1, 2006. For the fiscal
477 year ending June 30, 2008, each facility shall receive a rate that is two
478 and nine-tenths per cent greater than the rate in effect for the period
479 ending June 30, 2007, except any facility that would have been issued a
480 lower rate effective July 1, 2007, than for the rate period ending June
481 30, 2007, due to interim rate status, or agreement with the department,
482 shall be issued such lower rate effective July 1, 2007. For the fiscal year
483 ending June 30, 2009, rates in effect for the period ending June 30, 2008,
484 shall remain in effect until June 30, 2009, except any facility that would
485 have been issued a lower rate for the fiscal year ending June 30, 2009,
486 due to interim rate status or agreement with the department, shall be
487 issued such lower rate. For the fiscal years ending June 30, 2010, and
488 June 30, 2011, rates in effect for the period ending June 30, 2009, shall
489 remain in effect until June 30, 2011, except any facility that would have
490 been issued a lower rate for the fiscal year ending June 30, 2010, or the
491 fiscal year ending June 30, 2011, due to interim rate status or
492 agreement with the department, shall be issued such lower rate. For
493 the fiscal year ending June 30, 2012, rates in effect for the period
494 ending June 30, 2011, shall remain in effect until June 30, 2012, except
495 any facility that would have been issued a lower rate for the fiscal year
496 ending June 30, 2012, due to interim rate status or agreement with the
497 department, shall be issued such lower rate. For the fiscal years ending
498 June 30, 2014, and June 30, 2015, rates shall not exceed those in effect
499 for the period ending June 30, 2013, except the rate paid to a facility
500 may be higher than the rate paid to the facility for the period ending
501 June 30, 2013, if a capital improvement approved by the Department of
502 Developmental Services, in consultation with the Department of Social
503 Services, for the health or safety of the residents was made to the
504 facility during the fiscal year ending June 30, 2014, or June 30, 2015,
505 only to the extent such increases are within available appropriations.
506 Any facility that would have been issued a lower rate for the fiscal year
507 ending June 30, 2014, or the fiscal year ending June 30, 2015, due to

508 interim rate status or agreement with the department, shall be issued
509 such lower rate. For the fiscal year ending June 30, 2013, any facility
510 that has a significant decrease in land and building costs shall receive a
511 reduced rate to reflect such decrease in land and building costs. For the
512 fiscal years ending June 30, 2012, [and] June 30, 2013, June 30, 2014,
513 and June 30, 2015, the Commissioner of Social Services may provide
514 fair rent increases to any facility that has undergone a material change
515 in circumstances related to fair rent and has an approved certificate of
516 need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355.
517 Notwithstanding the provisions of this section, the Commissioner of
518 Social Services may, within available appropriations, increase or
519 decrease rates issued to intermediate care facilities for the mentally
520 retarded to reflect the rebasing of facility costs, or to reflect a reduction
521 in available appropriations as provided in subsection (a) of this
522 section, subject to a maximum increase or decrease as determined by
523 the commissioner.

524 Sec. 8. Subsection (a) of section 17b-244 of the general statutes is
525 repealed and the following is substituted in lieu thereof (*Effective July*
526 *1, 2013*):

527 (a) The room and board component of the rates to be paid by the
528 state to private facilities and facilities operated by regional education
529 service centers which are licensed to provide residential care pursuant
530 to section 17a-227, but not certified to participate in the Title XIX
531 Medicaid program as intermediate care facilities for persons with
532 mental retardation, shall be determined annually by the Commissioner
533 of Social Services, except that rates effective April 30, 1989, shall
534 remain in effect through October 31, 1989. Any facility with real
535 property other than land placed in service prior to July 1, 1991, shall,
536 for the fiscal year ending June 30, 1995, receive a rate of return on real
537 property equal to the average of the rates of return applied to real
538 property other than land placed in service for the five years preceding
539 July 1, 1993. For the fiscal year ending June 30, 1996, and any
540 succeeding fiscal year, the rate of return on real property for property

541 items shall be revised every five years. The commissioner shall, upon
542 submission of a request by such facility, allow actual debt service,
543 comprised of principal and interest, on the loan or loans in lieu of
544 property costs allowed pursuant to section 17-313b-5 of the regulations
545 of Connecticut state agencies, whether actual debt service is higher or
546 lower than such allowed property costs, provided such debt service
547 terms and amounts are reasonable in relation to the useful life and the
548 base value of the property. In the case of facilities financed through the
549 Connecticut Housing Finance Authority, the commissioner shall allow
550 actual debt service, comprised of principal, interest and a reasonable
551 repair and replacement reserve on the loan or loans in lieu of property
552 costs allowed pursuant to section 17-313b-5 of the regulations of
553 Connecticut state agencies, whether actual debt service is higher or
554 lower than such allowed property costs, provided such debt service
555 terms and amounts are determined by the commissioner at the time
556 the loan is entered into to be reasonable in relation to the useful life
557 and base value of the property. The commissioner may allow fees
558 associated with mortgage refinancing provided such refinancing will
559 result in state reimbursement savings, after comparing costs over the
560 terms of the existing proposed loans. For the fiscal year ending June 30,
561 1992, the inflation factor used to determine rates shall be one-half of
562 the gross national product percentage increase for the period between
563 the midpoint of the cost year through the midpoint of the rate year. For
564 fiscal year ending June 30, 1993, the inflation factor used to determine
565 rates shall be two-thirds of the gross national product percentage
566 increase from the midpoint of the cost year to the midpoint of the rate
567 year. For the fiscal years ending June 30, 1996, and June 30, 1997, no
568 inflation factor shall be applied in determining rates. The
569 Commissioner of Social Services shall prescribe uniform forms on
570 which such facilities shall report their costs. Such rates shall be
571 determined on the basis of a reasonable payment for necessary
572 services. Any increase in grants, gifts, fund-raising or endowment
573 income used for the payment of operating costs by a private facility in
574 the fiscal year ending June 30, 1992, shall be excluded by the

575 commissioner from the income of the facility in determining the rates
576 to be paid to the facility for the fiscal year ending June 30, 1993,
577 provided any operating costs funded by such increase shall not
578 obligate the state to increase expenditures in subsequent fiscal years.
579 Nothing contained in this section shall authorize a payment by the
580 state to any such facility in excess of the charges made by the facility
581 for comparable services to the general public. The service component
582 of the rates to be paid by the state to private facilities and facilities
583 operated by regional education service centers which are licensed to
584 provide residential care pursuant to section 17a-227, but not certified
585 to participate in the Title XIX Medicaid programs as intermediate care
586 facilities for persons with mental retardation, shall be determined
587 annually by the Commissioner of Developmental Services in
588 accordance with section 17b-244a. For the fiscal year ending June 30,
589 2008, no facility shall receive a rate that is more than two per cent
590 greater than the rate in effect for the facility on June 30, 2007, except
591 any facility that would have been issued a lower rate effective July 1,
592 2007, due to interim rate status or agreement with the department,
593 shall be issued such lower rate effective July 1, 2007. For the fiscal year
594 ending June 30, 2009, no facility shall receive a rate that is more than
595 two per cent greater than the rate in effect for the facility on June 30,
596 2008, except any facility that would have been issued a lower rate
597 effective July 1, 2008, due to interim rate status or agreement with the
598 department, shall be issued such lower rate effective July 1, 2008. For
599 the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect
600 for the period ending June 30, 2009, shall remain in effect until June 30,
601 2011, except that (1) the rate paid to a facility may be higher than the
602 rate paid to the facility for the period ending June 30, 2009, if a capital
603 improvement required by the Commissioner of Developmental
604 Services for the health or safety of the residents was made to the
605 facility during the fiscal [years] year ending June 30, 2010, or June 30,
606 2011, and (2) any facility that would have been issued a lower rate for
607 the fiscal [years] year ending June 30, 2010, or June 30, 2011, due to
608 interim rate status or agreement with the department, shall be issued

609 such lower rate. For the fiscal year ending June 30, 2012, rates in effect
610 for the period ending June 30, 2011, shall remain in effect until June 30,
611 2012, except that (A) the rate paid to a facility may be higher than the
612 rate paid to the facility for the period ending June 30, 2011, if a capital
613 improvement required by the Commissioner of Developmental
614 Services for the health or safety of the residents was made to the
615 facility during the fiscal year ending June 30, 2012, and (B) any facility
616 that would have been issued a lower rate for the fiscal year ending
617 June 30, 2012, due to interim rate status or agreement with the
618 department, shall be issued such lower rate. For the fiscal year ending
619 June 30, 2013, any facility that has a significant decrease in land and
620 building costs shall receive a reduced rate to reflect such decrease in
621 land and building costs. For the fiscal years ending June 30, 2014, and
622 June 30, 2015, rates in effect for the period ending June 30, 2013, shall
623 remain in effect until June 30, 2015, except that (i) the rate paid to a
624 facility may be higher than the rate paid to the facility for the period
625 ending June 30, 2013, if a capital improvement required by the
626 Commissioner of Developmental Services for the health or safety of the
627 residents was made to the facility during the fiscal year ending June
628 30, 2014, or June 30, 2015, and (ii) any facility that would have been
629 issued a lower rate for the fiscal year ending June 30, 2014, or June 30,
630 2015, due to interim rate status or agreement with the department,
631 shall be issued such lower rate.

632 Sec. 9. Subdivision (1) of subsection (h) of section 17b-340 of the
633 general statutes is repealed and the following is substituted in lieu
634 thereof (*Effective July 1, 2013*):

635 (h) (1) For the fiscal year ending June 30, 1993, any residential care
636 home with an operating cost component of its rate in excess of one
637 hundred thirty per cent of the median of operating cost components of
638 rates in effect January 1, 1992, shall not receive an operating cost
639 component increase. For the fiscal year ending June 30, 1993, any
640 residential care home with an operating cost component of its rate that
641 is less than one hundred thirty per cent of the median of operating cost

642 components of rates in effect January 1, 1992, shall have an allowance
643 for real wage growth equal to sixty-five per cent of the increase
644 determined in accordance with subsection (q) of section 17-311-52 of
645 the regulations of Connecticut state agencies, provided such operating
646 cost component shall not exceed one hundred thirty per cent of the
647 median of operating cost components in effect January 1, 1992.
648 Beginning with the fiscal year ending June 30, 1993, for the purpose of
649 determining allowable fair rent, a residential care home with allowable
650 fair rent less than the twenty-fifth percentile of the state-wide
651 allowable fair rent shall be reimbursed as having allowable fair rent
652 equal to the twenty-fifth percentile of the state-wide allowable fair
653 rent. Beginning with the fiscal year ending June 30, 1997, a residential
654 care home with allowable fair rent less than three dollars and ten cents
655 per day shall be reimbursed as having allowable fair rent equal to
656 three dollars and ten cents per day. Property additions placed in
657 service during the cost year ending September 30, 1996, or any
658 succeeding cost year shall receive a fair rent allowance for such
659 additions as an addition to three dollars and ten cents per day if the
660 fair rent for the facility for property placed in service prior to
661 September 30, 1995, is less than or equal to three dollars and ten cents
662 per day. For the fiscal year ending June 30, 1996, and any succeeding
663 fiscal year, the allowance for real wage growth, as determined in
664 accordance with subsection (q) of section 17-311-52 of the regulations
665 of Connecticut state agencies, shall not be applied. For the fiscal year
666 ending June 30, 1996, and any succeeding fiscal year, the inflation
667 adjustment made in accordance with subsection (p) of section 17-311-
668 52 of the regulations of Connecticut state agencies shall not be applied
669 to real property costs. Beginning with the fiscal year ending June 30,
670 1997, minimum allowable patient days for rate computation purposes
671 for a residential care home with twenty-five beds or less shall be
672 eighty-five per cent of licensed capacity. Beginning with the fiscal year
673 ending June 30, 2002, for the purposes of determining the allowable
674 salary of an administrator of a residential care home with sixty beds or
675 less the department shall revise the allowable base salary to thirty-

