



General Assembly

Substitute Bill No. 6367

January Session, 2013



**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2 repealed and the following is substituted in lieu thereof (*Effective July*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 the family members of persons with disabilities and senior
95 citizens for the purchase of assistive technology and adaptive
96 equipment and services. Each such loan shall be made for a term of not
97 more than [five] ten years. Any loans made under this section shall
98 bear interest at a [rate to be determined in accordance with subsection
99 (t) of section 3-20] fixed rate determined by the commissioner, not to
100 exceed six per cent. Said commissioner is authorized to expend any
101 funds necessary for the reasonable direct expenses relating to the
102 administration of said fund. Said commissioner shall adopt
103 regulations, in accordance with the provisions of chapter 54, to
104 implement the purposes of this section.

105 (b) The State Bond Commission shall have power from time to time
106 to authorize the issuance of bonds of the state in one or more series in
107 accordance with section 3-20 and in a principal amount necessary to
108 carry out the purposes of this section, but not in excess of an aggregate
109 amount of one million dollars. All of said bonds shall be payable at
110 such place or places as may be determined by the Treasurer pursuant
111 to section 3-19 and shall bear such date or dates, mature at such time or
112 times, not exceeding five years from their respective dates, bear
113 interest at such rate or different or varying rates and payable at such
114 time or times, be in such denominations, be in such form with or
115 without interest coupons attached, carry such registration and transfer
116 privileges, be payable in such medium of payment and be subject to
117 such terms of redemption with or without premium as, irrespective of

118 the provisions of said section 3-20, may be provided by the
119 authorization of the State Bond Commission or fixed in accordance
120 therewith. The proceeds of the sale of such bonds shall be deposited in
121 the Assistive Technology Revolving Fund created by this section. Such
122 bonds shall be general obligations of the state and the full faith and
123 credit of the state of Connecticut are pledged for the payment of the
124 principal of and interest on such bonds as the same become due.
125 Accordingly, and as part of the contract of the state with the holders of
126 such bonds, appropriation of all amounts necessary for punctual
127 payment of such principal and interest is hereby made and the
128 Treasurer shall pay such principal and interest as the same become
129 due. Net earnings on investments or reinvestments of proceeds,
130 accrued interest and premiums on the issuance of such bonds, after
131 payment therefrom of expenses incurred by the Treasurer or State
132 Bond Commission in connection with their issuance, shall be deposited
133 in the General Fund of the state.

134 (c) The Connecticut Tech Act Project, within the Department of
135 Rehabilitation Services and as authorized by 29 USC 3001, may
136 provide assistive technology evaluation and training services upon the
137 request of any person or any public or private entity, to the extent
138 persons who provide assistive technology services are available. The
139 project may charge a fee to any person or entity receiving such
140 assistive technology evaluation and training services to reimburse the
141 department for its costs. The Commissioner of Rehabilitation Services
142 shall establish fees at reasonable rates that will cover the department's
143 direct and indirect costs.

144 Sec. 3. Subdivision (5) of section 17a-1 of the general statutes is
145 repealed and the following is substituted in lieu thereof (*Effective July*
146 *1, 2013*):

147 (5) "Child" means [a child, as defined in section 46b-120] any person
148 (A) under eighteen years of age, or (B) eighteen years of age or older
149 but under twenty-one years of age who was committed to the
150 commissioner before attaining his or her eighteenth birthday and is: (i)

151 Enrolled full time, or in the commissioner's discretion part time, in an
152 approved secondary education program or an approved program
153 leading to an equivalent credential; (ii) enrolled full time, or in the
154 commissioner's discretion part time, in an institution which provides
155 post-secondary or vocational education; or (iii) participating in a
156 program or activity approved by the commissioner that is designed to
157 promote or remove barriers to employment;

158 Sec. 4. Subsection (a) of section 17a-93 of the general statutes is
159 repealed and the following is substituted in lieu thereof (*Effective July*
160 *1, 2013*):

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

174 Sec. 5. Subdivision (1) of section 46b-120 of the general statutes is
175 repealed and the following is substituted in lieu thereof (*Effective July*
176 *1, 2013*):

177 (1) "Child" means any person under eighteen years of age who has
178 not been legally emancipated, except that (A) for purposes of
179 delinquency matters and proceedings, "child" means any person who
180 (i) is at least seven years of age at the time of the alleged commission of
181 a delinquent act and who is (I) under eighteen years of age and has not
182 been legally emancipated, or (II) eighteen years of age or older and

183 committed a delinquent act prior to attaining eighteen years of age, or
184 (ii) is subsequent to attaining eighteen years of age, and (I) violates any
185 order of the Superior Court or any condition of probation ordered by
186 the Superior Court with respect to a delinquency proceeding, or (II)
187 wilfully fails to appear in response to a summons under section 46b-
188 133 or at any other court hearing in a delinquency proceeding of which
189 the child had notice, [and] (B) for purposes of family with service
190 needs matters and proceedings, child means a person who is at least
191 seven years of age and is under eighteen years of age, and (C) for
192 purposes of providing post-majority services, any person eighteen
193 years of age or older but under twenty-one years of age who was
194 committed to the Commissioner of Children and Families before
195 attaining his or her eighteenth birthday and is: (i) Enrolled full time, or
196 in said commissioner's discretion part time, in an approved secondary
197 education program or an approved program leading to an equivalent
198 credential; (ii) enrolled full time, or in said commissioner's discretion
199 part time, in an institution which provides post-secondary or
200 vocational education; or (iii) participating in a program or activity
201 approved by said commissioner that is designed to promote or remove
202 barriers to employment;

203 Sec. 6. Subdivision (4) of subsection (f) of section 17b-340 of the
204 general statutes is repealed and the following is substituted in lieu
205 thereof (*Effective July 1, 2013*):

206 (4) For the fiscal year ending June 30, 1992, (A) no facility shall
207 receive a rate that is less than the rate it received for the rate year
208 ending June 30, 1991; (B) no facility whose rate, if determined pursuant
209 to this subsection, would exceed one hundred twenty per cent of the
210 state-wide median rate, as determined pursuant to this subsection,
211 shall receive a rate which is five and one-half per cent more than the
212 rate it received for the rate year ending June 30, 1991; and (C) no
213 facility whose rate, if determined pursuant to this subsection, would be
214 less than one hundred twenty per cent of the state-wide median rate,
215 as determined pursuant to this subsection, shall receive a rate which is

216 six and one-half per cent more than the rate it received for the rate year
217 ending June 30, 1991. For the fiscal year ending June 30, 1993, no
218 facility shall receive a rate that is less than the rate it received for the
219 rate year ending June 30, 1992, or six per cent more than the rate it
220 received for the rate year ending June 30, 1992. For the fiscal year
221 ending June 30, 1994, no facility shall receive a rate that is less than the
222 rate it received for the rate year ending June 30, 1993, or six per cent
223 more than the rate it received for the rate year ending June 30, 1993.
224 For the fiscal year ending June 30, 1995, no facility shall receive a rate
225 that is more than five per cent less than the rate it received for the rate
226 year ending June 30, 1994, or six per cent more than the rate it received
227 for the rate year ending June 30, 1994. For the fiscal years ending June
228 30, 1996, and June 30, 1997, no facility shall receive a rate that is more
229 than three per cent more than the rate it received for the prior rate
230 year. For the fiscal year ending June 30, 1998, a facility shall receive a
231 rate increase that is not more than two per cent more than the rate that
232 the facility received in the prior year. For the fiscal year ending June
233 30, 1999, a facility shall receive a rate increase that is not more than
234 three per cent more than the rate that the facility received in the prior
235 year and that is not less than one per cent more than the rate that the
236 facility received in the prior year, exclusive of rate increases associated
237 with a wage, benefit and staffing enhancement rate adjustment added
238 for the period from April 1, 1999, to June 30, 1999, inclusive. For the
239 fiscal year ending June 30, 2000, each facility, except a facility with an
240 interim rate or replaced interim rate for the fiscal year ending June 30,
241 1999, and a facility having a certificate of need or other agreement
242 specifying rate adjustments for the fiscal year ending June 30, 2000,
243 shall receive a rate increase equal to one per cent applied to the rate the
244 facility received for the fiscal year ending June 30, 1999, exclusive of
245 the facility's wage, benefit and staffing enhancement rate adjustment.
246 For the fiscal year ending June 30, 2000, no facility with an interim rate,
247 replaced interim rate or scheduled rate adjustment specified in a
248 certificate of need or other agreement for the fiscal year ending June
249 30, 2000, shall receive a rate increase that is more than one per cent
250 more than the rate the facility received in the fiscal year ending June

251 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a
252 facility with an interim rate or replaced interim rate for the fiscal year
253 ending June 30, 2000, and a facility having a certificate of need or other
254 agreement specifying rate adjustments for the fiscal year ending June
255 30, 2001, shall receive a rate increase equal to two per cent applied to
256 the rate the facility received for the fiscal year ending June 30, 2000,
257 subject to verification of wage enhancement adjustments pursuant to
258 subdivision (14) of this subsection. For the fiscal year ending June 30,
259 2001, no facility with an interim rate, replaced interim rate or
260 scheduled rate adjustment specified in a certificate of need or other
261 agreement for the fiscal year ending June 30, 2001, shall receive a rate
262 increase that is more than two per cent more than the rate the facility
263 received for the fiscal year ending June 30, 2000. For the fiscal year
264 ending June 30, 2002, each facility shall receive a rate that is two and
265 one-half per cent more than the rate the facility received in the prior
266 fiscal year. For the fiscal year ending June 30, 2003, each facility shall
267 receive a rate that is two per cent more than the rate the facility
268 received in the prior fiscal year, except that such increase shall be
269 effective January 1, 2003, and such facility rate in effect for the fiscal
270 year ending June 30, 2002, shall be paid for services provided until
271 December 31, 2002, except any facility that would have been issued a
272 lower rate effective July 1, 2002, than for the fiscal year ending June 30,
273 2002, due to interim rate status or agreement with the department shall
274 be issued such lower rate effective July 1, 2002, and have such rate
275 increased two per cent effective June 1, 2003. For the fiscal year ending
276 June 30, 2004, rates in effect for the period ending June 30, 2003, shall
277 remain in effect, except any facility that would have been issued a
278 lower rate effective July 1, 2003, than for the fiscal year ending June 30,
279 2003, due to interim rate status or agreement with the department shall
280 be issued such lower rate effective July 1, 2003. For the fiscal year
281 ending June 30, 2005, rates in effect for the period ending June 30, 2004,
282 shall remain in effect until December 31, 2004, except any facility that
283 would have been issued a lower rate effective July 1, 2004, than for the
284 fiscal year ending June 30, 2004, due to interim rate status or
285 agreement with the department shall be issued such lower rate