676 seven thousand dollars to be annually inflated thereafter in accordance
677 with section 17-311-52 of the regulations of Connecticut state agencies.
678 The rates for the fiscal year ending June 30, 2002, shall be based upon
679 the increased allowable salary of an administrator, regardless of
680 whether such amount was expended in the 2000 cost report period
681 upon which the rates are based. Beginning with the fiscal year ending
682 June 30, 2000, and until the fiscal year ending June 30, 2009, inclusive,
683 the inflation adjustment for rates made in accordance with subsection
684 (p) of section 17-311-52 of the regulations of Connecticut state agencies
685 shall be increased by two per cent, and beginning with the fiscal year
686 ending June 30, 2002, the inflation adjustment for rates made in
687 accordance with subsection (c) of said section shall be increased by one
688 per cent. Beginning with the fiscal year ending June 30, 1999, for the
689 purpose of determining the allowable salary of a related party, the
690 department shall revise the maximum salary to twenty-seven
691 thousand eight hundred fifty-six dollars to be annually inflated
692 thereafter in accordance with section 17-311-52 of the regulations of
693 Connecticut state agencies and beginning with the fiscal year ending
694 June 30, 2001, such allowable salary shall be computed on an hourly
695 basis and the maximum number of hours allowed for a related party
696 other than the proprietor shall be increased from forty hours to forty-
697 eight hours per work week. For the fiscal year ending June 30, 2005,
698 each facility shall receive a rate that is two and one-quarter per cent
699 more than the rate the facility received in the prior fiscal year, except
700 any facility that would have been issued a lower rate effective July 1,
701 2004, than for the fiscal year ending June 30, 2004, due to interim rate
702 status or agreement with the department shall be issued such lower
703 rate effective July 1, 2004. Effective upon receipt of all the necessary
704 federal approvals to secure federal financial participation matching
705 funds associated with the rate increase provided in subdivision (4) of
706 subsection (f) of this section, but in no event earlier than October 1,
707 2005, and provided the user fee imposed under section 17b-320 is
708 required to be collected, each facility shall receive a rate that is
709 determined in accordance with applicable law and subject to

710 appropriations, except any facility that would have been issued a
711 lower rate effective October 1, 2005, than for the fiscal year ending June
712 30, 2005, due to interim rate status or agreement with the department,
713 shall be issued such lower rate effective October 1, 2005. Such rate
714 increase shall remain in effect unless: (A) The federal financial
715 participation matching funds associated with the rate increase are no
716 longer available; or (B) the user fee created pursuant to section 17b-320
717 is not in effect. For the fiscal year ending June 30, 2007, rates in effect
718 for the period ending June 30, 2006, shall remain in effect until
719 September 30, 2006, except any facility that would have been issued a
720 lower rate effective July 1, 2006, than for the fiscal year ending June 30,
721 2006, due to interim rate status or agreement with the department,
722 shall be issued such lower rate effective July 1, 2006. Effective October
723 1, 2006, no facility shall receive a rate that is more than four per cent
724 greater than the rate in effect for the facility on September 30, 2006,
725 except for any facility that would have been issued a lower rate
726 effective October 1, 2006, due to interim rate status or agreement with
727 the department, shall be issued such lower rate effective October 1,
728 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates
729 in effect for the period ending June 30, 2009, shall remain in effect until
730 June 30, 2011, except any facility that would have been issued a lower
731 rate for the fiscal year ending June 30, 2010, or the fiscal year ending
732 June 30, 2011, due to interim rate status or agreement with the
733 department, shall be issued such lower rate, except (i) any facility that
734 would have been issued a lower rate for the fiscal year ending June 30,
735 2010, or the fiscal year ending June 30, 2011, due to interim rate status
736 or agreement with the Commissioner of Social Services shall be issued
737 such lower rate; and (ii) the commissioner may increase a facility's rate
738 for reasonable costs associated with such facility's compliance with the
739 provisions of section 19a-495a concerning the administration of
740 medication by unlicensed personnel. For the fiscal year ending June 30,
741 2012, rates in effect for the period ending June 30, 2011, shall remain in
742 effect until June 30, 2012, except that (I) any facility that would have
743 been issued a lower rate for the fiscal year ending June 30, 2012, due to

744 interim rate status or agreement with the Commissioner of Social
745 Services shall be issued such lower rate; and (II) the commissioner may
746 increase a facility's rate for reasonable costs associated with such
747 facility's compliance with the provisions of section 19a-495a
748 concerning the administration of medication by unlicensed personnel.
749 For the fiscal year ending June 30, 2013, the Commissioner of Social
750 Services may, within available appropriations, provide a rate increase
751 to a residential care home. Any facility that would have been issued a
752 lower rate for the fiscal year ending June 30, 2013, due to interim rate
753 status or agreement with the Commissioner of Social Services shall be
754 issued such lower rate. For the fiscal years ending June 30, 2012, and
755 June 30, 2013, the Commissioner of Social Services may provide fair
756 rent increases to any facility that has undergone a material change in
757 circumstances related to fair rent and has an approved certificate of
758 need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. For the
759 fiscal years ending June 30, 2014, and June 30, 2015, rates in effect for
760 the period ending June 30, 2013, shall remain in effect until June 30,
761 2015, except any facility that would have been issued a lower rate for
762 the fiscal year ending June 30, 2014, or the fiscal year ending June 30,
763 2015, due to interim rate status or agreement with the commissioner,
764 shall be issued such lower rate. The department may, within available
765 appropriations, increase or decrease residential care home rates to
766 reflect the rebasing of facility costs as provided in subsection (a) of this
767 section, subject to a maximum increase, as determined by the
768 commissioner.

769 Sec. 10. (NEW) (*Effective October 1, 2014*) The Commissioner of Social
770 Services shall implement the tenth revision of the International
771 Statistical Classification of Diseases and Related Health Problems for
772 the purposes of all medical assistance programs administered by the
773 Department of Social Services. The Commissioner of Social Services
774 may implement policies and procedures as necessary to carry out the
775 provisions of this section while in the process of adopting the policies
776 and procedures as regulations, provided notice of intent to adopt the

777 regulations is published in the Connecticut Law Journal within twenty
778 days of implementation.

779 Sec. 11. Section 17b-239 of the general statutes is repealed and the
780 following is substituted in lieu thereof (*Effective July 1, 2013*):

781 (a) [The rate to be paid by the state to hospitals receiving
782 appropriations granted by the General Assembly and to freestanding
783 chronic disease hospitals, providing services to persons aided or cared
784 for by the state for routine services furnished to state patients, shall be
785 based upon reasonable cost to such hospital, or the charge to the
786 general public for ward services or the lowest charge for semiprivate
787 services if the hospital has no ward facilities, imposed by such
788 hospital, whichever is lowest, except to the extent, if any, that the
789 commissioner determines that a greater amount is appropriate in the
790 case of hospitals serving a disproportionate share of indigent patients.
791 Such rate shall be promulgated annually by the Commissioner of
792 Social Services.] On and after July 1, 2013, Medicaid rates paid to acute
793 care and children's hospitals shall be based on diagnosis-related
794 groups established and periodically rebased by the Commissioner of
795 Social Services. Rates shall be annually determined for each hospital by
796 multiplying diagnostic-related group relative weights by a base rate.
797 Within available appropriations, the commissioner may, in his or her
798 discretion, make additional payments to hospitals based on criteria to
799 be determined by the commissioner. Nothing contained in this section
800 shall authorize [a] Medicaid payment by the state [for such services] to
801 any such hospital in excess of the charges made by such hospital for
802 comparable services to the general public. [Notwithstanding the
803 provisions of this section, for the rate period beginning July 1, 2000,
804 rates paid to freestanding chronic disease hospitals and freestanding
805 psychiatric hospitals shall be increased by three per cent. For the rate
806 period beginning July 1, 2001, a freestanding chronic disease hospital
807 or freestanding psychiatric hospital shall receive a rate that is two and
808 one-half per cent more than the rate it received in the prior fiscal year
809 and such rate shall remain effective until December 31, 2002. Effective

810 January 1, 2003, a freestanding chronic disease hospital or freestanding
811 psychiatric hospital shall receive a rate that is two per cent more than
812 the rate it received in the prior fiscal year. Notwithstanding the
813 provisions of this subsection, for the period commencing July 1, 2001,
814 and ending June 30, 2003, the commissioner may pay an additional
815 total of no more than three hundred thousand dollars annually for
816 services provided to long-term ventilator patients. For purposes of this
817 subsection, "long-term ventilator patient" means any patient at a
818 freestanding chronic disease hospital on a ventilator for a total of sixty
819 days or more in any consecutive twelve-month period. Effective July 1,
820 2007, each freestanding chronic disease hospital shall receive a rate
821 that is four per cent more than the rate it received in the prior fiscal
822 year.]

823 (b) Effective October 1, 1991, the rate to be paid by the state for the
824 cost of special services rendered by such hospitals shall be established
825 annually by the commissioner for each such hospital based on the
826 reasonable cost to each hospital of such services furnished to state
827 patients. Nothing contained in this subsection shall authorize a
828 payment by the state for such services to any such hospital in excess of
829 the charges made by such hospital for comparable services to the
830 general public.

831 (c) The term "reasonable cost" as used in this section means the cost
832 of care furnished such patients by an efficient and economically
833 operated facility, computed in accordance with accepted principles of
834 hospital cost reimbursement. The commissioner may adjust the rate of
835 payment established under the provisions of this section for the year
836 during which services are furnished to reflect fluctuations in hospital
837 costs. Such adjustment may be made prospectively to cover anticipated
838 fluctuations or may be made retroactive to any date subsequent to the
839 date of the initial rate determination for such year or in such other
840 manner as may be determined by the commissioner. In determining
841 "reasonable cost" the commissioner may give due consideration to
842 allowances for fully or partially unpaid bills, reasonable costs

843 mandated by collective bargaining agreements with certified collective
844 bargaining agents or other agreements between the employer and
845 employees, provided "employees" shall not include persons employed
846 as managers or chief administrators, requirements for working capital
847 and cost of development of new services, including additions to and
848 replacement of facilities and equipment. The commissioner shall not
849 give consideration to amounts paid by the facilities to employees as
850 salary, or to attorneys or consultants as fees, where the responsibility
851 of the employees, attorneys or consultants is to persuade or seek to
852 persuade the other employees of the facility to support or oppose
853 unionization. Nothing in this subsection shall prohibit the
854 commissioner from considering amounts paid for legal counsel related
855 to the negotiation of collective bargaining agreements, the settlement
856 of grievances or normal administration of labor relations.

857 (d) [The state shall also pay to such hospitals for each outpatient
858 clinic and emergency room visit a reasonable rate to be established
859 annually by the commissioner for each hospital, such rate to be
860 determined by the reasonable cost of such services. The emergency
861 room visit rates in effect June 30, 1991, shall remain in effect through
862 June 30, 1993, except those which would have been decreased effective
863 July 1, 1991, or July 1, 1992, shall be decreased.] On or after July 1,
864 2013, hospitals shall be paid for outpatient and emergency room
865 episodes of care based on prospective rates established by the
866 commissioner in accordance with the Medicare Ambulatory Payment
867 Classification system in conjunction with a state conversion factor. The
868 Medicare Ambulatory Payment Classification system shall be modified
869 to provide payment for services not generally covered by Medicare,
870 including, but not limited to, pediatric, obstetric, neonatal and
871 perinatal services. Nothing contained in this subsection shall authorize
872 a payment by the state for such [services] episodes of care to any
873 hospital in excess of the charges made by such hospital for comparable
874 services to the general public. [For those] Those outpatient hospital
875 services that do not have an established Ambulatory Payment

876 Classification code shall be paid on the basis of a ratio of cost to
877 charges, [the ratios] or the fixed fee in effect [June 30, 1991, shall be
878 reduced effective July 1, 1991, by the most recent annual increase in the
879 consumer price index for medical care. For those outpatient hospital
880 services paid on the basis of a ratio of cost to charges, the ratios
881 computed to be effective July 1, 1994, shall be reduced by the most
882 recent annual increase in the consumer price index for medical care.
883 The emergency room visit rates in effect June 30, 1994, shall remain in
884 effect through December 31, 1994] as of July 1, 2014. The
885 Commissioner of Social Services shall establish a fee schedule for
886 outpatient hospital services to be effective on and after January 1, 1995,
887 and may annually modify such fee schedule if such modification is
888 needed to ensure that the conversion to an administrative services
889 organization is cost neutral to hospitals in the aggregate and ensures
890 patient access. Utilization may be a factor in determining cost
891 neutrality. [for the fiscal year ending June 30, 2013. Except with respect
892 to the rate periods beginning July 1, 1999, and July 1, 2000, such fee
893 schedule shall be adjusted annually beginning July 1, 1996, to reflect
894 necessary increases in the cost of services. Notwithstanding the
895 provisions of this subsection, the fee schedule for the rate period
896 beginning July 1, 2000, shall be increased by ten and one-half per cent,
897 effective June 1, 2001. Notwithstanding the provisions of this
898 subsection, outpatient rates in effect as of June 30, 2003, shall remain in
899 effect through June 30, 2005. Effective July 1, 2006, subject to available
900 appropriations, the commissioner shall increase outpatient service fees
901 for services that may include clinic, emergency room, magnetic
902 resonance imaging, and computerized axial tomography.]

903 (e) The commissioner shall adopt regulations, in accordance with
904 the provisions of chapter 54, establishing criteria for defining
905 emergency and nonemergency visits to hospital emergency rooms. All
906 nonemergency visits to hospital emergency rooms shall be paid at the
907 hospital's outpatient clinic services rate. Nothing contained in this
908 subsection or the regulations adopted [hereunder] under this section

909 shall authorize a payment by the state for such services to any hospital
910 in excess of the charges made by such hospital for comparable services
911 to the general public.

912 (f) [On and after October 1, 1984, the state shall pay to an acute care
913 general hospital for the inpatient care of a patient who no longer
914 requires acute care a rate determined by the following schedule: For
915 the first seven days following certification that the patient no longer
916 requires acute care the state shall pay the hospital at a rate of fifty per
917 cent of the hospital's actual cost; for the second seven-day period
918 following certification that the patient no longer requires acute care the
919 state shall pay seventy-five per cent of the hospital's actual cost; for the
920 third seven-day period following certification that the patient no
921 longer requires acute care and for any period of time thereafter, the
922 state shall pay the hospital at a rate of one hundred per cent of the
923 hospital's actual cost.] On and after July 1, 1995, no payment shall be
924 made by the state to an acute care general hospital for the inpatient
925 care of a patient who no longer requires acute care and is eligible for
926 Medicare unless the hospital does not obtain reimbursement from
927 Medicare for that stay.

928 (g) The Commissioner of Social Services may implement policies
929 and procedures as necessary to carry out the provisions of this section
930 while in the process of adopting the policies and procedures as
931 regulations, provided notice of intent to adopt the regulations is
932 published in the Connecticut Law Journal within twenty days of
933 implementation.

934 Sec. 12. Subsection (b) of section 17b-239e of the general statutes is
935 repealed and the following is substituted in lieu thereof (*Effective July*
936 *1, 2013*):

937 (b) The commissioner may establish a blended in-patient hospital
938 case rate that includes services provided to all Medicaid recipients and
939 may exclude certain diagnoses, as determined by the commissioner, if

940 the establishment of such rates is needed to ensure that the conversion
941 to an administrative services organization is cost neutral to hospitals in
942 the aggregate and ensures patient access. Utilization may be a factor in
943 determining cost neutrality. [for the fiscal year ending June 30, 2013.]

944 Sec. 13. Subsection (a) of section 17b-242 of the general statutes is
945 repealed and the following is substituted in lieu thereof (*Effective July*
946 *1, 2013*):

947 (a) The Department of Social Services shall determine the rates to be
948 paid to home health care agencies and homemaker-home health aide
949 agencies by the state or any town in the state for persons aided or
950 cared for by the state or any such town. For the period from February
951 1, 1991, to January 31, 1992, inclusive, payment for each service to the
952 state shall be based upon the rate for such service as determined by the
953 Office of Health Care Access, except that for those providers whose
954 Medicaid rates for the year ending January 31, 1991, exceed the median
955 rate, no increase shall be allowed. For those providers whose rates for
956 the year ending January 31, 1991, are below the median rate, increases
957 shall not exceed the lower of the prior rate increased by the most
958 recent annual increase in the consumer price index for urban
959 consumers or the median rate. In no case shall any such rate exceed the
960 eightieth percentile of rates in effect January 31, 1991, nor shall any rate
961 exceed the charge to the general public for similar services. Rates
962 effective February 1, 1992, shall be based upon rates as determined by
963 the Office of Health Care Access, except that increases shall not exceed
964 the prior year's rate increased by the most recent annual increase in the
965 consumer price index for urban consumers and rates effective
966 February 1, 1992, shall remain in effect through June 30, 1993. Rates
967 effective July 1, 1993, shall be based upon rates as determined by the
968 Office of Health Care Access except if the Medicaid rates for any
969 service for the period ending June 30, 1993, exceed the median rate for
970 such service, the increase effective July 1, 1993, shall not exceed one
971 per cent. If the Medicaid rate for any service for the period ending June
972 30, 1993, is below the median rate, the increase effective July 1, 1993,

973 shall not exceed the lower of the prior rate increased by one and one-
974 half times the most recent annual increase in the consumer price index
975 for urban consumers or the median rate plus one per cent. The
976 Commissioner of Social Services shall establish a fee schedule for home
977 health services to be effective on and after July 1, 1994. The
978 commissioner may annually modify such fee schedule if such
979 modification is needed to ensure that the conversion to an
980 administrative services organization is cost neutral to home health care
981 agencies and homemaker-home health aide agencies in the aggregate
982 and ensures patient access. Utilization may be a factor in determining
983 cost neutrality. [for the fiscal year ending June 30, 2013.] The
984 commissioner shall increase the fee schedule for home health services
985 provided under the Connecticut home-care program for the elderly
986 established under section 17b-342, effective July 1, 2000, by two per
987 cent over the fee schedule for home health services for the previous
988 year. The commissioner may increase any fee payable to a home health
989 care agency or homemaker-home health aide agency upon the
990 application of such an agency evidencing extraordinary costs related to
991 (1) serving persons with AIDS; (2) high-risk maternal and child health
992 care; (3) escort services; or (4) extended hour services. In no case shall
993 any rate or fee exceed the charge to the general public for similar
994 services. A home health care agency or homemaker-home health aide
995 agency which, due to any material change in circumstances, is
996 aggrieved by a rate determined pursuant to this subsection may,
997 within ten days of receipt of written notice of such rate from the
998 Commissioner of Social Services, request in writing a hearing on all
999 items of aggrievement. The commissioner shall, upon the receipt of all
1000 documentation necessary to evaluate the request, determine whether
1001 there has been such a change in circumstances and shall conduct a
1002 hearing if appropriate. The Commissioner of Social Services shall
1003 adopt regulations, in accordance with chapter 54, to implement the
1004 provisions of this subsection. The commissioner may implement
1005 policies and procedures to carry out the provisions of this subsection
1006 while in the process of adopting regulations, provided notice of intent

1007 to adopt the regulations is published in the Connecticut Law Journal
1008 within twenty days of implementing the policies and procedures. Such
1009 policies and procedures shall be valid for not longer than nine months.

1010 Sec. 14. Subsection (a) of section 17b-261m of the general statutes is
1011 repealed and the following is substituted in lieu thereof (*Effective July*
1012 *1, 2013*):

1013 (a) The Commissioner of Social Services may contract with one or
1014 more administrative services organizations to provide care
1015 coordination, utilization management, disease management, customer
1016 service and review of grievances for recipients of assistance under
1017 Medicaid, HUSKY Plan, Parts A and B, and the Charter Oak Health
1018 Plan. Such organization may also provide network management,
1019 credentialing of providers, monitoring of copayments and premiums
1020 and other services as required by the commissioner. Subject to
1021 approval by applicable federal authority, the Department of Social
1022 Services shall utilize the contracted organization's provider network
1023 and billing systems in the administration of the program. In order to
1024 implement the provisions of this section, the commissioner may
1025 establish rates of payment to providers of medical services under this
1026 section if the establishment of such rates is required to ensure that any
1027 contract entered into with an administrative services organization
1028 pursuant to this section is cost neutral to such providers in the
1029 aggregate and ensures patient access. Utilization may be a factor in
1030 determining cost neutrality. [for the fiscal year ending June 30, 2013.]

1031 Sec. 15. Subsection (a) of section 17b-239c of the general statutes is
1032 repealed and the following is substituted in lieu thereof (*Effective July*
1033 *1, 2013*):

1034 (a) Notwithstanding any provision of the general statutes, on and
1035 after July 1, 2011, the Department of Social Services may, within
1036 available appropriations, make interim [monthly] quarterly medical
1037 assistance disproportionate share payments to short-term general

1038 hospitals. The total amount of interim payments made to such
1039 hospitals individually and in the aggregate shall maximize federal
1040 matching payments under the medical assistance program as
1041 determined by the Department of Social Services, in consultation with
1042 the Office of Policy and Management. No payments shall be made
1043 under this section to (1) any hospital which, on July 1, 2011, is within
1044 the class of hospitals licensed by the Department of Public Health as a
1045 children's general hospital, or (2) a short-term acute hospital operated
1046 exclusively by the state other than a short-term acute hospital operated
1047 by the state as a receiver pursuant to chapter 920. The [monthly]
1048 quarterly interim payment amount for each hospital shall be
1049 determined by the Commissioner of Social Services based upon the
1050 information submitted by the hospital pursuant to Section 1001(d) of
1051 Public Law 108-173, the Medicare Prescription Drug, Improvement,
1052 and Modernization Act of 2003.

1053 Sec. 16. Section 17b-28e of the general statutes is repealed and the
1054 following is substituted in lieu thereof (*Effective July 1, 2013*):

1055 (a) The Commissioner of Social Services shall amend the Medicaid
1056 state plan to include, on and after January 1, 2009, hospice services as
1057 optional services covered under the Medicaid program. Said state plan
1058 amendment shall supersede any regulations of Connecticut state
1059 agencies concerning such optional services. [From January 1, 2013, to
1060 June 30, 2013, inclusive, hospice] Hospice services covered under the
1061 Medicaid program for individuals who are residents in long-term care
1062 facilities shall be paid at a rate that is ninety-five per cent of the
1063 facility's per diem rate.

1064 [(b) Effective July 1, 2013, the Commissioner of Social Services shall
1065 amend the Medicaid state plan to include foreign language interpreter
1066 services provided to any beneficiary with limited English proficiency
1067 as a covered service under the Medicaid program. Not later than July
1068 1, 2013, the commissioner shall develop and implement the use of
1069 medical billing codes for foreign language interpreter services.

1070 (c) Effective July 1, 2013, the Department of Social Services shall
1071 report, in accordance with the provisions of section 11-4a, semi-
1072 annually, to the Council on Medical Assistance Program Oversight on
1073 the foreign language interpreter services provided to recipients of
1074 benefits under the program.]

1075 [(d)] (b) Not later than October 1, 2011, the Commissioner of Social
1076 Services shall amend the Medicaid state plan to include podiatry as an
1077 optional service under the Medicaid program.