286 effective July 1, 2004. Effective January 1, 2005, each facility shall
287 receive a rate that is one per cent greater than the rate in effect
288 December 31, 2004. Effective upon receipt of all the necessary federal
289 approvals to secure federal financial participation matching funds
290 associated with the rate increase provided in this subdivision, but in
291 no event earlier than July 1, 2005, and provided the user fee imposed
292 under section 17b-320 is required to be collected, for the fiscal year
293 ending June 30, 2006, the department shall compute the rate for each
294 facility based upon its 2003 cost report filing or a subsequent cost year
295 filing for facilities having an interim rate for the period ending June 30,
296 2005, as provided under section 17-311-55 of the regulations of
297 Connecticut state agencies. For each facility not having an interim rate
298 for the period ending June 30, 2005, the rate for the period ending June
299 30, 2006, shall be determined beginning with the higher of the
300 computed rate based upon its 2003 cost report filing or the rate in
301 effect for the period ending June 30, 2005. Such rate shall then be
302 increased by eleven dollars and eighty cents per day except that in no
303 event shall the rate for the period ending June 30, 2006, be thirty-two
304 dollars more than the rate in effect for the period ending June 30, 2005,
305 and for any facility with a rate below one hundred ninety-five dollars
306 per day for the period ending June 30, 2005, such rate for the period
307 ending June 30, 2006, shall not be greater than two hundred seventeen
308 dollars and forty-three cents per day and for any facility with a rate
309 equal to or greater than one hundred ninety-five dollars per day for
310 the period ending June 30, 2005, such rate for the period ending June
311 30, 2006, shall not exceed the rate in effect for the period ending June
312 30, 2005, increased by eleven and one-half per cent. For each facility
313 with an interim rate for the period ending June 30, 2005, the interim
314 replacement rate for the period ending June 30, 2006, shall not exceed
315 the rate in effect for the period ending June 30, 2005, increased by
316 eleven dollars and eighty cents per day plus the per day cost of the
317 user fee payments made pursuant to section 17b-320 divided by
318 annual resident service days, except for any facility with an interim
319 rate below one hundred ninety-five dollars per day for the period
320 ending June 30, 2005, the interim replacement rate for the period

321 ending June 30, 2006, shall not be greater than two hundred seventeen
322 dollars and forty-three cents per day and for any facility with an
323 interim rate equal to or greater than one hundred ninety-five dollars
324 per day for the period ending June 30, 2005, the interim replacement
325 rate for the period ending June 30, 2006, shall not exceed the rate in
326 effect for the period ending June 30, 2005, increased by eleven and one-
327 half per cent. Such July 1, 2005, rate adjustments shall remain in effect
328 unless (i) the federal financial participation matching funds associated
329 with the rate increase are no longer available; or (ii) the user fee
330 created pursuant to section 17b-320 is not in effect. For the fiscal year
331 ending June 30, 2007, each facility shall receive a rate that is three per
332 cent greater than the rate in effect for the period ending June 30, 2006,
333 except any facility that would have been issued a lower rate effective
334 July 1, 2006, than for the rate period ending June 30, 2006, due to
335 interim rate status or agreement with the department, shall be issued
336 such lower rate effective July 1, 2006. For the fiscal year ending June
337 30, 2008, each facility shall receive a rate that is two and nine-tenths
338 per cent greater than the rate in effect for the period ending June 30,
339 2007, except any facility that would have been issued a lower rate
340 effective July 1, 2007, than for the rate period ending June 30, 2007, due
341 to interim rate status or agreement with the department, shall be
342 issued such lower rate effective July 1, 2007. For the fiscal year ending
343 June 30, 2009, rates in effect for the period ending June 30, 2008, shall
344 remain in effect until June 30, 2009, except any facility that would have
345 been issued a lower rate for the fiscal year ending June 30, 2009, due to
346 interim rate status or agreement with the department shall be issued
347 such lower rate. For the fiscal years ending June 30, 2010, and June 30,
348 2011, rates in effect for the period ending June 30, 2009, shall remain in
349 effect until June 30, 2011, except any facility that would have been
350 issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal
351 year ending June 30, 2011, due to interim rate status or agreement with
352 the department, shall be issued such lower rate. For the fiscal years
353 ending June 30, 2012, and June 30, 2013, rates in effect for the period
354 ending June 30, 2011, shall remain in effect until June 30, 2013, except
355 any facility that would have been issued a lower rate for the fiscal year

356 ending June 30, 2012, or the fiscal year ending June 30, 2013, due to
357 interim rate status or agreement with the department, shall be issued
358 such lower rate. For the fiscal years ending June 30, 2014, and June 30,
359 2015, rates shall not exceed those in effect for the period ending June
360 30, 2013. Any facility that would have been issued a lower rate for the
361 fiscal year ending June 30, 2014, or the fiscal year ending June 30, 2015,
362 due to rebasing, available appropriations, interim rate status or
363 agreement with the department, shall be issued such lower rate. The
364 Commissioner of Social Services shall add fair rent increases to any
365 other rate increases established pursuant to this subdivision for a
366 facility which has undergone a material change in circumstances
367 related to fair rent, except for the fiscal years ending June 30, 2010, June
368 30, 2011, and June 30, 2012, such fair rent increases shall only be
369 provided to facilities with an approved certificate of need pursuant to
370 section 17b-352, 17b-353, 17b-354 or 17b-355. For the fiscal year ending
371 June 30, 2013, the commissioner may, within available appropriations,
372 provide pro rata fair rent increases for facilities which have undergone
373 a material change in circumstances related to fair rent additions placed
374 in service in cost report years ending September 30, 2008, to September
375 30, 2011, inclusive, and not otherwise included in rates issued. For the
376 fiscal year ending June 30, 2013, the commissioner shall add fair rent
377 increases associated with an approved certificate of need pursuant to
378 section 17b-352, 17b-353, 17b-354 or 17b-355. Interim rates may take
379 into account reasonable costs incurred by a facility, including wages
380 and benefits. Notwithstanding the provisions of this section, the
381 Commissioner of Social Services may, [within] subject to available
382 appropriations, increase or decrease rates issued to licensed chronic
383 and convalescent nursing homes and licensed rest homes with nursing
384 supervision.

385 Sec. 7. Subsection (g) of section 17b-340 of the general statutes is
386 repealed and the following is substituted in lieu thereof (*Effective July*
387 *1, 2013*):

388 (g) For the fiscal year ending June 30, 1993, any intermediate care

389 facility for the mentally retarded with an operating cost component of
390 its rate in excess of one hundred forty per cent of the median of
391 operating cost components of rates in effect January 1, 1992, shall not
392 receive an operating cost component increase. For the fiscal year
393 ending June 30, 1993, any intermediate care facility for the mentally
394 retarded with an operating cost component of its rate that is less than
395 one hundred forty per cent of the median of operating cost
396 components of rates in effect January 1, 1992, shall have an allowance
397 for real wage growth equal to thirty per cent of the increase
398 determined in accordance with subsection (q) of section 17-311-52 of
399 the regulations of Connecticut state agencies, provided such operating
400 cost component shall not exceed one hundred forty per cent of the
401 median of operating cost components in effect January 1, 1992. Any
402 facility with real property other than land placed in service prior to
403 October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a
404 rate of return on real property equal to the average of the rates of
405 return applied to real property other than land placed in service for the
406 five years preceding October 1, 1993. For the fiscal year ending June 30,
407 1996, and any succeeding fiscal year, the rate of return on real property
408 for property items shall be revised every five years. The commissioner
409 shall, upon submission of a request, allow actual debt service,
410 comprised of principal and interest, in excess of property costs allowed
411 pursuant to section 17-311-52 of the regulations of Connecticut state
412 agencies, provided such debt service terms and amounts are
413 reasonable in relation to the useful life and the base value of the
414 property. For the fiscal year ending June 30, 1995, and any succeeding
415 fiscal year, the inflation adjustment made in accordance with
416 subsection (p) of section 17-311-52 of the regulations of Connecticut
417 state agencies shall not be applied to real property costs. For the fiscal
418 year ending June 30, 1996, and any succeeding fiscal year, the
419 allowance for real wage growth, as determined in accordance with
420 subsection (q) of section 17-311-52 of the regulations of Connecticut
421 state agencies, shall not be applied. For the fiscal year ending June 30,
422 1996, and any succeeding fiscal year, no rate shall exceed three
423 hundred seventy-five dollars per day unless the commissioner, in

424 consultation with the Commissioner of Developmental Services,
425 determines after a review of program and management costs, that a
426 rate in excess of this amount is necessary for care and treatment of
427 facility residents. For the fiscal year ending June 30, 2002, rate period,
428 the Commissioner of Social Services shall increase the inflation
429 adjustment for rates made in accordance with subsection (p) of section
430 17-311-52 of the regulations of Connecticut state agencies to update
431 allowable fiscal year 2000 costs to include a three and one-half per cent
432 inflation factor. For the fiscal year ending June 30, 2003, rate period, the
433 commissioner shall increase the inflation adjustment for rates made in
434 accordance with subsection (p) of section 17-311-52 of the regulations
435 of Connecticut state agencies to update allowable fiscal year 2001 costs
436 to include a one and one-half per cent inflation factor, except that such
437 increase shall be effective November 1, 2002, and such facility rate in
438 effect for the fiscal year ending June 30, 2002, shall be paid for services
439 provided until October 31, 2002, except any facility that would have
440 been issued a lower rate effective July 1, 2002, than for the fiscal year
441 ending June 30, 2002, due to interim rate status or agreement with the
442 department shall be issued such lower rate effective July 1, 2002, and
443 have such rate updated effective November 1, 2002, in accordance with
444 applicable statutes and regulations. For the fiscal year ending June 30,
445 2004, rates in effect for the period ending June 30, 2003, shall remain in
446 effect, except any facility that would have been issued a lower rate
447 effective July 1, 2003, than for the fiscal year ending June 30, 2003, due
448 to interim rate status or agreement with the department shall be issued
449 such lower rate effective July 1, 2003. For the fiscal year ending June
450 30, 2005, rates in effect for the period ending June 30, 2004, shall
451 remain in effect until September 30, 2004. Effective October 1, 2004,
452 each facility shall receive a rate that is five per cent greater than the
453 rate in effect September 30, 2004. Effective upon receipt of all the
454 necessary federal approvals to secure federal financial participation
455 matching funds associated with the rate increase provided in
456 subdivision (4) of subsection (f) of this section, but in no event earlier
457 than October 1, 2005, and provided the user fee imposed under section
458 17b-320 is required to be collected, each facility shall receive a rate that