1078 [(e)] (c) The Commissioner of Social Services shall amend the
1079 Medicaid state plan to provide that chiropractic services shall be
1080 covered under the Medicaid program only to the extent required by
1081 federal law.

1082 Sec. 17. Subsection (a) of section 17b-280 of the general statutes is
1083 repealed and the following is substituted in lieu thereof (*Effective July*
1084 *1, 2013*):

1085 (a) The state shall reimburse for all legend drugs provided under
1086 medical assistance programs administered by the Department of Social
1087 Services at the lower of (1) the rate established by the Centers for
1088 Medicare and Medicaid Services as the federal acquisition cost, (2) the
1089 average wholesale price minus sixteen per cent, or (3) an equivalent
1090 percentage as established under the Medicaid state plan.
1091 [Notwithstanding the provisions of this section, contingent upon
1092 federal approval, on and after October 1, 2012, for independent
1093 pharmacies, the state shall reimburse for such legend drugs at the
1094 lower of (A) the rate established by the Centers for Medicare and
1095 Medicaid Services as the federal acquisition cost, (B) the average
1096 wholesale price minus fifteen per cent, or (C) an equivalent percentage
1097 as established under the Medicaid state plan.] The state shall pay a
1098 professional fee of one dollar and [seventy] forty cents to licensed
1099 pharmacies for each prescription dispensed to a recipient of benefits
1100 under a medical assistance program administered by the Department

1101 of Social Services in accordance with federal regulations. On and after
1102 September 4, 1991, payment for legend and nonlegend drugs provided
1103 to Medicaid recipients shall be based upon the actual package size
1104 dispensed. Effective October 1, 1991, reimbursement for over-the-
1105 counter drugs for such recipients shall be limited to those over-the-
1106 counter drugs and products published in the Connecticut Formulary,
1107 or the cross reference list, issued by the commissioner. The cost of all
1108 over-the-counter drugs and products provided to residents of nursing
1109 facilities, chronic disease hospitals, and intermediate care facilities for
1110 the mentally retarded shall be included in the facilities' per diem rate.
1111 Notwithstanding the provisions of this subsection, no dispensing fee
1112 shall be issued for a prescription drug dispensed to a ConnPACE or
1113 Medicaid recipient who is a Medicare Part D beneficiary when the
1114 prescription drug is a Medicare Part D drug, as defined in Public Law
1115 108-173, the Medicare Prescription Drug, Improvement, and
1116 Modernization Act of 2003.

1117 Sec. 18. Subsection (b) of section 17b-104 of the general statutes is
1118 repealed and the following is substituted in lieu thereof (*Effective July*
1119 *1, 2013*):

1120 (b) On July 1, 2007, and annually thereafter, the commissioner shall
1121 increase the payment standards over those of the previous fiscal year
1122 under the temporary family assistance program and the
1123 state-administered general assistance program by the percentage
1124 increase, if any, in the most recent calendar year average in the
1125 consumer price index for urban consumers over the average for the
1126 previous calendar year, provided the annual increase, if any, shall not
1127 exceed five per cent, except that the payment standards for the fiscal
1128 years ending June 30, 2010, June 30, 2011, June 30, 2012, [and] June 30,
1129 2013, June 30, 2014, and June 30, 2015, shall not be increased.

1130 Sec. 19. Subsection (a) of section 17b-106 of the general statutes is
1131 repealed and the following is substituted in lieu thereof (*Effective July*
1132 *1, 2013*):

1133 (a) [On January 1, 2006, and on each January first thereafter, the
1134 Commissioner of Social Services shall increase the unearned income
1135 disregard for recipients of the state supplement to the federal
1136 Supplemental Security Income Program by an amount equal to the
1137 federal cost-of-living adjustment, if any, provided to recipients of
1138 federal Supplemental Security Income Program benefits for the
1139 corresponding calendar year.] On July 1, 1989, and annually thereafter,
1140 the commissioner shall increase the adult payment standards over
1141 those of the previous fiscal year for the state supplement to the federal
1142 Supplemental Security Income Program by the percentage increase, if
1143 any, in the most recent calendar year average in the consumer price
1144 index for urban consumers over the average for the previous calendar
1145 year, provided the annual increase, if any, shall not exceed five per
1146 cent, except that the adult payment standards for the fiscal years
1147 ending June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June
1148 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June
1149 30, 2002, June 30, 2003, June 30, 2004, June 30, 2005, June 30, 2006, June
1150 30, 2007, June 30, 2008, June 30, 2009, June 30, 2010, June 30, 2011, June
1151 30, 2012, [and] June 30, 2013, June 30, 2014, and June 30, 2015, shall not
1152 be increased. Effective October 1, 1991, the coverage of excess utility
1153 costs for recipients of the state supplement to the federal Supplemental
1154 Security Income Program is eliminated. Notwithstanding the
1155 provisions of this section, the commissioner may increase the personal
1156 needs allowance component of the adult payment standard as
1157 necessary to meet federal maintenance of effort requirements.

1158 Sec. 20. Section 17b-261n of the general statutes is repealed and the
1159 following is substituted in lieu thereof (*Effective January 1, 2014*):

1160 (a) The Commissioner of Social Services shall, subject to federal
1161 approval, administer coverage under the Medicaid program for low-
1162 income adults in accordance with Section 1902(a)(10)(A)(i)(VIII) of the
1163 Social Security Act. [To the extent permitted under federal law,
1164 eligibility for individuals covered pursuant to this section shall be
1165 based on the rules used to determine eligibility for the state-

1166 administered general assistance medical assistance program,
1167 including, but not limited to, the use of medically needy income limits,
1168 a one-hundred-fifty-dollars-per-month employment deduction and a
1169 three-month extension of assistance for individuals who become
1170 ineligible solely due to an increase in earnings.] In determining
1171 eligibility for individuals covered under this section, the commissioner
1172 shall not consider as income Aid and Attendance pension benefits
1173 granted to a veteran, as defined in section 27-103, or the surviving
1174 spouse of such veteran. The commissioner may amend the Medicaid
1175 state plan to establish an alternative benefit package for individuals
1176 eligible for Medicaid in accordance with the provisions of this section
1177 and as permitted by federal law. For purposes of this section,
1178 "alternative benefit package" may include, but is not limited to, limits
1179 on any of the following: (1) Health care provider office visits; (2)
1180 independent therapy services; (3) hospital emergency department
1181 services; (4) inpatient hospital services; (5) outpatient hospital services;
1182 (6) medical equipment, devices and supplies; (7) ambulatory surgery
1183 center services; (8) pharmacy services; (9) nonemergency medical
1184 transportation; and (10) licensed home care agency services.

1185 [(b) The commissioner shall apply for a Medicaid waiver, pursuant
1186 to Section 1115 of the Social Security Act, to modify eligibility and
1187 coverage for such low-income adults by establishing that (1) an
1188 individual with assets exceeding ten thousand dollars is ineligible for
1189 the program; (2) the income and assets of the parents of an individual
1190 who is under twenty-six years of age will be counted when
1191 determining the individual's eligibility for the program, provided the
1192 individual lives with a parent or is declared as a dependent by a parent
1193 for income tax purposes; and (3) each eligible individual shall be
1194 limited to ninety days of nursing facility care.]

1195 [(c)] (b) The commissioner may implement policies and procedures
1196 necessary to administer the provisions of this section while in the
1197 process of adopting such policies and procedures in regulation form,
1198 provided the commissioner prints notice of intent to adopt regulations

1199 in the Connecticut Law Journal not later than twenty days after the
1200 date of implementation. Such policies and procedures shall remain
1201 valid for three years following the date of publication in the
1202 Connecticut Law Journal unless otherwise provided for by the General
1203 Assembly. Notwithstanding the time frames established in subsection
1204 (c) of section 17b-10, the commissioner shall submit such policies and
1205 procedures in proposed regulation form to the legislative regulation
1206 review committee not later than three years following the date of
1207 publication of its intent to adopt regulations as provided for in this
1208 subsection. In the event that the commissioner is unable to submit
1209 proposed regulations prior to the expiration of the three-year time
1210 period as provided for in this subsection, the commissioner shall
1211 submit written notice, not later than thirty-five days prior to the date
1212 of expiration of such time period, to the legislative regulation review
1213 committee and the joint standing committees of the General Assembly
1214 having cognizance of matters relating to human services and
1215 appropriations and the budgets of state agencies indicating that the
1216 department will not be able to submit the proposed regulations on or
1217 before such date and shall include in such notice (1) the reasons why
1218 the department will not submit the proposed regulations by such date,
1219 and (2) the date by which the department will submit the proposed
1220 regulations. The legislative regulation review committee may require
1221 the department to appear before the committee at a time prescribed by
1222 the committee to further explain such reasons and to respond to any
1223 questions by the committee about the policy. The legislative regulation
1224 review committee may request the joint standing committee of the
1225 General Assembly having cognizance of matters relating to human
1226 services to review the department's policy, the department's reasons
1227 for not submitting the proposed regulations by the date specified in
1228 this section and the date by which the department will submit the
1229 proposed regulations. Said joint standing committee may review the
1230 policy, such reasons and such date, may schedule a hearing thereon
1231 and may make a recommendation to the legislative regulation review
1232 committee.

1233 [(d)] (c) Effective July 1, 2011, no payment shall be made to a
1234 provider of medical services for services provided prior to April 1,
1235 2010, to a recipient of benefits under this section.

1236 Sec. 21. Subsection (a) of section 17b-261 of the general statutes is
1237 repealed and the following is substituted in lieu thereof (*Effective*
1238 *January 1, 2014*):

1239 (a) Medical assistance shall be provided for any otherwise eligible
1240 person whose income, including any available support from legally
1241 liable relatives and the income of the person's spouse or dependent
1242 child, is not more than one hundred forty-three per cent, pending
1243 approval of a federal waiver applied for pursuant to subsection (e) of
1244 this section, of the benefit amount paid to a person with no income
1245 under the temporary family assistance program in the appropriate
1246 region of residence and if such person is an institutionalized
1247 individual as defined in Section 1917(c) of the Social Security Act, 42
1248 USC 1396p(c), and has not made an assignment or transfer or other
1249 disposition of property for less than fair market value for the purpose
1250 of establishing eligibility for benefits or assistance under this section.
1251 Any such disposition shall be treated in accordance with Section
1252 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
1253 property made on behalf of an applicant or recipient or the spouse of
1254 an applicant or recipient by a guardian, conservator, person
1255 authorized to make such disposition pursuant to a power of attorney
1256 or other person so authorized by law shall be attributed to such
1257 applicant, recipient or spouse. A disposition of property ordered by a
1258 court shall be evaluated in accordance with the standards applied to
1259 any other such disposition for the purpose of determining eligibility.
1260 The commissioner shall establish the standards for eligibility for
1261 medical assistance at one hundred forty-three per cent of the benefit
1262 amount paid to a family unit of equal size with no income under the
1263 temporary family assistance program in the appropriate region of
1264 residence. In determining eligibility, the commissioner shall not
1265 consider as income Aid and Attendance pension benefits granted to a

1266 veteran, as defined in section 27-103, or the surviving spouse of such
1267 veteran. Except as provided in section 17b-277, the medical assistance
1268 program shall provide coverage to persons under the age of nineteen
1269 with family income up to one hundred eighty-five per cent of the
1270 federal poverty level without an asset limit and to persons under the
1271 age of nineteen, who qualify for coverage under Section 1931 of the
1272 Social Security Act, with family income up to one hundred eighty-five
1273 per cent of the federal poverty level without an asset limit and their
1274 parents and needy caretaker relatives, who qualify for coverage under
1275 Section 1931 of the Social Security Act, with family income up to one
1276 hundred [eighty-five] thirty-three per cent of the federal poverty level
1277 without an asset limit. Such levels shall be based on the regional
1278 differences in such benefit amount, if applicable, unless such levels
1279 based on regional differences are not in conformance with federal law.
1280 Any income in excess of the applicable amounts shall be applied as
1281 may be required by said federal law, and assistance shall be granted
1282 for the balance of the cost of authorized medical assistance. The
1283 Commissioner of Social Services shall provide applicants for assistance
1284 under this section, at the time of application, with a written statement
1285 advising them of (1) the effect of an assignment or transfer or other
1286 disposition of property on eligibility for benefits or assistance, (2) the
1287 effect that having income that exceeds the limits prescribed in this
1288 subsection will have with respect to program eligibility, and (3) the
1289 availability of, and eligibility for, services provided by the Nurturing
1290 Families Network established pursuant to section 17b-751b. Persons
1291 who are determined ineligible for assistance pursuant to this section
1292 shall be provided a written statement notifying such persons of their
1293 ineligibility and advising such persons of the availability of HUSKY
1294 Plan, Part B health insurance benefits.

1295 Sec. 22. Section 17b-256f of the general statutes is repealed and the
1296 following is substituted in lieu thereof (*Effective January 1, 2014*):

1297 [Beginning March 1, 2012, and annually thereafter, the] The
1298 Commissioner of Social Services shall increase income disregards used

1299 to determine eligibility by the Department of Social Services for the
1300 federal Specified Low-Income Medicare Beneficiary, the Qualified
1301 Medicare Beneficiary and the Qualifying Individual [Programs]
1302 programs, administered in accordance with the provisions of 42 USC
1303 1396d(p), by [an amount that equalizes the income levels and
1304 deductions used to determine eligibility for said programs with
1305 income levels and deductions used to determine eligibility for the
1306 ConnPACE program under subsection (a) of section 17b-492] such
1307 amounts that will result in persons with income up to two hundred
1308 thirty-one per cent of the federal poverty level qualifying for coverage
1309 under the Specified Low-Income Medicare Beneficiary program,
1310 persons with income up to two hundred eleven per cent of the federal
1311 poverty level qualifying for the Qualified Medicare Beneficiary
1312 program and persons with income up to two hundred forty-six per
1313 cent of the federal poverty level qualifying for the Qualifying
1314 Individual program. The commissioner shall not apply an asset test for
1315 eligibility under the Medicare Savings Program. The commissioner
1316 shall not consider as income Aid and Attendance pension benefits
1317 granted to a veteran, as defined in section 27-103, or the surviving
1318 spouse of such veteran. The Commissioner of Social Services, pursuant
1319 to section 17b-10, may implement policies and procedures to
1320 administer the provisions of this section while in the process of
1321 adopting such policies and procedures in regulation form, provided
1322 the commissioner prints notice of the intent to adopt the regulations in
1323 the Connecticut Law Journal not later than twenty days after the date
1324 of implementation. Such policies and procedures shall be valid until
1325 the time final regulations are adopted.

1326 Sec. 23. Section 17b-551 of the general statutes is repealed and the
1327 following is substituted in lieu thereof (*Effective January 1, 2014*):

1328 Eligibility for participation in the program shall be limited to a
1329 resident who is enrolled in Medicare Part B whose annual income does
1330 not exceed [one hundred sixty-five per cent of the qualifying income
1331 level established in the ConnPACE program, pursuant to subsection

1332 (a) of section 17b-492] forty-three thousand five hundred sixty dollars
1333 or if such resident has a spouse, the combined income of such resident
1334 and his spouse does not exceed [one hundred sixty-five per cent of the
1335 qualifying income level established in the ConnPACE program,
1336 pursuant to subsection (a) of section 17b-492] fifty-eight thousand
1337 seven hundred forty dollars. On January 1, 2014, and annually
1338 thereafter, the commissioner shall increase the income limit established
1339 under this subsection over that of the previous fiscal year to reflect the
1340 annual inflation adjustment in Social Security income, if any. Each
1341 such adjustment shall be determined to the nearest one hundred
1342 dollars.

1343 Sec. 24. Section 17b-552 of the general statutes is repealed and the
1344 following is substituted in lieu thereof (*Effective January 1, 2014*):

1345 (a) A health care provider shall limit charges for care, treatment,
1346 service or equipment covered by Medicare Part B under Title XVIII of
1347 the Social Security Act, as amended, provided to a Medicare
1348 beneficiary who meets the eligibility requirements specified in section
1349 17b-551, as amended by this act, to the reasonable charge for the care,
1350 treatment, service or equipment provided as determined by the United
1351 States Secretary of Health and Human Services. No health care
1352 provider shall collect from such qualified beneficiary any amount in
1353 excess of the approved reasonable charge. Any violation of this
1354 subsection shall constitute grounds for the assessment of a civil
1355 penalty in accordance with subdivision (6) of subsection (a) of section
1356 19a-17. Any complaint alleging a violation of this section shall be made
1357 to the Department of Public Health or the appropriate professional
1358 licensing board or commission.

1359 (b) The Commissioner of Social Services shall adopt regulations in
1360 accordance with the provisions of chapter 54, necessary to administer
1361 the program and to determine eligibility in accordance with the
1362 provisions of section 17b-551, as amended by this act.

1363 [(c) All health care providers shall accept the identification card
1364 issued for the ConnPACE program pursuant to sections 17b-490 to
1365 17b-498, inclusive, as a substitute for a Medicare assignment card.]

1366 Sec. 25. Subsection (a) of section 17b-278i of the general statutes is
1367 repealed and the following is substituted in lieu thereof (*Effective from*
1368 *passage*):

1369 (a) Customized wheelchairs shall be covered under the Medicaid
1370 program only when a standard wheelchair will not meet an
1371 individual's needs as determined by the Department of Social Services.
1372 [Assessment of the need for a customized wheelchair may be
1373 performed by a vendor or nursing facility only if specifically requested
1374 by the department.] Wheelchair repairs and parts replacements may be
1375 subject to review and approval by the department. Refurbished
1376 wheelchairs, parts and components shall be utilized whenever
1377 practicable.

1378 Sec. 26. Subsection (a) of section 17b-340c of the general statutes is
1379 repealed and the following is substituted in lieu thereof (*Effective from*
1380 *passage*):

1381 (a) The Commissioner of Social Services may, upon the request of a
1382 nursing facility providing services eligible for payment under the
1383 medical assistance program, [and after consultation with the Secretary
1384 of the Office of Policy and Management,] make a payment to such
1385 nursing facility in advance of normal bill payment processing. Except
1386 as provided in subsection (b) of this section, (1) such advance shall not
1387 exceed estimated amounts due to such nursing facility for services
1388 provided to eligible recipients over the most recent two-month period,
1389 and (2) the commissioner shall recover such payment through
1390 reductions to payments due to such nursing facility or cash receipt not
1391 later than ninety days after issuance of such payment. The
1392 commissioner shall take prudent measures to assure that such advance
1393 payments are not provided to any nursing facility that is at risk of

1394 bankruptcy or insolvency, and may execute agreements appropriate
1395 for the security of repayment.

1396 Sec. 27. Subsection (e) of section 17b-28 of the general statutes is
1397 repealed and the following is substituted in lieu thereof (*Effective July*
1398 *1, 2013*):

1399 (e) The council shall monitor and make recommendations
1400 concerning: (1) An enrollment process that ensures access for each
1401 Department of Social Services administered health care program and
1402 effective outreach and client education for such programs; (2) available
1403 services comparable to those already in the Medicaid state plan,
1404 including those guaranteed under the federal Early and Periodic
1405 Screening, Diagnostic and Treatment Services Program under 42 USC
1406 1396d; (3) the sufficiency of accessible adult and child primary care
1407 providers, specialty providers and hospitals in Medicaid provider
1408 networks; (4) the sufficiency of provider rates to maintain the Medicaid
1409 network of providers and service access; (5) funding and agency
1410 personnel resources to guarantee timely access to services and effective
1411 management of the Medicaid program; (6) participation in care
1412 management programs including, but not limited to, medical home
1413 and health home models by existing community Medicaid providers;
1414 (7) the linguistic and cultural competency of providers and other
1415 program facilitators and data on the provision of Medicaid linguistic
1416 translation services; (8) program quality, including outcome measures
1417 and continuous quality improvement initiatives that may include
1418 provider quality performance incentives and performance targets for
1419 administrative services organizations; (9) timely, accessible and
1420 effective client grievance procedures; (10) coordination of the Medicaid
1421 care management programs with state and federal health care reforms;
1422 (11) eligibility levels for inclusion in the programs; (12) enrollee cost-
1423 sharing provisions; (13) a benefit package for each of the health care
1424 programs set forth in subsection (a) of this section; (14) the Behavioral
1425 Health Partnership, including, but not limited to, review of periodic
1426 reports on program activities, finances and outcomes, and achievement

1427 of service delivery system goals; (15) coordination of coverage
1428 continuity among Medicaid programs and integration of care,
1429 including, but not limited to, behavioral health, dental and pharmacy
1430 care provided through programs administered by the Department of
1431 Social Services; and [(15)] (16) the need for program quality studies
1432 within the areas identified in this section and the department's
1433 application for available grant funds for such studies. The chairperson
1434 of the council shall ensure that sufficient members of the council
1435 participate in the review of any contract entered into by the
1436 Department of Social Services and an administrative services
1437 organization.

1438 Sec. 28. Section 17a-22h of the general statutes is repealed and the
1439 following is substituted in lieu thereof (*Effective July 1, 2013*):

1440 [(a)] The Commissioners of Social Services, Children and Families,
1441 and Mental Health and Addiction Services shall develop and
1442 implement an integrated behavioral health service system for
1443 Medicaid and HUSKY Plan [Parts A and] Part B members and children
1444 enrolled in the voluntary services program operated by the
1445 Department of Children and Families and may, at the discretion of the
1446 commissioners, include: (1) Other children, adolescents and families
1447 served by the Department of Children and Families or the Court
1448 Support Services Division of the Judicial Branch; and (2) [Medicaid
1449 recipients who are not enrolled in HUSKY Plan Part A; and (3)]
1450 Charter Oak Health Plan members. The integrated behavioral health
1451 service system shall be known as the Behavioral Health Partnership.
1452 The Behavioral Health Partnership shall seek to increase access to
1453 quality behavioral health services by: (A) Expanding individualized,
1454 family-centered and community-based services; (B) maximizing
1455 federal revenue to fund behavioral health services; (C) reducing
1456 unnecessary use of institutional and residential services for children
1457 and adults; (D) capturing and investing enhanced federal revenue and
1458 savings derived from reduced residential services and increased
1459 community-based services for HUSKY Plan Parts A and B recipients;

1460 (E) improving administrative oversight and efficiencies; and (F)
1461 monitoring individual outcomes and provider performance, taking
1462 into consideration the acuity of the patients served by each provider,
1463 and overall program performance.

1464 [(b) The Behavioral Health Partnership shall operate in accordance
1465 with the financial requirements specified in this subsection. Prior to the
1466 conversion of any grant-funded services to a rate-based, fee-for-service
1467 payment system, the Department of Social Services, the Department of
1468 Children and Families and the Department of Mental Health and
1469 Addiction Services shall submit documentation verifying that the
1470 proposed rates seek to cover the reasonable cost of providing services
1471 to the Behavioral Health Partnership Oversight Council, established
1472 pursuant to section 17a-22j.]