459 is four per cent more than the rate the facility received in the prior
460 fiscal year, except any facility that would have been issued a lower rate
461 effective October 1, 2005, than for the fiscal year ending June 30, 2005,
462 due to interim rate status or agreement with the department, shall be
463 issued such lower rate effective October 1, 2005. Such rate increase
464 shall remain in effect unless: (1) The federal financial participation
465 matching funds associated with the rate increase are no longer
466 available; or (2) the user fee created pursuant to section 17b-320 is not
467 in effect. For the fiscal year ending June 30, 2007, rates in effect for the
468 period ending June 30, 2006, shall remain in effect until September 30,
469 2006, except any facility that would have been issued a lower rate
470 effective July 1, 2006, than for the fiscal year ending June 30, 2006, due
471 to interim rate status or agreement with the department, shall be
472 issued such lower rate effective July 1, 2006. Effective October 1, 2006,
473 no facility shall receive a rate that is more than three per cent greater
474 than the rate in effect for the facility on September 30, 2006, except any
475 facility that would have been issued a lower rate effective October 1,
476 2006, due to interim rate status or agreement with the department,
477 shall be issued such lower rate effective October 1, 2006. For the fiscal
478 year ending June 30, 2008, each facility shall receive a rate that is two
479 and nine-tenths per cent greater than the rate in effect for the period
480 ending June 30, 2007, except any facility that would have been issued a
481 lower rate effective July 1, 2007, than for the rate period ending June
482 30, 2007, due to interim rate status, or agreement with the department,
483 shall be issued such lower rate effective July 1, 2007. For the fiscal year
484 ending June 30, 2009, rates in effect for the period ending June 30, 2008,
485 shall remain in effect until June 30, 2009, except any facility that would
486 have been issued a lower rate for the fiscal year ending June 30, 2009,
487 due to interim rate status or agreement with the department, shall be
488 issued such lower rate. For the fiscal years ending June 30, 2010, and
489 June 30, 2011, rates in effect for the period ending June 30, 2009, shall
490 remain in effect until June 30, 2011, except any facility that would have
491 been issued a lower rate for the fiscal year ending June 30, 2010, or the
492 fiscal year ending June 30, 2011, due to interim rate status or
493 agreement with the department, shall be issued such lower rate. For

494 the fiscal year ending June 30, 2012, rates in effect for the period
495 ending June 30, 2011, shall remain in effect until June 30, 2012, except
496 any facility that would have been issued a lower rate for the fiscal year
497 ending June 30, 2012, due to interim rate status or agreement with the
498 department, shall be issued such lower rate. Any facility that would
499 have been issued a lower rate for the fiscal year ending June 30, 2014,
500 or the fiscal year ending June 30, 2015, due to interim rate status or
501 agreement with the department, shall be issued such lower rate. For
502 the fiscal year ending June 30, 2013, any facility that has a significant
503 decrease in land and building costs shall receive a reduced rate to
504 reflect such decrease in land and building costs. For the fiscal years
505 ending June 30, 2012, [and] June 30, 2013, June 30, 2014, and June 30,
506 2015, the Commissioner of Social Services may provide fair rent
507 increases to any facility that has undergone a material change in
508 circumstances related to fair rent and has an approved certificate of
509 need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355.
510 Notwithstanding the provisions of this section, the Commissioner of
511 Social Services may, within available appropriations, increase or
512 decrease rates issued to intermediate care facilities for the mentally
513 retarded to reflect the rebasing of facility costs.

514 Sec. 8. Subsection (a) of section 17b-244 of the general statutes is
515 repealed and the following is substituted in lieu thereof (*Effective July*
516 *1, 2013*):

517 (a) The room and board component of the rates to be paid by the
518 state to private facilities and facilities operated by regional education
519 service centers which are licensed to provide residential care pursuant
520 to section 17a-227, but not certified to participate in the Title XIX
521 Medicaid program as intermediate care facilities for persons with
522 mental retardation, shall be determined annually by the Commissioner
523 of Social Services, except that rates effective April 30, 1989, shall
524 remain in effect through October 31, 1989. Any facility with real
525 property other than land placed in service prior to July 1, 1991, shall,
526 for the fiscal year ending June 30, 1995, receive a rate of return on real

527 property equal to the average of the rates of return applied to real
528 property other than land placed in service for the five years preceding
529 July 1, 1993. For the fiscal year ending June 30, 1996, and any
530 succeeding fiscal year, the rate of return on real property for property
531 items shall be revised every five years. The commissioner shall, upon
532 submission of a request by such facility, allow actual debt service,
533 comprised of principal and interest, on the loan or loans in lieu of
534 property costs allowed pursuant to section 17-313b-5 of the regulations
535 of Connecticut state agencies, whether actual debt service is higher or
536 lower than such allowed property costs, provided such debt service
537 terms and amounts are reasonable in relation to the useful life and the
538 base value of the property. In the case of facilities financed through the
539 Connecticut Housing Finance Authority, the commissioner shall allow
540 actual debt service, comprised of principal, interest and a reasonable
541 repair and replacement reserve on the loan or loans in lieu of property
542 costs allowed pursuant to section 17-313b-5 of the regulations of
543 Connecticut state agencies, whether actual debt service is higher or
544 lower than such allowed property costs, provided such debt service
545 terms and amounts are determined by the commissioner at the time
546 the loan is entered into to be reasonable in relation to the useful life
547 and base value of the property. The commissioner may allow fees
548 associated with mortgage refinancing provided such refinancing will
549 result in state reimbursement savings, after comparing costs over the
550 terms of the existing proposed loans. For the fiscal year ending June 30,
551 1992, the inflation factor used to determine rates shall be one-half of
552 the gross national product percentage increase for the period between
553 the midpoint of the cost year through the midpoint of the rate year. For
554 fiscal year ending June 30, 1993, the inflation factor used to determine
555 rates shall be two-thirds of the gross national product percentage
556 increase from the midpoint of the cost year to the midpoint of the rate
557 year. For the fiscal years ending June 30, 1996, and June 30, 1997, no
558 inflation factor shall be applied in determining rates. The
559 Commissioner of Social Services shall prescribe uniform forms on
560 which such facilities shall report their costs. Such rates shall be
561 determined on the basis of a reasonable payment for necessary

562 services. Any increase in grants, gifts, fund-raising or endowment
563 income used for the payment of operating costs by a private facility in
564 the fiscal year ending June 30, 1992, shall be excluded by the
565 commissioner from the income of the facility in determining the rates
566 to be paid to the facility for the fiscal year ending June 30, 1993,
567 provided any operating costs funded by such increase shall not
568 obligate the state to increase expenditures in subsequent fiscal years.
569 Nothing contained in this section shall authorize a payment by the
570 state to any such facility in excess of the charges made by the facility
571 for comparable services to the general public. The service component
572 of the rates to be paid by the state to private facilities and facilities
573 operated by regional education service centers which are licensed to
574 provide residential care pursuant to section 17a-227, but not certified
575 to participate in the Title XIX Medicaid programs as intermediate care
576 facilities for persons with mental retardation, shall be determined
577 annually by the Commissioner of Developmental Services in
578 accordance with section 17b-244a. For the fiscal year ending June 30,
579 2008, no facility shall receive a rate that is more than two per cent
580 greater than the rate in effect for the facility on June 30, 2007, except
581 any facility that would have been issued a lower rate effective July 1,
582 2007, due to interim rate status or agreement with the department,
583 shall be issued such lower rate effective July 1, 2007. For the fiscal year
584 ending June 30, 2009, no facility shall receive a rate that is more than
585 two per cent greater than the rate in effect for the facility on June 30,
586 2008, except any facility that would have been issued a lower rate
587 effective July 1, 2008, due to interim rate status or agreement with the
588 department, shall be issued such lower rate effective July 1, 2008. For
589 the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect
590 for the period ending June 30, 2009, shall remain in effect until June 30,
591 2011, except that (1) the rate paid to a facility may be higher than the
592 rate paid to the facility for the period ending June 30, 2009, if a capital
593 improvement required by the Commissioner of Developmental
594 Services for the health or safety of the residents was made to the
595 facility during the fiscal [years] year ending June 30, 2010, or June 30,
596 2011, and (2) any facility that would have been issued a lower rate for

597 the fiscal [years] year ending June 30, 2010, or June 30, 2011, due to
598 interim rate status or agreement with the department, shall be issued
599 such lower rate. For the fiscal year ending June 30, 2012, rates in effect
600 for the period ending June 30, 2011, shall remain in effect until June 30,
601 2012, except that (A) the rate paid to a facility may be higher than the
602 rate paid to the facility for the period ending June 30, 2011, 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 year ending June 30, 2012, and (B) any facility
606 that would have been issued a lower rate for the fiscal year ending
607 June 30, 2012, due to interim rate status or agreement with the
608 department, shall be issued such lower rate. For the fiscal year ending
609 June 30, 2013, any facility that has a significant decrease in land and
610 building costs shall receive a reduced rate to reflect such decrease in
611 land and building costs. Any facility that would have been issued a
612 lower rate for the fiscal year ending June 30, 2014, or June 30, 2015, due
613 to interim rate status or agreement with the department, shall be
614 issued such lower rate.

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

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

630 median of operating cost components in effect January 1, 1992.
631 Beginning with the fiscal year ending June 30, 1993, for the purpose of
632 determining allowable fair rent, a residential care home with allowable
633 fair rent less than the twenty-fifth percentile of the state-wide
634 allowable fair rent shall be reimbursed as having allowable fair rent
635 equal to the twenty-fifth percentile of the state-wide allowable fair
636 rent. Beginning with the fiscal year ending June 30, 1997, a residential
637 care home with allowable fair rent less than three dollars and ten cents
638 per day shall be reimbursed as having allowable fair rent equal to
639 three dollars and ten cents per day. Property additions placed in
640 service during the cost year ending September 30, 1996, or any
641 succeeding cost year shall receive a fair rent allowance for such
642 additions as an addition to three dollars and ten cents per day if the
643 fair rent for the facility for property placed in service prior to
644 September 30, 1995, is less than or equal to three dollars and ten cents
645 per day. For the fiscal year ending June 30, 1996, and any succeeding
646 fiscal year, the allowance for real wage growth, as determined in
647 accordance with subsection (q) of section 17-311-52 of the regulations
648 of Connecticut state agencies, shall not be applied. For the fiscal year
649 ending June 30, 1996, and any succeeding fiscal year, the inflation
650 adjustment made in accordance with subsection (p) of section 17-311-
651 52 of the regulations of Connecticut state agencies shall not be applied
652 to real property costs. Beginning with the fiscal year ending June 30,
653 1997, minimum allowable patient days for rate computation purposes
654 for a residential care home with twenty-five beds or less shall be
655 eighty-five per cent of licensed capacity. Beginning with the fiscal year
656 ending June 30, 2002, for the purposes of determining the allowable
657 salary of an administrator of a residential care home with sixty beds or
658 less the department shall revise the allowable base salary to thirty-
659 seven thousand dollars to be annually inflated thereafter in accordance
660 with section 17-311-52 of the regulations of Connecticut state agencies.
661 The rates for the fiscal year ending June 30, 2002, shall be based upon
662 the increased allowable salary of an administrator, regardless of
663 whether such amount was expended in the 2000 cost report period
664 upon which the rates are based. Beginning with the fiscal year ending