1473 Sec. 29. Section 17a-22k of the general statutes is repealed and the
1474 following is substituted in lieu thereof (*Effective July 1, 2013*):

1475 There is established a clinical management committee to [develop]
1476 advise the Departments of Children and Families, Social Services and
1477 Mental Health and Addiction Services on clinical management
1478 guidelines to be used for the Behavioral Health Partnership. The
1479 committee shall consist of two members selected by the Commissioner
1480 of Children and Families, two members selected by the Commissioner
1481 of Social Services, two members selected by the Commissioner of
1482 Mental Health and Addiction Services and two members selected by
1483 the [Behavioral Health Partnership Oversight] Council on Medical
1484 Assistance Program Oversight, established pursuant to section [17a-
1485 22j] 17b-28, as amended by this act. Members of the committee shall
1486 have requisite expertise or experience in behavioral health services.

1487 Sec. 30. Section 17a-22l of the general statutes is repealed and the
1488 following is substituted in lieu thereof (*Effective July 1, 2013*):

1489 [The Departments of Children and Families, Social Services and
1490 Mental Health and Addiction Services shall develop consumer and

1491 provider appeal procedures and shall submit such procedures to the
1492 Behavioral Health Partnership Oversight Council for review and
1493 comment. Such procedures shall include, but not be limited to,
1494 procedures for a consumer or any provider acting on behalf of a
1495 consumer to appeal a denial or determination.] The Departments of
1496 Children and Families, Social Services and Mental Health and
1497 Addiction Services shall establish time frames for appealing decisions
1498 made by an administrative services organization, including an
1499 expedited review in emergency situations. Any procedure for appeals
1500 shall require that an appeal be heard not later than thirty days after
1501 such appeal is filed and shall be decided not later than forty-five days
1502 after such appeal is filed.

1503 Sec. 31. Section 17a-22p of the general statutes is repealed and the
1504 following is substituted in lieu thereof (*Effective July 1, 2013*):

1505 (a) The Departments of Children and Families, Social Services and
1506 Mental Health and Addiction Services shall enter into one or more
1507 joint contracts or agreements with an administrative services
1508 organization or organizations to perform eligibility verification,
1509 utilization management, intensive care management, quality
1510 management, coordination of medical and behavioral health services,
1511 provider network development and management, recipient and
1512 provider services and reporting.

1513 (b) Claims under the Behavioral Health Partnership shall be paid by
1514 the Department of Social Services' Medicaid management information
1515 systems vendor, except that the Department of Children and Families
1516 and the Department of Mental Health and Addiction Services may, at
1517 their discretion, continue to use existing claims payment systems.

1518 (c) [Administrative services organizations] An administrative
1519 services organization shall authorize services, based solely on medical
1520 necessity, as defined in section 17b-259b. Such organization shall use
1521 guidelines established by the clinical management committee,

1522 established pursuant to section 17a-22k, as amended by this act, to
1523 inform and guide the authorization decision. [Administrative services
1524 organizations] An administrative services organization may make
1525 exceptions to the guidelines when requested by a member, or the
1526 member's legal guardian or service provider, and determined by the
1527 administrative services organization to be in the best interest of the
1528 member. Decisions regarding the interpretation of such guidelines
1529 shall be made by the Departments of Children and Families, Social
1530 Services and Mental Health and Addiction Services. No administrative
1531 services organization shall have any financial incentive to approve,
1532 deny or reduce services. Administrative services organizations shall
1533 ensure that service providers and persons seeking services have timely
1534 access to program information and timely responses to inquiries,
1535 including inquiries concerning the clinical guidelines for services.

1536 (d) [The] An administrative services organization for Medicaid and
1537 HUSKY Plan [Parts A and] Part B shall provide or arrange for on-site
1538 assistance to facilitate the appropriate placement, as soon as
1539 practicable, of children with behavioral health diagnoses who the
1540 administrative services organization knows to have been in an
1541 emergency department for over forty-eight hours. The administrative
1542 services organization shall provide or arrange for on-site assistance to
1543 arrange for the discharge or appropriate placement, as soon as
1544 practicable, for children who the administrative services organization
1545 knows to have remained in an inpatient hospital unit for more than
1546 five days longer than is medically necessary, as agreed by the
1547 administrative services organization and the hospital.

1548 (e) The Departments of Children and Families, Social Services and
1549 Mental Health and Addiction Services shall develop, in consultation
1550 with the Behavioral Health Partnership, a comprehensive plan for
1551 monitoring the performance of administrative services organizations
1552 which shall include data on service authorizations, individual
1553 outcomes, appeals, outreach and accessibility, comments from
1554 program participants compiled from written surveys and face-to-face

1555 interviews.

1556 [(f) The Behavioral Health Partnership shall establish policies to
1557 coordinate benefits received under the partnership with other benefits
1558 received under Medicaid. Such policies shall specify a coordinated
1559 delivery of both physical and behavioral health care. The policies shall
1560 be submitted to the Behavioral Health Partnership Oversight Council
1561 for review and comment.]

1562 Sec. 32. Subsection (b) of section 2c-2h of the general statutes is
1563 repealed and the following is substituted in lieu thereof (*Effective July*
1564 *1, 2013*):

1565 (b) Not later than July 1, 2015, and not later than every ten years
1566 thereafter, the joint standing committee of the General Assembly
1567 having cognizance of any of the following governmental entities or
1568 programs shall conduct a review of the applicable entity or program in
1569 accordance with the provisions of section 2c-3:

1570 (1) Board of Examiners of Embalmers and Funeral Directors,
1571 established under section 20-208;

1572 (2) Connecticut Homeopathic Medical Examining Board, established
1573 under section 20-8;

1574 (3) Board of Examiners in Podiatry, established under section 20-51;

1575 (4) Mobile Manufactured Home Advisory Council, established
1576 under section 21-84a;

1577 [(5) Family support grant program of the Department of Social
1578 Services, established under section 17b-616;]

1579 [(6)] (5) State Commission on Capitol Preservation and Restoration,
1580 established under section 4b-60;

1581 [(7)] (6) Council on Environmental Quality, established under

1582 section 22a-11; and

1583 [(8)] (7) Police Officer Standards and Training Council, established
1584 under section 7-294b.

1585 Sec. 33. Section 17b-10a of the general statutes is repealed and the
1586 following is substituted in lieu thereof (*Effective January 1, 2014*):

1587 The Commissioner of Social Services, pursuant to section 17b-10,
1588 may implement policies and procedures necessary to administer
1589 section 17b-197, subsection (d) of section 17b-266, section 17b-280a [,]
1590 and subsection (a) of section 17b-295, [and subsection (c) of section
1591 17b-311,] while in the process of adopting such policies and procedures
1592 as regulation, provided the commissioner prints notice of intent to
1593 adopt regulations in the Connecticut Law Journal not later than twenty
1594 days after the date of implementation. Policies and procedures
1595 implemented pursuant to this section shall be valid until the time final
1596 regulations are adopted.

1597 Sec. 34. Subsection (b) of section 38a-556a of the general statutes is
1598 repealed and the following is substituted in lieu thereof (*Effective*
1599 *January 1, 2014*):

1600 (b) Said association shall, in consultation with the Insurance
1601 Commissioner and the Healthcare Advocate, develop, within available
1602 appropriations, a web site, telephone number or other method to serve
1603 as a clearinghouse for information about individual and small
1604 employer health insurance policies and health care plans that are
1605 available to consumers in this state, including, but not limited to, the
1606 Medicaid program, the HUSKY Plan, [the Charter Oak Health Plan set
1607 forth in section 17b-311,] the Municipal Employee Health Insurance
1608 Plan set forth in subsection (i) of section 5-259, and any individual or
1609 small employer health insurance policies or health care plans an
1610 insurer, health care center or other entity chooses to list with the
1611 Connecticut Clearinghouse.

1612 Sec. 35. Section 17b-494 of the general statutes is repealed and the
1613 following is substituted in lieu thereof (*Effective January 1, 2014*):

1614 The Commissioner of Social Services shall adopt regulations, in
1615 accordance with the provisions of chapter 54, to establish (1) a system
1616 for determining eligibility and disqualification under the program,
1617 including provisions for an identification number and a renewable,
1618 nontransferable identification card; (2) requirements for the use of the
1619 identification number and card by the pharmacy and the eligible
1620 person; (3) a system of payments; (4) limitations on the maximum
1621 quantity per prescription which shall not exceed a thirty-day supply or
1622 one hundred twenty oral dosage units whichever is greater; (5)
1623 requirements as to records to be kept by the pharmacy, including
1624 patient profiles; (6) products prescribed for cosmetic and other
1625 purposes which shall not be covered under the program; and (7) such
1626 other provisions as are necessary to implement the provisions of
1627 sections [17b-490 to 17b-495, inclusive] 17b-491 to 17b-491c, inclusive,
1628 and 17b-492b.

1629 Sec. 36. Subsection (a) of section 29-1s of the general statutes is
1630 repealed and the following is substituted in lieu thereof (*Effective*
1631 *January 1, 2014*):

1632 (a) (1) Wherever the term "Department of Public Safety" is used in
1633 the following general statutes, the term "Department of Emergency
1634 Services and Public Protection" shall be substituted in lieu thereof; and
1635 (2) wherever the term "Commissioner of Public Safety" is used in the
1636 following general statutes, the term "Commissioner of Emergency
1637 Services and Public Protection" shall be substituted in lieu thereof: 1-
1638 24, 1-84b, 1-217, 2-90b, 3-2b, 4-68m, 4a-2a, 4a-18, 4a-67d, 4b-1, 4b-130, 5-
1639 142, 5-146, 5-149, 5-150, 5-169, 5-173, 5-192f, 5-192t, 5-246, 6-32g, 7-169,
1640 7-285, 7-294f to 7-294h, inclusive, 7-294l, 7-294n, 7-294y, 7-425, 9-7a, 10-
1641 233h, 12-562, 12-564a, 12-586f, 12-586g, 13a-123, 13b-69, 13b-376, 14-10,
1642 14-64, 14-67m, 14-67w, 14-103, 14-108a, 14-138, 14-152, 14-163c, 14-211a,
1643 14-212a, 14-212f, 14-219c, 14-227a, 14-227c, 14-267a, 14-270c to 14-270f,

1644 inclusive, 14-283, 14-291, 14-298, 14-315, 15-98, 15-140r, 15-140u, 16-
1645 256g, 16a-103, 17a-105a, 17a-106a, 17a-500, 17b-90, 17b-137, 17b-192,
1646 17b-225, 17b-279, [17b-490,] 18-87k, 19a-112a, 19a-112f, 19a-179b, 19a-
1647 409, 19a-904, 20-12c, 20-327b, 21a-36, 21a-283, 22a-2, 23-8b, 23-18, 26-5,
1648 26-67b, 27-19a, 27-107, 28-25b, 28-27, 28-27a, 28-30a, 29-1c, 29-1e to 29-
1649 1h, inclusive, 29-1q, 29-1zz, 29-2, 29-2a, 29-2b, 29-3a, 29-4a, 29-6a, 29-7,
1650 29-7b, 29-7c, 29-7h, 29-7m, 29-7n, 29-8, 29-10, 29-10a, 29-10c, 29-11, 29-
1651 12, 29-17a, 29-17b, 29-17c, 29-18 to 29-23a, inclusive, 29-25, 29-26, 29-28,
1652 29-28a, 29-30 to 29-32, inclusive, 29-32b, 29-33, 29-36f to 29-36i,
1653 inclusive, 29-36k, 29-36m, 29-36n, 29-37a, 29-37f, 29-38b, 29-38e, 29-38f,
1654 29-108b, 29-143i, 29-143j, 29-145 to 29-151, inclusive, 29-152f to 29-152j,
1655 inclusive, 29-152m, 29-152o, 29-152u, 29-153, 29-155d, 29-156a, 29-161g
1656 to 29-161i, inclusive, 29-161k to 29-161m, inclusive, 29-161o to 29-161t,
1657 inclusive, 29-161v to 29-161z, inclusive, 29-163, 29-164g, 29-166, 29-176
1658 to 29-179, inclusive, 29-179f to 29-179h, 31-275, 38a-18, 38a-356, 45a-63,
1659 46a-4b, 46a-170, 46b-15a, 46b-38d, 46b-38f, 51-5c, 51-10c, 51-51o, 51-
1660 277a, 52-11, 53-39a, 53-134, 53-199, 53-202, 53-202b, 53-202c, 53-202g,
1661 53-202l, 53-202n, 53-202o, 53-278c, 53-341b, 53a-3, 53a-30, 53a-54b, 53a-
1662 130, 53a-130a, 54-1f, 54-1l, 54-36e, 54-36i, 54-36n, 54-47aa, 54-63c, 54-76l,
1663 54-86k, 54-102g to 54-102j, inclusive, 54-102m, 54-102pp, 54-142j, 54-
1664 222a, 54-240, 54-240m, 54-250 to 54-258, inclusive, 54-259a, 54-260b, and
1665 54-300.

1666 Sec. 37. Section 17b-497 of the general statutes is repealed and the
1667 following is substituted in lieu thereof (*Effective January 1, 2014*):

1668 (a) Any person acting for a pharmacy who submits a false or
1669 fraudulent claim under sections [17b-490 to 17b-498, inclusive, or the
1670 regulations adopted pursuant to section 17b-494] 17b-491 to 17b-491c,
1671 inclusive, and 17b-492b, or who aids or abets another in the submission
1672 of a false or fraudulent claim, or otherwise violates any provision of
1673 sections [17b-490 to 17b-498, inclusive] 17b-491 to 17b-491c, inclusive,
1674 and 17b-492b, or said regulations, shall be subject to a fine of not less
1675 than one thousand dollars or imprisonment for a term of not more
1676 than one year, or both.

1677 (b) Any person who wilfully misrepresents any fact in connection
1678 with obtaining a replacement prescription [pursuant to section 17b-
1679 492] or in connection with obtaining an identification number or card,
1680 or who misuses such identification number or card to obtain
1681 prescription drugs shall be subject to suspension of eligibility for a
1682 period of not more than one year for a first offense and a permanent
1683 revocation of eligibility for a second offense.

1684 (c) Any pharmacy found guilty of a violation under subsection (a) of
1685 this section shall be immediately terminated from participation in the
1686 program, and shall be liable to the state for five times the value of any
1687 material gain received.

1688 (d) Any person found guilty of a violation under subsection (b) of
1689 this section shall be liable to the state for five times the value of any
1690 material gain received.

1691 Sec. 38. Subsection (e) of section 12-746 of the general statutes is
1692 repealed and the following is substituted in lieu thereof (*Effective*
1693 *January 1, 2014*):

1694 (e) Amounts rebated pursuant to this section shall not be considered
1695 income for purposes of sections 8-119l, 12-170d, 12-170aa, [17b-490,]
1696 17b-550, 17b-812, 47-88d and 47-287.

1697 Sec. 39. Subsection (b) of section 10a-132e of the general statutes is
1698 repealed and the following is substituted in lieu thereof (*Effective*
1699 *January 1, 2014*):

1700 (b) The program established pursuant to subsection (a) of this
1701 section shall: (1) Arrange for licensed physicians, pharmacists and
1702 nurses to conduct in person educational visits with prescribing
1703 practitioners, utilizing evidence-based materials, borrowing methods
1704 from behavioral science and educational theory and, when
1705 appropriate, utilizing pharmaceutical industry data and outreach
1706 techniques; (2) inform prescribing practitioners about drug marketing

1707 that is designed to prevent competition to brand name drugs from
1708 generic or other therapeutically-equivalent pharmaceutical alternatives
1709 or other evidence-based treatment options; and (3) provide outreach
1710 and education to licensed physicians and other health care
1711 practitioners who are participating providers in state-funded health
1712 care programs, including, but not limited to, Medicaid, the HUSKY
1713 Plan, Parts A and B, [the Charter Oak Health Plan, the ConnPACE
1714 program,] the Department of Correction inmate health services
1715 program and the state employees' health insurance plan.

1716 Sec. 40. Subsection (a) of section 17a-22f of the general statutes is
1717 repealed and the following is substituted in lieu thereof (*Effective*
1718 *January 1, 2014*):

1719 (a) The Commissioner of Social Services may, with regard to the
1720 provision of behavioral health services provided pursuant to a state
1721 plan under Title XIX or Title XXI of the Social Security Act; [, or under
1722 the Charter Oak Health Plan:] (1) Contract with one or more
1723 administrative services organizations to provide clinical management,
1724 provider network development and other administrative services; (2)
1725 delegate responsibility to the Department of Children and Families for
1726 the clinical management portion of such administrative contract or
1727 contracts that pertain to HUSKY Plan Parts A and B, and other
1728 children, adolescents and families served by the Department of
1729 Children and Families; and (3) delegate responsibility to the
1730 Department of Mental Health and Addiction Services for the clinical
1731 management portion of such administrative contract or contracts that
1732 pertain to Medicaid recipients who are not enrolled in HUSKY Plan
1733 Part A. [and recipients enrolled in the Charter Oak Health Plan.]

1734 Sec. 41. Section 17a-22h of the general statutes, as amended by
1735 section 28 of this act, is repealed and the following is substituted in lieu
1736 thereof (*Effective January 1, 2014*):

1737 The Commissioners of Social Services, Children and Families, and

1738 Mental Health and Addiction Services shall develop and implement an
1739 integrated behavioral health service system for Medicaid and HUSKY
1740 Plan Part B members and children enrolled in the voluntary services
1741 program operated by the Department of Children and Families and
1742 may, at the discretion of the commissioners, include [:(1) Other] other
1743 children, adolescents and families served by the Department of
1744 Children and Families or the Court Support Services Division of the
1745 Judicial Branch. [; and (2) Charter Oak Health Plan members.] The
1746 integrated behavioral health service system shall be known as the
1747 Behavioral Health Partnership. The Behavioral Health Partnership
1748 shall seek to increase access to quality behavioral health services by:
1749 (A) Expanding individualized, family-centered and community-based
1750 services; (B) maximizing federal revenue to fund behavioral health
1751 services; (C) reducing unnecessary use of institutional and residential
1752 services for children and adults; (D) capturing and investing enhanced
1753 federal revenue and savings derived from reduced residential services
1754 and increased community-based services for HUSKY Plan Parts A and
1755 B recipients; (E) improving administrative oversight and efficiencies;
1756 and (F) monitoring individual outcomes and provider performance,
1757 taking into consideration the acuity of the patients served by each
1758 provider, and overall program performance.

1759 Sec. 42. Subsection (a) of section 17b-28 of the general statutes is
1760 repealed and the following is substituted in lieu thereof (*Effective*
1761 *January 1, 2014*):

1762 (a) There is established a Council on Medical Assistance Program
1763 Oversight which shall advise the Commissioner of Social Services on
1764 the planning and implementation of the health care delivery system
1765 for the following health care programs: The HUSKY Plan, Parts A and
1766 B [, the Charter Oak Health Plan] and the Medicaid program,
1767 including, but not limited to, the portions of the program serving low
1768 income adults, the aged, blind and disabled individuals, individuals
1769 who are dually eligible for Medicaid and Medicare and individuals
1770 with preexisting medical conditions. The council shall monitor

1771 planning and implementation of matters related to Medicaid care
1772 management initiatives including, but not limited to, (1) eligibility
1773 standards, (2) benefits, (3) access, (4) quality assurance, (5) outcome
1774 measures, and (6) the issuance of any request for proposal by the
1775 Department of Social Services for utilization of an administrative
1776 services organization in connection with such initiatives.

1777 Sec. 43. Subsection (a) of section 17b-261m of the general statutes, as
1778 amended by section 14 of this act, is repealed and the following is
1779 substituted in lieu thereof (*Effective January 1, 2014*):

1780 (a) The Commissioner of Social Services may contract with one or
1781 more administrative services organizations to provide care
1782 coordination, utilization management, disease management, customer
1783 service and review of grievances for recipients of assistance under
1784 Medicaid [] and HUSKY Plan, Parts A and B. [] and the Charter Oak
1785 Health Plan.] Such organization may also provide network
1786 management, credentialing of providers, monitoring of copayments
1787 and premiums and other services as required by the commissioner.
1788 Subject to approval by applicable federal authority, the Department of
1789 Social Services shall utilize the contracted organization's provider
1790 network and billing systems in the administration of the program. In
1791 order to implement the provisions of this section, the commissioner
1792 may establish rates of payment to providers of medical services under
1793 this section if the establishment of such rates is required to ensure that
1794 any contract entered into with an administrative services organization
1795 pursuant to this section is cost neutral to such providers in the
1796 aggregate and ensures patient access. Utilization may be a factor in
1797 determining cost neutrality.

1798 Sec. 44. Section 17b-274 of the general statutes is repealed and the
1799 following is substituted in lieu thereof (*Effective January 1, 2014*):

1800 (a) The Division of Criminal Justice shall periodically investigate
1801 pharmacies to ensure that the state is not billed for a brand name drug

1802 product when a less expensive generic substitute drug product is
1803 dispensed to a Medicaid recipient. The Commissioner of Social
1804 Services shall cooperate and provide information as requested by such
1805 division.

1806 (b) A licensed medical practitioner may specify in writing or by a
1807 telephonic or electronic communication that there shall be no
1808 substitution for the specified brand name drug product in any
1809 prescription for a Medicaid [or ConnPACE] recipient, provided (1) the
1810 practitioner specifies the basis on which the brand name drug product
1811 and dosage form is medically necessary in comparison to a chemically
1812 equivalent generic drug product substitution, and (2) the phrase
1813 "brand medically necessary" shall be in the practitioner's handwriting
1814 on the prescription form or, if the prohibition was communicated by
1815 telephonic communication, in the pharmacist's handwriting on such
1816 form, and shall not be preprinted or stamped or initialed on such form.
1817 If the practitioner specifies by telephonic communication that there
1818 shall be no substitution for the specified brand name drug product in
1819 any prescription for a Medicaid [or ConnPACE] recipient, written
1820 certification in the practitioner's handwriting bearing the phrase
1821 "brand medically necessary" shall be sent to the dispensing pharmacy
1822 within ten days. A pharmacist shall dispense a generically equivalent
1823 drug product for any drug listed in accordance with the Code of
1824 Federal Regulations Title 42 Part 447.332 for a drug prescribed for a
1825 Medicaid, or state-administered general assistance [, or ConnPACE]
1826 recipient unless the phrase "brand medically necessary" is ordered in
1827 accordance with this subsection and such pharmacist has received
1828 approval to dispense the brand name drug product in accordance with
1829 subsection (c) of this section.

1830 (c) The Commissioner of Social Services shall implement a
1831 procedure by which a pharmacist shall obtain approval from an
1832 independent pharmacy consultant acting on behalf of the Department
1833 of Social Services, under an administrative services only contract,
1834 whenever the pharmacist dispenses a brand name drug product to a

1835 Medicaid [or ConnPACE] recipient and a chemically equivalent
1836 generic drug product substitution is available. The length of
1837 authorization for brand name drugs shall be in accordance with section
1838 17b-491a. In cases where the brand name drug is less costly than the
1839 chemically equivalent generic drug when factoring in manufacturers'
1840 rebates, the pharmacist shall dispense the brand name drug. If such
1841 approval is not granted or denied within two hours of receipt by the
1842 commissioner of the request for approval, it shall be deemed granted.
1843 Notwithstanding any provision of this section, a pharmacist shall not
1844 dispense any initial maintenance drug prescription for which there is a
1845 chemically equivalent generic substitution that is for less than fifteen
1846 days without the department's granting of prior authorization,
1847 provided prior authorization shall not otherwise be required for
1848 atypical antipsychotic drugs if the individual is currently taking such
1849 drug at the time the pharmacist receives the prescription. The
1850 pharmacist may appeal a denial of reimbursement to the department
1851 based on the failure of such pharmacist to substitute a generic drug
1852 product in accordance with this section.