665 June 30, 2000, and until the fiscal year ending June 30, 2009, inclusive,
666 the inflation adjustment for rates made in accordance with subsection
667 (p) of section 17-311-52 of the regulations of Connecticut state agencies
668 shall be increased by two per cent, and beginning with the fiscal year
669 ending June 30, 2002, the inflation adjustment for rates made in
670 accordance with subsection (c) of said section shall be increased by one
671 per cent. Beginning with the fiscal year ending June 30, 1999, for the
672 purpose of determining the allowable salary of a related party, the
673 department shall revise the maximum salary to twenty-seven
674 thousand eight hundred fifty-six dollars to be annually inflated
675 thereafter in accordance with section 17-311-52 of the regulations of
676 Connecticut state agencies and beginning with the fiscal year ending
677 June 30, 2001, such allowable salary shall be computed on an hourly
678 basis and the maximum number of hours allowed for a related party
679 other than the proprietor shall be increased from forty hours to forty-
680 eight hours per work week. For the fiscal year ending June 30, 2005,
681 each facility shall receive a rate that is two and one-quarter per cent
682 more than the rate the facility received in the prior fiscal year, except
683 any facility that would have been issued a lower rate effective July 1,
684 2004, than for the fiscal year ending June 30, 2004, due to interim rate
685 status or agreement with the department shall be issued such lower
686 rate effective July 1, 2004. Effective upon receipt of all the necessary
687 federal approvals to secure federal financial participation matching
688 funds associated with the rate increase provided in subdivision (4) of
689 subsection (f) of this section, but in no event earlier than October 1,
690 2005, and provided the user fee imposed under section 17b-320 is
691 required to be collected, each facility shall receive a rate that is
692 determined in accordance with applicable law and subject to
693 appropriations, except any facility that would have been issued a
694 lower rate effective October 1, 2005, than for the fiscal year ending June
695 30, 2005, due to interim rate status or agreement with the department,
696 shall be issued such lower rate effective October 1, 2005. Such rate
697 increase shall remain in effect unless: (A) The federal financial
698 participation matching funds associated with the rate increase are no
699 longer available; or (B) the user fee created pursuant to section 17b-320

700 is not in effect. For the fiscal year ending June 30, 2007, rates in effect
701 for the period ending June 30, 2006, shall remain in effect until
702 September 30, 2006, except any facility that would have been issued a
703 lower rate effective July 1, 2006, than for the fiscal year ending June 30,
704 2006, due to interim rate status or agreement with the department,
705 shall be issued such lower rate effective July 1, 2006. Effective October
706 1, 2006, no facility shall receive a rate that is more than four per cent
707 greater than the rate in effect for the facility on September 30, 2006,
708 except for any facility that would have been issued a lower rate
709 effective October 1, 2006, due to interim rate status or agreement with
710 the department, shall be issued such lower rate effective October 1,
711 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates
712 in effect for the period ending June 30, 2009, shall remain in effect until
713 June 30, 2011, except any facility that would have been issued a lower
714 rate for the fiscal year ending June 30, 2010, or the fiscal year ending
715 June 30, 2011, due to interim rate status or agreement with the
716 department, shall be issued such lower rate, except (i) any facility that
717 would have been issued a lower rate for the fiscal year ending June 30,
718 2010, or the fiscal year ending June 30, 2011, due to interim rate status
719 or agreement with the Commissioner of Social Services shall be issued
720 such lower rate; and (ii) the commissioner may increase a facility's rate
721 for reasonable costs associated with such facility's compliance with the
722 provisions of section 19a-495a concerning the administration of
723 medication by unlicensed personnel. For the fiscal year ending June 30,
724 2012, rates in effect for the period ending June 30, 2011, shall remain in
725 effect until June 30, 2012, except that (I) any facility that would have
726 been issued a lower rate for the fiscal year ending June 30, 2012, due to
727 interim rate status or agreement with the Commissioner of Social
728 Services shall be issued such lower rate; and (II) the commissioner may
729 increase a facility's rate for reasonable costs associated with such
730 facility's compliance with the provisions of section 19a-495a
731 concerning the administration of medication by unlicensed personnel.
732 For the fiscal year ending June 30, 2013, the Commissioner of Social
733 Services may, within available appropriations, provide a rate increase
734 to a residential care home. Any facility that would have been issued a

735 lower rate for the fiscal year ending June 30, 2013, due to interim rate
736 status or agreement with the Commissioner of Social Services shall be
737 issued such lower rate. For the fiscal years ending June 30, 2012, and
738 June 30, 2013, the Commissioner of Social Services may provide fair
739 rent increases to any facility that has undergone a material change in
740 circumstances related to fair rent and has an approved certificate of
741 need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. Any
742 facility that would have been issued a lower rate for the fiscal year
743 ending June 30, 2014, or the fiscal year ending June 30, 2015, due to
744 interim rate status or agreement with the commissioner, shall be issued
745 such lower rate. The department may, within available appropriations,
746 increase or decrease residential care home rates to reflect the rebasing
747 of facility costs as provided in subsection (a) of this section.

748 Sec. 10. (NEW) (*Effective October 1, 2014*) The Commissioner of Social
749 Services shall implement the tenth revision of the International
750 Statistical Classification of Diseases and Related Health Problems for
751 the purposes of all medical assistance programs administered by the
752 Department of Social Services. The Commissioner of Social Services
753 may implement policies and procedures as necessary to carry out the
754 provisions of this section while in the process of adopting the policies
755 and procedures as regulations, provided notice of intent to adopt the
756 regulations is published in the Connecticut Law Journal within twenty
757 days of implementation.

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

760 (a) [The rate to be paid by the state to hospitals receiving
761 appropriations granted by the General Assembly and to freestanding
762 chronic disease hospitals, providing services to persons aided or cared
763 for by the state for routine services furnished to state patients, shall be
764 based upon reasonable cost to such hospital, or the charge to the
765 general public for ward services or the lowest charge for semiprivate
766 services if the hospital has no ward facilities, imposed by such
767 hospital, whichever is lowest, except to the extent, if any, that the

768 commissioner determines that a greater amount is appropriate in the
769 case of hospitals serving a disproportionate share of indigent patients.
770 Such rate shall be promulgated annually by the Commissioner of
771 Social Services.] On and after July 1, 2013, Medicaid rates paid to acute
772 care and children's hospitals shall be based on diagnosis-related
773 groups established and periodically rebased by the Commissioner of
774 Social Services, provided the Department of Social Services completes
775 a fiscal analysis of the impact of such rate payment system on each
776 hospital. The Commissioner of Social Services shall, in accordance with
777 the provisions of section 11-4a, file a report on the results of the fiscal
778 analysis not later than December 31, 2013, with the joint standing
779 committees of the General Assembly having cognizance of matters
780 relating to human services and appropriations and the budgets of state
781 agencies. Inpatient rates shall be annually determined for each hospital
782 by multiplying diagnostic-related group relative weights by a base
783 rate. Within available appropriations, the commissioner may, in his or
784 her discretion, make additional payments to hospitals based on criteria
785 to be determined by the commissioner. Nothing contained in this
786 section shall authorize [a] Medicaid payment by the state [for such
787 services] to any such hospital in excess of the charges made by such
788 hospital for comparable services to the general public.
789 [Notwithstanding the provisions of this section, for the rate period
790 beginning July 1, 2000, rates paid to freestanding chronic disease
791 hospitals and freestanding psychiatric hospitals shall be increased by
792 three per cent. For the rate period beginning July 1, 2001, a
793 freestanding chronic disease hospital or freestanding psychiatric
794 hospital shall receive a rate that is two and one-half per cent more than
795 the rate it received in the prior fiscal year and such rate shall remain
796 effective until December 31, 2002. Effective January 1, 2003, a
797 freestanding chronic disease hospital or freestanding psychiatric
798 hospital shall receive a rate that is two per cent more than the rate it
799 received in the prior fiscal year. Notwithstanding the provisions of this
800 subsection, for the period commencing July 1, 2001, and ending June
801 30, 2003, the commissioner may pay an additional total of no more
802 than three hundred thousand dollars annually for services provided to

803 long-term ventilator patients. For purposes of this subsection, "long-
804 term ventilator patient" means any patient at a freestanding chronic
805 disease hospital on a ventilator for a total of sixty days or more in any
806 consecutive twelve-month period. Effective July 1, 2007, each
807 freestanding chronic disease hospital shall receive a rate that is four
808 per cent more than the rate it received in the prior fiscal year.]

809 (b) Effective October 1, 1991, the rate to be paid by the state for the
810 cost of special services rendered by such hospitals shall be established
811 annually by the commissioner for each such hospital based on the
812 reasonable cost to each hospital of such services furnished to state
813 patients. Nothing contained in this subsection shall authorize a
814 payment by the state for such services to any such hospital in excess of
815 the charges made by such hospital for comparable services to the
816 general public.

817 (c) The term "reasonable cost" as used in this section means the cost
818 of care furnished such patients by an efficient and economically
819 operated facility, computed in accordance with accepted principles of
820 hospital cost reimbursement. The commissioner may adjust the rate of
821 payment established under the provisions of this section for the year
822 during which services are furnished to reflect fluctuations in hospital
823 costs. Such adjustment may be made prospectively to cover anticipated
824 fluctuations or may be made retroactive to any date subsequent to the
825 date of the initial rate determination for such year or in such other
826 manner as may be determined by the commissioner. In determining
827 "reasonable cost" the commissioner may give due consideration to
828 allowances for fully or partially unpaid bills, reasonable costs
829 mandated by collective bargaining agreements with certified collective
830 bargaining agents or other agreements between the employer and
831 employees, provided "employees" shall not include persons employed
832 as managers or chief administrators, requirements for working capital
833 and cost of development of new services, including additions to and
834 replacement of facilities and equipment. The commissioner shall not
835 give consideration to amounts paid by the facilities to employees as

836 salary, or to attorneys or consultants as fees, where the responsibility
837 of the employees, attorneys or consultants is to persuade or seek to
838 persuade the other employees of the facility to support or oppose
839 unionization. Nothing in this subsection shall prohibit the
840 commissioner from considering amounts paid for legal counsel related
841 to the negotiation of collective bargaining agreements, the settlement
842 of grievances or normal administration of labor relations.

843 (d) [The state shall also pay to such hospitals for each outpatient
844 clinic and emergency room visit a reasonable rate to be established
845 annually by the commissioner for each hospital, such rate to be
846 determined by the reasonable cost of such services. The emergency
847 room visit rates in effect June 30, 1991, shall remain in effect through
848 June 30, 1993, except those which would have been decreased effective
849 July 1, 1991, or July 1, 1992, shall be decreased.] On or after July 1,
850 2013, hospitals shall be paid for outpatient and emergency room
851 episodes of care based on prospective rates established by the
852 commissioner in accordance with the Medicare Ambulatory Payment
853 Classification system in conjunction with a state conversion factor,
854 provided the Department of Social Services completes a fiscal analysis
855 of the impact of such rate payment system on each hospital. The
856 Commissioner of Social Services shall, in accordance with the
857 provisions of section 11-4a, file a report on the results of the fiscal
858 analysis not later than December 31, 2013, with the joint standing
859 committees of the General Assembly having cognizance of matters
860 relating to human services and appropriations and the budgets of state
861 agencies. The Medicare Ambulatory Payment Classification system
862 shall be modified to provide payment for services not generally
863 covered by Medicare, including, but not limited to, pediatric, obstetric,
864 neonatal and perinatal services. Nothing contained in this subsection
865 shall authorize a payment by the state for such [services] episodes of
866 care to any hospital in excess of the charges made by such hospital for
867 comparable services to the general public. [For those] Those outpatient
868 hospital services that do not have an established Ambulatory Payment
869 Classification code shall be paid on the basis of a ratio of cost to

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

896 (e) The commissioner shall adopt regulations, in accordance with
897 the provisions of chapter 54, establishing criteria for defining
898 emergency and nonemergency visits to hospital emergency rooms. All
899 nonemergency visits to hospital emergency rooms shall be paid at the
900 hospital's outpatient clinic services rate. Nothing contained in this
901 subsection or the regulations adopted [hereunder] under this section
902 shall authorize a payment by the state for such services to any hospital
903 in excess of the charges made by such hospital for comparable services

904 to the general public.

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

921 (g) The Commissioner of Social Services may implement policies
922 and procedures as necessary to carry out the provisions of this section
923 while in the process of adopting the policies and procedures as
924 regulations, provided notice of intent to adopt the regulations is
925 published in the Connecticut Law Journal within twenty days of
926 implementation.

927 Sec. 12. Subsection (b) of section 17b-239e of the general statutes is
928 repealed and the following is substituted in lieu thereof (*Effective July*
929 *1, 2013*):

930 (b) The commissioner may establish a blended in-patient hospital
931 case rate that includes services provided to all Medicaid recipients and
932 may exclude certain diagnoses, as determined by the commissioner, if
933 the establishment of such rates is needed to ensure that the conversion
934 to an administrative services organization is cost neutral to hospitals in
935 the aggregate and ensures patient access. Utilization may be a factor in

936 determining cost neutrality. [for the fiscal year ending June 30, 2013.]

937 Sec. 13. Subsection (a) of section 17b-242 of the general statutes is
938 repealed and the following is substituted in lieu thereof (*Effective July*
939 *1, 2013*):

940 (a) The Department of Social Services shall determine the rates to be
941 paid to home health care agencies and homemaker-home health aide
942 agencies by the state or any town in the state for persons aided or
943 cared for by the state or any such town. For the period from February
944 1, 1991, to January 31, 1992, inclusive, payment for each service to the
945 state shall be based upon the rate for such service as determined by the
946 Office of Health Care Access, except that for those providers whose
947 Medicaid rates for the year ending January 31, 1991, exceed the median
948 rate, no increase shall be allowed. For those providers whose rates for
949 the year ending January 31, 1991, are below the median rate, increases
950 shall not exceed the lower of the prior rate increased by the most
951 recent annual increase in the consumer price index for urban
952 consumers or the median rate. In no case shall any such rate exceed the
953 eightieth percentile of rates in effect January 31, 1991, nor shall any rate
954 exceed the charge to the general public for similar services. Rates
955 effective February 1, 1992, shall be based upon rates as determined by
956 the Office of Health Care Access, except that increases shall not exceed
957 the prior year's rate increased by the most recent annual increase in the
958 consumer price index for urban consumers and rates effective
959 February 1, 1992, shall remain in effect through June 30, 1993. Rates
960 effective July 1, 1993, shall be based upon rates as determined by the
961 Office of Health Care Access except if the Medicaid rates for any
962 service for the period ending June 30, 1993, exceed the median rate for
963 such service, the increase effective July 1, 1993, shall not exceed one
964 per cent. If the Medicaid rate for any service for the period ending June
965 30, 1993, is below the median rate, the increase effective July 1, 1993,
966 shall not exceed the lower of the prior rate increased by one and one-
967 half times the most recent annual increase in the consumer price index
968 for urban consumers or the median rate plus one per cent. The

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

1003 Sec. 14. Subsection (a) of section 17b-261m of the general statutes is
1004 repealed and the following is substituted in lieu thereof (*Effective July*
1005 *1, 2013*):

1006 (a) The Commissioner of Social Services may contract with one or
1007 more administrative services organizations to provide care
1008 coordination, utilization management, disease management, customer
1009 service and review of grievances for recipients of assistance under
1010 Medicaid, HUSKY Plan, Parts A and B, and the Charter Oak Health
1011 Plan. Such organization may also provide network management,
1012 credentialing of providers, monitoring of copayments and premiums
1013 and other services as required by the commissioner. Subject to
1014 approval by applicable federal authority, the Department of Social
1015 Services shall utilize the contracted organization's provider network
1016 and billing systems in the administration of the program. In order to
1017 implement the provisions of this section, the commissioner may
1018 establish rates of payment to providers of medical services under this
1019 section if the establishment of such rates is required to ensure that any
1020 contract entered into with an administrative services organization
1021 pursuant to this section is cost neutral to such providers in the
1022 aggregate and ensures patient access. Utilization may be a factor in
1023 determining cost neutrality. [for the fiscal year ending June 30, 2013.]

1024 Sec. 15. Subsection (a) of section 17b-239c of the general statutes is
1025 repealed and the following is substituted in lieu thereof (*Effective July*
1026 *1, 2013*):

1027 (a) Notwithstanding any provision of the general statutes, on and
1028 after July 1, 2011, the Department of Social Services may, within
1029 available appropriations, make interim [monthly] quarterly medical
1030 assistance disproportionate share payments to short-term general
1031 hospitals. The total amount of interim payments made to such
1032 hospitals individually and in the aggregate shall maximize federal
1033 matching payments under the medical assistance program as
1034 determined by the Department of Social Services, in consultation with
1035 the Office of Policy and Management. No payments shall be made

1036 under this section to (1) any hospital which, on July 1, 2011, is within
1037 the class of hospitals licensed by the Department of Public Health as a
1038 children's general hospital, or (2) a short-term acute hospital operated
1039 exclusively by the state other than a short-term acute hospital operated
1040 by the state as a receiver pursuant to chapter 920. The [monthly]
1041 quarterly interim payment amount for each hospital shall be
1042 determined by the Commissioner of Social Services based upon the
1043 information submitted by the hospital pursuant to Section 1001(d) of
1044 Public Law 108-173, the Medicare Prescription Drug, Improvement,
1045 and Modernization Act of 2003.

1046 Sec. 16. Section 17b-28e of the general statutes is repealed and the
1047 following is substituted in lieu thereof (*Effective July 1, 2013*):

1048 (a) The Commissioner of Social Services shall amend the Medicaid
1049 state plan to include, on and after January 1, 2009, hospice services as
1050 optional services covered under the Medicaid program. Said state plan
1051 amendment shall supersede any regulations of Connecticut state
1052 agencies concerning such optional services. [From January 1, 2013, to
1053 June 30, 2013, inclusive, hospice] Hospice services covered under the
1054 Medicaid program for individuals who are residents in long-term care
1055 facilities shall be paid at a rate that is ninety-five per cent of the
1056 facility's per diem rate.

1057 [(b) Effective July 1, 2013, the Commissioner of Social Services shall
1058 amend the Medicaid state plan to include foreign language interpreter
1059 services provided to any beneficiary with limited English proficiency
1060 as a covered service under the Medicaid program. Not later than July
1061 1, 2013, the commissioner shall develop and implement the use of
1062 medical billing codes for foreign language interpreter services.

1063 (c) Effective July 1, 2013, the Department of Social Services shall
1064 report, in accordance with the provisions of section 11-4a, semi-
1065 annually, to the Council on Medical Assistance Program Oversight on
1066 the foreign language interpreter services provided to recipients of
1067 benefits under the program.]

1068 [(d)] (b) Not later than October 1, 2011, the Commissioner of Social
1069 Services shall amend the Medicaid state plan to include podiatry as an
1070 optional service under the Medicaid program.

1071 [(e) The Commissioner of Social Services shall amend the Medicaid
1072 state plan to provide that chiropractic services shall be covered under
1073 the Medicaid program only to the extent required by federal law.]

1074 Sec. 17. Subsection (b) of section 17b-104 of the general statutes is
1075 repealed and the following is substituted in lieu thereof (*Effective July*
1076 *1, 2013*):

1077 (b) On July 1, 2007, and annually thereafter, the commissioner shall
1078 increase the payment standards over those of the previous fiscal year
1079 under the temporary family assistance program and the
1080 state-administered general assistance program by the percentage
1081 increase, if any, in the most recent calendar year average in the
1082 consumer price index for urban consumers over the average for the
1083 previous calendar year, provided the annual increase, if any, shall not
1084 exceed five per cent, except that the payment standards for the fiscal
1085 years ending June 30, 2010, June 30, 2011, June 30, 2012, [and] June 30,
1086 2013, June 30, 2014, and June 30, 2015, shall not be increased.

1087 Sec. 18. Subsection (a) of section 17b-106 of the general statutes is
1088 repealed and the following is substituted in lieu thereof (*Effective July*
1089 *1, 2013*):

1090 (a) [On January 1, 2006, and on each January first thereafter, the
1091 Commissioner of Social Services shall increase the unearned income
1092 disregard for recipients of the state supplement to the federal
1093 Supplemental Security Income Program by an amount equal to the
1094 federal cost-of-living adjustment, if any, provided to recipients of
1095 federal Supplemental Security Income Program benefits for the
1096 corresponding calendar year.] On July 1, 1989, and annually thereafter,
1097 the commissioner shall increase the adult payment standards over
1098 those of the previous fiscal year for the state supplement to the federal

1099 Supplemental Security Income Program by the percentage increase, if
1100 any, in the most recent calendar year average in the consumer price
1101 index for urban consumers over the average for the previous calendar
1102 year, provided the annual increase, if any, shall not exceed five per
1103 cent, except that the adult payment standards for the fiscal years
1104 ending June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June
1105 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June
1106 30, 2002, June 30, 2003, June 30, 2004, June 30, 2005, June 30, 2006, June
1107 30, 2007, June 30, 2008, June 30, 2009, June 30, 2010, June 30, 2011, June
1108 30, 2012, [and] June 30, 2013, June 30, 2014, and June 30, 2015, shall not
1109 be increased. Effective October 1, 1991, the coverage of excess utility
1110 costs for recipients of the state supplement to the federal Supplemental
1111 Security Income Program is eliminated. Notwithstanding the
1112 provisions of this section, the commissioner may increase the personal
1113 needs allowance component of the adult payment standard as
1114 necessary to meet federal maintenance of effort requirements.