1853 (d) A licensed medical practitioner shall disclose to the Department
1854 of Social Services or such consultant, upon request, the basis on which
1855 the brand name drug product and dosage form is medically necessary
1856 in comparison to a chemically equivalent generic drug product
1857 substitution. The Commissioner of Social Services shall establish a
1858 procedure by which such a practitioner may appeal a determination
1859 that a chemically equivalent generic drug product substitution is
1860 required for a Medicaid [or ConnPACE] recipient.

1861 Sec. 45. Section 17b-274a of the general statutes is repealed and the
1862 following is substituted in lieu thereof (*Effective January 1, 2014*):

1863 The Commissioner of Social Services may establish maximum
1864 allowable costs to be paid under the Medicaid [, ConnPACE] and
1865 Connecticut AIDS drug assistance programs for generic prescription
1866 drugs based on, but not limited to, actual acquisition costs. The

1867 department shall implement and maintain a procedure to review and
1868 update the maximum allowable cost list at least annually, and shall
1869 report annually to the joint standing committee of the General
1870 Assembly having cognizance of matters relating to appropriations and
1871 the budgets of state agencies on its activities pursuant to this section.

1872 Sec. 46. Subsection (a) of section 17b-274c of the general statutes is
1873 repealed and the following is substituted in lieu thereof (*Effective*
1874 *January 1, 2014*):

1875 (a) The Commissioner of Social Services may establish a voluntary
1876 mail order option for any maintenance prescription drug covered
1877 under the Medicaid [, ConnPACE] or Connecticut AIDS drug
1878 assistance programs.

1879 Sec. 47. Subsection (e) of section 17b-274d of the general statutes is
1880 repealed and the following is substituted in lieu thereof (*Effective*
1881 *January 1, 2014*):

1882 (e) The Department of Social Services, in consultation with the
1883 Pharmaceutical and Therapeutics Committee, may adopt a preferred
1884 drug [lists] list for use in the Medicaid [and ConnPACE programs]
1885 program. To the extent feasible, the department shall review all drugs
1886 included on the preferred drug [lists] list at least every twelve months,
1887 and may recommend additions to, and deletions from, the preferred
1888 drug [lists] list, to ensure that the preferred drug [lists provide] list
1889 provides for medically appropriate drug therapies for Medicaid [and
1890 ConnPACE] patients. [For the fiscal year ending June 30, 2004, such
1891 drug lists shall be limited to use in the Medicaid and ConnPACE
1892 programs and cover three classes of drugs, including proton pump
1893 inhibitors and two other classes of drugs determined by the
1894 Commissioner of Social Services. Not later than June 30, 2005, the] The
1895 Department of Social Services, in consultation with the Pharmaceutical
1896 and [Therapeutic] Therapeutics Committee, shall expand such drug
1897 [lists] list to include other classes of drugs, except as provided in

1898 subsection (f) of this section, in order to achieve savings reflected in the
1899 amounts appropriated to the department, for the various components
1900 of the program, in the state budget act.

1901 Sec. 48. Section 17b-274e of the general statutes is repealed and the
1902 following is substituted in lieu thereof (*Effective January 1, 2014*):

1903 A pharmacist, when filling a prescription under the Medicaid [,
1904 ConnPACE] or Connecticut AIDS drug assistance programs, shall fill
1905 such prescription utilizing the most cost-efficient dosage, consistent
1906 with the prescription of a prescribing practitioner as defined in section
1907 20-571, unless such pharmacist receives permission to do otherwise
1908 pursuant to the prior authorization requirements set forth in sections
1909 17b-274, as amended by this act, and 17b-491a.

1910 Sec. 49. Subsection (a) of section 17b-280 of the general statutes, as
1911 amended by section 17 of this act, is repealed and the following is
1912 substituted in lieu thereof (*Effective January 1, 2014*):

1913 (a) The state shall reimburse for all legend drugs provided under
1914 medical assistance programs administered by the Department of Social
1915 Services at the lower of (1) the rate established by the Centers for
1916 Medicare and Medicaid Services as the federal acquisition cost, (2) the
1917 average wholesale price minus sixteen per cent, or (3) an equivalent
1918 percentage as established under the Medicaid state plan. The state
1919 shall pay a professional fee of one dollar and forty cents to licensed
1920 pharmacies for each prescription dispensed to a recipient of benefits
1921 under a medical assistance program administered by the Department
1922 of Social Services in accordance with federal regulations. On and after
1923 September 4, 1991, payment for legend and nonlegend drugs provided
1924 to Medicaid recipients shall be based upon the actual package size
1925 dispensed. Effective October 1, 1991, reimbursement for over-the-
1926 counter drugs for such recipients shall be limited to those over-the-
1927 counter drugs and products published in the Connecticut Formulary,
1928 or the cross reference list, issued by the commissioner. The cost of all

1929 over-the-counter drugs and products provided to residents of nursing
1930 facilities, chronic disease hospitals, and intermediate care facilities for
1931 the mentally retarded shall be included in the facilities' per diem rate.
1932 Notwithstanding the provisions of this subsection, no dispensing fee
1933 shall be issued for a prescription drug dispensed to a [ConnPACE or]
1934 Medicaid recipient who is a Medicare Part D beneficiary when the
1935 prescription drug is a Medicare Part D drug, as defined in Public Law
1936 108-173, the Medicare Prescription Drug, Improvement, and
1937 Modernization Act of 2003.

1938 Sec. 50. Section 17b-429 of the general statutes is repealed and the
1939 following is substituted in lieu thereof (*Effective January 1, 2014*):

1940 The Commissioner of Social Services shall, within available
1941 appropriations, make information available to senior citizens and
1942 disabled persons concerning any pharmaceutical company's drug
1943 program for indigent persons by utilizing the [ConnPACE program,
1944 the] CHOICES health insurance assistance program, as defined in
1945 section 17b-427, and Infoline of Connecticut to deliver such
1946 information.

1947 Sec. 51. Section 17b-491b of the general statutes is repealed and the
1948 following is substituted in lieu thereof (*Effective January 1, 2014*):

1949 The maximum allowable cost paid for Factor VIII pharmaceuticals
1950 under the Medicaid [and ConnPACE programs] program shall be the
1951 actual acquisition cost plus eight per cent. The Commissioner of Social
1952 Services may designate specific suppliers of Factor VIII
1953 pharmaceuticals from which a dispensing pharmacy shall order the
1954 prescription to be delivered to the pharmacy and billed by the supplier
1955 to the Department of Social Services. If the commissioner so designates
1956 specific suppliers of Factor VIII pharmaceuticals, the department shall
1957 pay the dispensing pharmacy a handling fee equal to eight per cent of
1958 the actual acquisition cost for such prescription.

1959 Sec. 52. Subsection (c) of section 20-619 of the general statutes is

1960 repealed and the following is substituted in lieu thereof (*Effective*
1961 *January 1, 2014*):

1962 (c) A prescribing practitioner may specify in writing or by a
1963 telephonic or other electronic communication that there shall be no
1964 substitution for the specified brand name drug product in any
1965 prescription, provided (1) in any prescription for a Medicaid [or
1966 ConnPACE] recipient, such practitioner specifies the basis on which
1967 the brand name drug product and dosage form is medically necessary
1968 in comparison to a chemically equivalent generic name drug product
1969 substitution, and (2) the phrase "BRAND MEDICALLY NECESSARY",
1970 shall be in the practitioner's handwriting on the prescription form or
1971 on an electronically produced copy of the prescription form or, if the
1972 prohibition was communicated by telephonic or other electronic
1973 communication that did not reproduce the practitioner's handwriting,
1974 a statement to that effect appears on the form. The phrase "BRAND
1975 MEDICALLY NECESSARY" shall not be preprinted or stamped or
1976 initialed on the form. If the practitioner specifies by telephonic or other
1977 electronic communication that did not reproduce the practitioner's
1978 handwriting that there shall be no substitution for the specified brand
1979 name drug product in any prescription for a Medicaid [or ConnPACE]
1980 recipient, written certification in the practitioner's handwriting bearing
1981 the phrase "BRAND MEDICALLY NECESSARY" shall be sent to the
1982 dispensing pharmacy not later than ten days after the date of such
1983 communication.

1984 Sec. 53. Sections 17a-22j, 17a-22m, 17a-22n, 17a-22o, 17b-260d and
1985 17b-616 of the general statutes are repealed. (*Effective July 1, 2013*)

1986 Sec. 54. Sections 17b-311, 17b-490, 17b-492, 17b-492a and 17b-493 to
1987 17b-498, inclusive, of the general statutes are repealed. (*Effective*
1988 *January 1, 2014*)

This act shall take effect as follows and shall amend the following sections:

Section 1	July 1, 2013	10-295(b)
Sec. 2	July 1, 2013	17b-607
Sec. 3	July 1, 2013	17a-1(5)
Sec. 4	July 1, 2013	17a-93(a)
Sec. 5	July 1, 2013	46b-120(1)
Sec. 6	July 1, 2013	17b-340(f)(4)
Sec. 7	July 1, 2013	17b-340(g)
Sec. 8	July 1, 2013	17b-244(a)
Sec. 9	July 1, 2013	17b-340(h)(1)
Sec. 10	October 1, 2014	New section
Sec. 11	July 1, 2013	17b-239
Sec. 12	July 1, 2013	17b-239e(b)
Sec. 13	July 1, 2013	17b-242(a)
Sec. 14	July 1, 2013	17b-261m(a)
Sec. 15	July 1, 2013	17b-239c(a)
Sec. 16	July 1, 2013	17b-28e
Sec. 17	July 1, 2013	17b-280(a)
Sec. 18	July 1, 2013	17b-104(b)
Sec. 19	July 1, 2013	17b-106(a)
Sec. 20	January 1, 2014	17b-261n
Sec. 21	January 1, 2014	17b-261(a)
Sec. 22	January 1, 2014	17b-256f
Sec. 23	January 1, 2014	17b-551
Sec. 24	January 1, 2014	17b-552
Sec. 25	from passage	17b-278i(a)
Sec. 26	from passage	17b-340c(a)
Sec. 27	July 1, 2013	17b-28(e)
Sec. 28	July 1, 2013	17a-22h
Sec. 29	July 1, 2013	17a-22k
Sec. 30	July 1, 2013	17a-22l
Sec. 31	July 1, 2013	17a-22p
Sec. 32	July 1, 2013	2c-2h(b)
Sec. 33	January 1, 2014	17b-10a
Sec. 34	January 1, 2014	38a-556a(b)
Sec. 35	January 1, 2014	17b-494
Sec. 36	January 1, 2014	29-1s(a)
Sec. 37	January 1, 2014	17b-497
Sec. 38	January 1, 2014	12-746(e)
Sec. 39	January 1, 2014	10a-132e(b)

Sec. 40	January 1, 2014	17a-22f(a)
Sec. 41	January 1, 2014	17a-22h
Sec. 42	January 1, 2014	17b-28(a)
Sec. 43	January 1, 2014	17b-261m(a)
Sec. 44	January 1, 2014	17b-274
Sec. 45	January 1, 2014	17b-274a
Sec. 46	January 1, 2014	17b-274c(a)
Sec. 47	January 1, 2014	17b-274d(e)
Sec. 48	January 1, 2014	17b-274e
Sec. 49	January 1, 2014	17b-280(a)
Sec. 50	January 1, 2014	17b-429
Sec. 51	January 1, 2014	17b-491b
Sec. 52	January 1, 2014	20-619(c)
Sec. 53	July 1, 2013	Repealer section
Sec. 54	January 1, 2014	Repealer section

Statement of Purpose:

To implement the Governor's budget recommendations concerning human services programs.

[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.]