1115 Sec. 19. Subsection (b) of section 17b-90 of the general statutes is
1116 repealed and the following is substituted in lieu thereof (*Effective*
1117 *January 1, 2014*):

1118 (b) No person shall, except for purposes directly connected with the
1119 administration of programs of the Department of Social Services and in
1120 accordance with the regulations of the commissioner, solicit, disclose,
1121 receive or make use of, or authorize, knowingly permit, participate in
1122 or acquiesce in the use of, any list of the names of, or any information
1123 concerning, persons applying for or receiving assistance from the
1124 Department of Social Services or persons participating in a program
1125 administered by said department, directly or indirectly derived from
1126 the records, papers, files or communications of the state or its
1127 subdivisions or agencies, or acquired in the course of the performance
1128 of official duties. The Commissioner of Social Services shall disclose (1)
1129 to any authorized representative of the Labor Commissioner such
1130 information directly related to unemployment compensation,
1131 administered pursuant to chapter 567 or information necessary for

1132 implementation of sections 17b-688b, 17b-688c and 17b-688h and
1133 section 122 of public act 97-2 of the June 18 special session, (2) to any
1134 authorized representative of the Commissioner of Mental Health and
1135 Addiction Services any information necessary for the implementation
1136 and operation of the basic needs supplement program, or the Medicaid
1137 program for low-income adults, [established] pursuant to section [17b-
1138 261n] 17b-261 as amended by this act, (3) to any authorized
1139 representative of the Commissioner of Administrative Services or the
1140 Commissioner of Emergency Services and Public Protection such
1141 information as the Commissioner of Social Services determines is
1142 directly related to and necessary for the Department of Administrative
1143 Services or the Department of Emergency Services and Public
1144 Protection for purposes of performing their functions of collecting
1145 social services recoveries and overpayments or amounts due as
1146 support in social services cases, investigating social services fraud or
1147 locating absent parents of public assistance recipients, (4) to any
1148 authorized representative of the Commissioner of Children and
1149 Families necessary information concerning a child or the immediate
1150 family of a child receiving services from the Department of Social
1151 Services, including safety net services, if the Commissioner of Children
1152 and Families or the Commissioner of Social Services has determined
1153 that imminent danger to such child's health, safety or welfare exists to
1154 target the services of the family services programs administered by the
1155 Department of Children and Families, (5) to a town official or other
1156 contractor or authorized representative of the Labor Commissioner
1157 such information concerning an applicant for or a recipient of
1158 assistance under state-administered general assistance deemed
1159 necessary by the Commissioner of Social Services and the Labor
1160 Commissioner to carry out their respective responsibilities to serve
1161 such persons under the programs administered by the Labor
1162 Department that are designed to serve applicants for or recipients of
1163 state-administered general assistance, (6) to any authorized
1164 representative of the Commissioner of Mental Health and Addiction
1165 Services for the purposes of the behavioral health managed care
1166 program established by section 17a-453, (7) to any authorized

1167 representative of the Commissioner of Public Health to carry out his or
1168 her respective responsibilities under programs that regulate child day
1169 care services or youth camps, (8) to a health insurance provider, in IV-
1170 D support cases, as defined in subdivision (13) of subsection (b) of
1171 section 46b-231, information concerning a child and the custodial
1172 parent of such child that is necessary to enroll such child in a health
1173 insurance plan available through such provider when the noncustodial
1174 parent of such child is under court order to provide health insurance
1175 coverage but is unable to provide such information, provided the
1176 Commissioner of Social Services determines, after providing prior
1177 notice of the disclosure to such custodial parent and an opportunity for
1178 such parent to object, that such disclosure is in the best interests of the
1179 child, (9) to any authorized representative of the Department of
1180 Correction, in IV-D support cases, as defined in subdivision (13) of
1181 subsection (b) of section 46b-231, information concerning noncustodial
1182 parents that is necessary to identify inmates or parolees with IV-D
1183 support cases who may benefit from Department of Correction
1184 educational, training, skill building, work or rehabilitation
1185 programming that will significantly increase an inmate's or parolee's
1186 ability to fulfill such inmate's support obligation, (10) to any
1187 authorized representative of the Judicial Branch, in IV-D support cases,
1188 as defined in subdivision (13) of subsection (b) of section 46b-231,
1189 information concerning noncustodial parents that is necessary to: (A)
1190 Identify noncustodial parents with IV-D support cases who may
1191 benefit from educational, training, skill building, work or
1192 rehabilitation programming that will significantly increase such
1193 parent's ability to fulfill such parent's support obligation, (B) assist in
1194 the administration of the Title IV-D child support program, or (C)
1195 assist in the identification of cases involving family violence, or (11) to
1196 any authorized representative of the State Treasurer, in IV-D support
1197 cases, as defined in subdivision (13) of subsection (b) of section 46b-
1198 231, information that is necessary to identify child support obligors
1199 who owe overdue child support prior to the Treasurer's payment of
1200 such obligors' claim for any property unclaimed or presumed
1201 abandoned under part III of chapter 32. No such representative shall

1202 disclose any information obtained pursuant to this section, except as
1203 specified in this section. Any applicant for assistance provided through
1204 said department shall be notified that, if and when such applicant
1205 receives benefits, the department will be providing law enforcement
1206 officials with the address of such applicant upon the request of any
1207 such official pursuant to section 17b-16a.

1208 Sec. 20. Section 17b-261 of the general statutes is repealed and the
1209 following is substituted in lieu thereof (*Effective January 1, 2014*):

1210 (a) Medical assistance shall be provided for any otherwise eligible
1211 person whose income, including any available support from legally
1212 liable relatives and the income of the person's spouse or dependent
1213 child, is not more than one hundred forty-three per cent, pending
1214 approval of a federal waiver applied for pursuant to subsection (e) of
1215 this section, of the benefit amount paid to a person with no income
1216 under the temporary family assistance program in the appropriate
1217 region of residence and if such person is an institutionalized
1218 individual as defined in Section 1917(c) of the Social Security Act, 42
1219 USC 1396p(c), and has not made an assignment or transfer or other
1220 disposition of property for less than fair market value for the purpose
1221 of establishing eligibility for benefits or assistance under this section.
1222 Any such disposition shall be treated in accordance with Section
1223 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
1224 property made on behalf of an applicant or recipient or the spouse of
1225 an applicant or recipient by a guardian, conservator, person
1226 authorized to make such disposition pursuant to a power of attorney
1227 or other person so authorized by law shall be attributed to such
1228 applicant, recipient or spouse. A disposition of property ordered by a
1229 court shall be evaluated in accordance with the standards applied to
1230 any other such disposition for the purpose of determining eligibility.
1231 The commissioner shall establish the standards for eligibility for
1232 medical assistance at one hundred forty-three per cent of the benefit
1233 amount paid to a family unit of equal size with no income under the
1234 temporary family assistance program in the appropriate region of

1235 residence. In determining eligibility, the commissioner shall not
1236 consider as income Aid and Attendance pension benefits granted to a
1237 veteran, as defined in section 27-103, or the surviving spouse of such
1238 veteran. Except as provided in section 17b-277, the medical assistance
1239 program shall provide coverage to persons under the age of nineteen
1240 with family income up to one hundred eighty-five per cent of the
1241 federal poverty level without an asset limit and to persons under the
1242 age of nineteen, who qualify for coverage under Section 1931 of the
1243 Social Security Act, with family income up to one hundred eighty-five
1244 per cent of the federal poverty level without an asset limit and their
1245 parents and needy caretaker relatives, who qualify for coverage under
1246 Section 1931 of the Social Security Act, with family income up to one
1247 hundred [eighty-five] thirty-three per cent of the federal poverty level
1248 without an asset limit, unless transitional Medicaid assistance
1249 pursuant to subsection (f) of this section and federal law is not
1250 available. If transitional Medicaid assistance is not authorized under
1251 federal and state law, such parents and needy caretaker relatives with
1252 family income up to one hundred eighty-five per cent of the federal
1253 poverty level shall be covered under the medical assistance program
1254 until June 1, 2014. Such levels shall be based on the regional differences
1255 in such benefit amount, if applicable, unless such levels based on
1256 regional differences are not in conformance with federal law. Any
1257 income in excess of the applicable amounts shall be applied as may be
1258 required by said federal law, and assistance shall be granted for the
1259 balance of the cost of authorized medical assistance. The
1260 Commissioner of Social Services shall provide applicants for assistance
1261 under this section, at the time of application, with a written statement
1262 advising them of (1) the effect of an assignment or transfer or other
1263 disposition of property on eligibility for benefits or assistance, (2) the
1264 effect that having income that exceeds the limits prescribed in this
1265 subsection will have with respect to program eligibility, and (3) the
1266 availability of, and eligibility for, services provided by the Nurturing
1267 Families Network established pursuant to section 17b-751b. Persons
1268 who are determined ineligible for assistance pursuant to this section
1269 shall be provided a written statement notifying such persons of their

1270 ineligibility and advising such persons of the availability of HUSKY
1271 Plan, Part B health insurance benefits.

1272 (b) For the purposes of the Medicaid program, the Commissioner of
1273 Social Services shall consider parental income and resources as
1274 available to a child under eighteen years of age who is living with his
1275 or her parents and is blind or disabled for purposes of the Medicaid
1276 program, or to any other child under twenty-one years of age who is
1277 living with his or her parents.

1278 (c) For the purposes of determining eligibility for the Medicaid
1279 program, an available asset is one that is actually available to the
1280 applicant or one that the applicant has the legal right, authority or
1281 power to obtain or to have applied for the applicant's general or
1282 medical support. If the terms of a trust provide for the support of an
1283 applicant, the refusal of a trustee to make a distribution from the trust
1284 does not render the trust an unavailable asset. Notwithstanding the
1285 provisions of this subsection, the availability of funds in a trust or
1286 similar instrument funded in whole or in part by the applicant or the
1287 applicant's spouse shall be determined pursuant to the Omnibus
1288 Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of
1289 this subsection shall not apply to a special needs trust, as defined in 42
1290 USC 1396p(d)(4)(A). For purposes of determining whether a
1291 beneficiary under a special needs trust, who has not received a
1292 disability determination from the Social Security Administration, is
1293 disabled, as defined in 42 USC 1382c(a)(3), the Commissioner of Social
1294 Services, or the commissioner's designee, shall independently make
1295 such determination. The commissioner shall not require such
1296 beneficiary to apply for Social Security disability benefits or obtain a
1297 disability determination from the Social Security Administration for
1298 purposes of determining whether the beneficiary is disabled.

1299 (d) The transfer of an asset in exchange for other valuable
1300 consideration shall be allowable to the extent the value of the other
1301 valuable consideration is equal to or greater than the value of the asset
1302 transferred.

1303 (e) The Commissioner of Social Services shall seek a waiver from
1304 federal law to permit federal financial participation for Medicaid
1305 expenditures for families with incomes of one hundred forty-three per
1306 cent of the temporary family assistance program payment standard.

1307 (f) To the extent permitted by federal law, Medicaid eligibility shall
1308 be extended for one year to a family that becomes ineligible for
1309 medical assistance under Section 1931 of the Social Security Act due to
1310 income from employment by one of its members who is a caretaker
1311 relative or due to receipt of child support income. A family receiving
1312 extended benefits on July 1, 2005, shall receive the balance of such
1313 extended benefits, provided no such family shall receive more than
1314 twelve additional months of such benefits.

1315 (g) An institutionalized spouse applying for Medicaid and having a
1316 spouse living in the community shall be required, to the maximum
1317 extent permitted by law, to divert income to such community spouse
1318 in order to raise the community spouse's income to the level of the
1319 minimum monthly needs allowance, as described in Section 1924 of
1320 the Social Security Act. Such diversion of income shall occur before the
1321 community spouse is allowed to retain assets in excess of the
1322 community spouse protected amount described in Section 1924 of the
1323 Social Security Act. The Commissioner of Social Services, pursuant to
1324 section 17b-10, may implement the provisions of this subsection while
1325 in the process of adopting regulations, provided the commissioner
1326 prints notice of intent to adopt the regulations in the Connecticut Law
1327 Journal within twenty days of adopting such policy. Such policy shall
1328 be valid until the time final regulations are effective.

1329 (h) Medical assistance shall be provided, in accordance with the
1330 provisions of subsection (e) of section 17a-6, to any child under the
1331 supervision of the Commissioner of Children and Families who is not
1332 receiving Medicaid benefits, has not yet qualified for Medicaid benefits
1333 or is otherwise ineligible for such benefits. Medical assistance shall also
1334 be provided to any child in the voluntary services program operated
1335 by the Department of Developmental Services who is not receiving

1336 Medicaid benefits, has not yet qualified for Medicaid benefits or is
1337 otherwise ineligible for benefits. To the extent practicable, the
1338 Commissioner of Children and Families and the Commissioner of
1339 Developmental Services shall apply for, or assist such child in
1340 qualifying for, the Medicaid program.

1341 (i) The Commissioner of Social Services shall provide Early and
1342 Periodic Screening, Diagnostic and Treatment program services, as
1343 required and defined as of December 31, 2005, by 42 USC 1396a(a)(43),
1344 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal
1345 regulations, to all persons who are under the age of twenty-one and
1346 otherwise eligible for medical assistance under this section.

1347 (j) A veteran, as defined in section 27-103, and any member of his or
1348 her family, who applies for or receives assistance under the Medicaid
1349 program, shall apply for all benefits for which he or she may be
1350 eligible through the Veterans' Administration or the United States
1351 Department of Defense.

1352 (k) In addition to persons eligible for medical assistance under the
1353 provisions of subsections (a) to (j), inclusive, of this section, on and
1354 after January 1, 2014, medical assistance shall be provided without an
1355 asset test to low-income adults whose income does not exceed one
1356 hundred thirty-three per cent of the federal poverty level, in
1357 accordance with Section 1902(a)(10)(A)(i)(VIII) of the Social Security
1358 Act. In determining eligibility, the commissioner shall not consider as
1359 income Aid and Attendance pension benefits granted to a veteran, as
1360 defined in section 27-103, or the surviving spouse of such veteran.
1361 Pursuant to the legislative review process described in section 17b-8,
1362 the commissioner may amend the Medicaid state plan to establish an
1363 alternative benefit package for individuals eligible for Medicaid in
1364 accordance with the provisions of this subsection and as permitted by
1365 federal law. For purposes of this subsection, "alternative benefit
1366 package" may include, but is not limited to, limits on any of the
1367 following: (1) Health care provider office visits; (2) independent
1368 therapy services; (3) hospital emergency department services; (4)

1369 inpatient hospital services; (5) outpatient hospital services; (6) medical
1370 equipment, devices and supplies; (7) ambulatory surgery center
1371 services; (8) pharmacy services; (9) nonemergency medical
1372 transportation; and (10) licensed home care agency services. Effective
1373 July 1, 2011, no payment shall be made to a provider of medical
1374 services for services provided prior to April 1, 2010, to a recipient of
1375 benefits under this subsection.

1376 Sec. 21. Section 17b-256f of the general statutes is repealed and the
1377 following is substituted in lieu thereof (*Effective January 1, 2014*):

1378 [Beginning March 1, 2012, and annually thereafter, the] The
1379 Commissioner of Social Services shall increase income disregards used
1380 to determine eligibility by the Department of Social Services for the
1381 federal Specified Low-Income Medicare Beneficiary, the Qualified
1382 Medicare Beneficiary and the Qualifying Individual [Programs]
1383 programs, administered in accordance with the provisions of 42 USC
1384 1396d(p), by [an amount that equalizes the income levels and
1385 deductions used to determine eligibility for said programs with
1386 income levels and deductions used to determine eligibility for the
1387 ConnPACE program under subsection (a) of section 17b-492] such
1388 amounts that will result in persons with income up to two hundred
1389 thirty-one per cent of the federal poverty level qualifying for coverage
1390 under the Specified Low-Income Medicare Beneficiary program,
1391 persons with income up to two hundred eleven per cent of the federal
1392 poverty level qualifying for the Qualified Medicare Beneficiary
1393 program and persons with income up to two hundred forty-six per
1394 cent of the federal poverty level qualifying for the Qualifying
1395 Individual program. The commissioner shall not apply an asset test for
1396 eligibility under the Medicare Savings Program. The commissioner
1397 shall not consider as income Aid and Attendance pension benefits
1398 granted to a veteran, as defined in section 27-103, or the surviving
1399 spouse of such veteran. The Commissioner of Social Services, pursuant
1400 to section 17b-10, may implement policies and procedures to
1401 administer the provisions of this section while in the process of

1402 adopting such policies and procedures in regulation form, provided
1403 the commissioner prints notice of the intent to adopt the regulations in
1404 the Connecticut Law Journal not later than twenty days after the date
1405 of implementation. Such policies and procedures shall be valid until
1406 the time final regulations are adopted.

1407 Sec. 22. Section 17b-551 of the general statutes is repealed and the
1408 following is substituted in lieu thereof (*Effective January 1, 2014*):

1409 Eligibility for participation in the program shall be limited to a
1410 resident who is enrolled in Medicare Part B whose annual income does
1411 not exceed [one hundred sixty-five per cent of the qualifying income
1412 level established in the ConnPACE program, pursuant to subsection
1413 (a) of section 17b-492] forty-three thousand five hundred sixty dollars
1414 or if such resident has a spouse, the combined income of such resident
1415 and his spouse does not exceed [one hundred sixty-five per cent of the
1416 qualifying income level established in the ConnPACE program,
1417 pursuant to subsection (a) of section 17b-492] fifty-eight thousand
1418 seven hundred forty dollars. On January 1, 2014, and annually
1419 thereafter, the commissioner shall increase the income limit established
1420 under this subsection over that of the previous fiscal year to reflect the
1421 annual inflation adjustment in Social Security income, if any. Each
1422 such adjustment shall be determined to the nearest one hundred
1423 dollars.

1424 Sec. 23. Section 17b-552 of the general statutes is repealed and the
1425 following is substituted in lieu thereof (*Effective January 1, 2014*):

1426 (a) A health care provider shall limit charges for care, treatment,
1427 service or equipment covered by Medicare Part B under Title XVIII of
1428 the Social Security Act, as amended, provided to a Medicare
1429 beneficiary who meets the eligibility requirements specified in section
1430 17b-551, as amended by this act, to the reasonable charge for the care,
1431 treatment, service or equipment provided as determined by the United
1432 States Secretary of Health and Human Services. No health care
1433 provider shall collect from such qualified beneficiary any amount in

1434 excess of the approved reasonable charge. Any violation of this
1435 subsection shall constitute grounds for the assessment of a civil
1436 penalty in accordance with subdivision (6) of subsection (a) of section
1437 19a-17. Any complaint alleging a violation of this section shall be made
1438 to the Department of Public Health or the appropriate professional
1439 licensing board or commission.

1440 (b) The Commissioner of Social Services shall adopt regulations in
1441 accordance with the provisions of chapter 54, necessary to administer
1442 the program and to determine eligibility in accordance with the
1443 provisions of section 17b-551, as amended by this act.

1444 [(c) All health care providers shall accept the identification card
1445 issued for the ConnPACE program pursuant to sections 17b-490 to
1446 17b-498, inclusive, as a substitute for a Medicare assignment card.]

1447 Sec. 24. Subsection (a) of section 17b-278i of the general statutes is
1448 repealed and the following is substituted in lieu thereof (*Effective from*
1449 *passage*):

1450 (a) Customized wheelchairs shall be covered under the Medicaid
1451 program only when a standard wheelchair will not meet an
1452 individual's needs as determined by the Department of Social Services.
1453 [Assessment of the need for a customized wheelchair may be
1454 performed by a vendor or nursing facility only if specifically requested
1455 by the department.] Wheelchair repairs and parts replacements may be
1456 subject to review and approval by the department. Refurbished
1457 wheelchairs, parts and components shall be utilized whenever
1458 practicable.

1459 Sec. 25. Subsection (a) of section 17b-340c of the general statutes is
1460 repealed and the following is substituted in lieu thereof (*Effective from*
1461 *passage*):

1462 (a) The Commissioner of Social Services may, upon the request of a
1463 nursing facility providing services eligible for payment under the
1464 medical assistance program, [and after consultation with the Secretary

1465 of the Office of Policy and Management,] make a payment to such
1466 nursing facility in advance of normal bill payment processing. Except
1467 as provided in subsection (b) of this section, (1) such advance shall not
1468 exceed estimated amounts due to such nursing facility for services
1469 provided to eligible recipients over the most recent two-month period,
1470 and (2) the commissioner shall recover such payment through
1471 reductions to payments due to such nursing facility or cash receipt not
1472 later than ninety days after issuance of such payment. The
1473 commissioner shall take prudent measures to assure that such advance
1474 payments are not provided to any nursing facility that is at risk of
1475 bankruptcy or insolvency, and may execute agreements appropriate
1476 for the security of repayment.

1477 Sec. 26. Section 17a-22h of the general statutes is repealed and the
1478 following is substituted in lieu thereof (*Effective July 1, 2013*):

1479 (a) The Commissioners of Social Services, Children and Families,
1480 and Mental Health and Addiction Services shall develop and
1481 implement an integrated behavioral health service system for
1482 Medicaid and HUSKY Plan [Parts A and] Part B members and children
1483 enrolled in the voluntary services program operated by the
1484 Department of Children and Families and may, at the discretion of the
1485 commissioners, include: (1) Other children, adolescents and families
1486 served by the Department of Children and Families or the Court
1487 Support Services Division of the Judicial Branch; and (2) [Medicaid
1488 recipients who are not enrolled in HUSKY Plan Part A; and (3)]
1489 Charter Oak Health Plan members. The integrated behavioral health
1490 service system shall be known as the Behavioral Health Partnership.
1491 The Behavioral Health Partnership shall seek to increase access to
1492 quality behavioral health services by: (A) Expanding individualized,
1493 family-centered and community-based services; (B) maximizing
1494 federal revenue to fund behavioral health services; (C) reducing
1495 unnecessary use of institutional and residential services for children
1496 and adults; (D) capturing and investing enhanced federal revenue and
1497 savings derived from reduced residential services and increased

1498 community-based services for HUSKY Plan Parts A and B recipients;
1499 (E) improving administrative oversight and efficiencies; and (F)
1500 monitoring individual outcomes and provider performance, taking
1501 into consideration the acuity of the patients served by each provider,
1502 and overall program performance.

1503 (b) The Behavioral Health Partnership shall operate in accordance
1504 with the financial requirements specified in this subsection. Prior to the
1505 conversion of any grant-funded services to a rate-based, fee-for-service
1506 payment system, the Department of Social Services, the Department of
1507 Children and Families and the Department of Mental Health and
1508 Addiction Services shall submit documentation verifying that the
1509 proposed rates seek to cover the reasonable cost of providing services
1510 to the Behavioral Health Partnership Oversight Council, established
1511 pursuant to section 17a-22j.

1512 Sec. 27. Section 17a-22p of the general statutes is repealed and the
1513 following is substituted in lieu thereof (*Effective July 1, 2013*):

1514 (a) The Departments of Children and Families, Social Services and
1515 Mental Health and Addiction Services shall enter into one or more
1516 joint contracts or agreements with an administrative services
1517 organization or organizations to perform eligibility verification,
1518 utilization management, intensive care management, quality
1519 management, coordination of medical and behavioral health services,
1520 provider network development and management, recipient and
1521 provider services and reporting.

1522 (b) Claims under the Behavioral Health Partnership shall be paid by
1523 the Department of Social Services' Medicaid management information
1524 systems vendor, except that the Department of Children and Families
1525 and the Department of Mental Health and Addiction Services may, at
1526 their discretion, continue to use existing claims payment systems.

1527 (c) [Administrative services organizations] An administrative
1528 services organization shall authorize services, based solely on medical

1529 necessity, as defined in section 17b-259b. Such organization shall use
1530 guidelines established by the clinical management committee,
1531 established pursuant to section 17a-22k, [Administrative services
1532 organizations may make exceptions to the guidelines when requested
1533 by a member, or the member's legal guardian or service provider, and
1534 determined by the administrative services organization to be in the
1535 best interest of the member] provided such guidelines may only be
1536 used as a basis for expeditiously approving a request for services. If a
1537 request for services does not meet such guidelines, the request may be
1538 deemed denied based solely on the request not being deemed
1539 medically necessary, as defined in section 17b-259b. Decisions
1540 regarding the interpretation of such guidelines shall be made by the
1541 Departments of Children and Families, Social Services and Mental
1542 Health and Addiction Services. No administrative services
1543 organization shall have any financial incentive to approve, deny or
1544 reduce services. Administrative services organizations shall ensure
1545 that service providers and persons seeking services have timely access
1546 to program information and timely responses to inquiries, including
1547 inquiries concerning the clinical guidelines for services.

1548 (d) [The] An administrative services organization for Medicaid and
1549 HUSKY Plan [Parts A and] Part B shall provide or arrange for on-site
1550 assistance to facilitate the appropriate placement, as soon as
1551 practicable, of children with behavioral health diagnoses who the
1552 administrative services organization knows to have been in an
1553 emergency department for over forty-eight hours. The administrative
1554 services organization shall provide or arrange for on-site assistance to
1555 arrange for the discharge or appropriate placement, as soon as
1556 practicable, for children who the administrative services organization
1557 knows to have remained in an inpatient hospital unit for more than
1558 five days longer than is medically necessary, as agreed by the
1559 administrative services organization and the hospital.

1560 (e) The Departments of Children and Families, Social Services and
1561 Mental Health and Addiction Services shall develop, in consultation

1562 with the Behavioral Health Partnership, a comprehensive plan for
1563 monitoring the performance of administrative services organizations
1564 which shall include data on service authorizations, individual
1565 outcomes, appeals, outreach and accessibility, comments from
1566 program participants compiled from written surveys and face-to-face
1567 interviews.

1568 (f) The Behavioral Health Partnership shall establish policies to
1569 coordinate benefits received under the partnership with other benefits
1570 received under Medicaid. Such policies shall specify a coordinated
1571 delivery of both physical and behavioral health care. The policies shall
1572 be submitted to the Behavioral Health Partnership Oversight Council
1573 for review and comment.

1574 Sec. 28. Section 17b-10a of the general statutes is repealed and the
1575 following is substituted in lieu thereof (*Effective January 1, 2014*):

1576 The Commissioner of Social Services, pursuant to section 17b-10,
1577 may implement policies and procedures necessary to administer
1578 section 17b-197, subsection (d) of section 17b-266, section 17b-280a []
1579 and subsection (a) of section 17b-295, [and subsection (c) of section
1580 17b-311,] while in the process of adopting such policies and procedures
1581 as regulation, provided the commissioner prints notice of intent to
1582 adopt regulations in the Connecticut Law Journal not later than twenty
1583 days after the date of implementation. Policies and procedures
1584 implemented pursuant to this section shall be valid until the time final
1585 regulations are adopted.

1586 Sec. 29. Subsection (b) of section 38a-556a of the general statutes is
1587 repealed and the following is substituted in lieu thereof (*Effective*
1588 *January 1, 2014*):

1589 (b) Said association shall, in consultation with the Insurance
1590 Commissioner and the Healthcare Advocate, develop, within available
1591 appropriations, a web site, telephone number or other method to serve
1592 as a clearinghouse for information about individual and small

1593 employer health insurance policies and health care plans that are
1594 available to consumers in this state, including, but not limited to, the
1595 Medicaid program, the HUSKY Plan, [the Charter Oak Health Plan set
1596 forth in section 17b-311,] the Municipal Employee Health Insurance
1597 Plan set forth in subsection (i) of section 5-259, and any individual or
1598 small employer health insurance policies or health care plans an
1599 insurer, health care center or other entity chooses to list with the
1600 Connecticut Clearinghouse.

1601 Sec. 30. Subsection (a) of section 29-1s of the general statutes is
1602 repealed and the following is substituted in lieu thereof (*Effective*
1603 *January 1, 2014*):

1604 (a) (1) Wherever the term "Department of Public Safety" is used in
1605 the following general statutes, the term "Department of Emergency
1606 Services and Public Protection" shall be substituted in lieu thereof; and
1607 (2) wherever the term "Commissioner of Public Safety" is used in the
1608 following general statutes, the term "Commissioner of Emergency
1609 Services and Public Protection" shall be substituted in lieu thereof: 1-
1610 24, 1-84b, 1-217, 2-90b, 3-2b, 4-68m, 4a-2a, 4a-18, 4a-67d, 4b-1, 4b-130, 5-
1611 142, 5-146, 5-149, 5-150, 5-169, 5-173, 5-192f, 5-192t, 5-246, 6-32g, 7-169,
1612 7-285, 7-294f to 7-294h, inclusive, 7-294l, 7-294n, 7-294y, 7-425, 9-7a, 10-
1613 233h, 12-562, 12-564a, 12-586f, 12-586g, 13a-123, 13b-69, 13b-376, 14-10,
1614 14-64, 14-67m, 14-67w, 14-103, 14-108a, 14-138, 14-152, 14-163c, 14-211a,
1615 14-212a, 14-212f, 14-219c, 14-227a, 14-227c, 14-267a, 14-270c to 14-270f,
1616 inclusive, 14-283, 14-291, 14-298, 14-315, 15-98, 15-140r, 15-140u, 16-
1617 256g, 16a-103, 17a-105a, 17a-106a, 17a-500, 17b-90, 17b-137, 17b-192,
1618 17b-225, 17b-279, [17b-490,] 18-87k, 19a-112a, 19a-112f, 19a-179b, 19a-
1619 409, 19a-904, 20-12c, 20-327b, 21a-36, 21a-283, 22a-2, 23-8b, 23-18, 26-5,
1620 26-67b, 27-19a, 27-107, 28-25b, 28-27, 28-27a, 28-30a, 29-1c, 29-1e to 29-
1621 1h, inclusive, 29-1q, 29-1zz, 29-2, 29-2a, 29-2b, 29-3a, 29-4a, 29-6a, 29-7,
1622 29-7b, 29-7c, 29-7h, 29-7m, 29-7n, 29-8, 29-10, 29-10a, 29-10c, 29-11, 29-
1623 12, 29-17a, 29-17b, 29-17c, 29-18 to 29-23a, inclusive, 29-25, 29-26, 29-28,
1624 29-28a, 29-30 to 29-32, inclusive, 29-32b, 29-33, 29-36f to 29-36i,
1625 inclusive, 29-36k, 29-36m, 29-36n, 29-37a, 29-37f, 29-38b, 29-38e, 29-38f,

1626 29-108b, 29-143i, 29-143j, 29-145 to 29-151, inclusive, 29-152f to 29-152j,
1627 inclusive, 29-152m, 29-152o, 29-152u, 29-153, 29-155d, 29-156a, 29-161g
1628 to 29-161i, inclusive, 29-161k to 29-161m, inclusive, 29-161o to 29-161t,
1629 inclusive, 29-161v to 29-161z, inclusive, 29-163, 29-164g, 29-166, 29-176
1630 to 29-179, inclusive, 29-179f to 29-179h, 31-275, 38a-18, 38a-356, 45a-63,
1631 46a-4b, 46a-170, 46b-15a, 46b-38d, 46b-38f, 51-5c, 51-10c, 51-51o, 51-
1632 277a, 52-11, 53-39a, 53-134, 53-199, 53-202, 53-202b, 53-202c, 53-202g,
1633 53-202l, 53-202n, 53-202o, 53-278c, 53-341b, 53a-3, 53a-30, 53a-54b, 53a-
1634 130, 53a-130a, 54-1f, 54-1l, 54-36e, 54-36i, 54-36n, 54-47aa, 54-63c, 54-76l,
1635 54-86k, 54-102g to 54-102j, inclusive, 54-102m, 54-102pp, 54-142j, 54-
1636 222a, 54-240, 54-240m, 54-250 to 54-258, inclusive, 54-259a, 54-260b, and
1637 54-300.

1638 Sec. 31. Subsection (e) of section 12-746 of the general statutes is
1639 repealed and the following is substituted in lieu thereof (*Effective*
1640 *January 1, 2014*):

1641 (e) Amounts rebated pursuant to this section shall not be considered
1642 income for purposes of sections 8-119l, 12-170d, 12-170aa, [17b-490,]
1643 17b-550, 17b-812, 47-88d and 47-287.

1644 Sec. 32. Subsection (b) of section 10a-132e of the general statutes is
1645 repealed and the following is substituted in lieu thereof (*Effective*
1646 *January 1, 2014*):

1647 (b) The program established pursuant to subsection (a) of this
1648 section shall: (1) Arrange for licensed physicians, pharmacists and
1649 nurses to conduct in person educational visits with prescribing
1650 practitioners, utilizing evidence-based materials, borrowing methods
1651 from behavioral science and educational theory and, when
1652 appropriate, utilizing pharmaceutical industry data and outreach
1653 techniques; (2) inform prescribing practitioners about drug marketing
1654 that is designed to prevent competition to brand name drugs from
1655 generic or other therapeutically-equivalent pharmaceutical alternatives
1656 or other evidence-based treatment options; and (3) provide outreach
1657 and education to licensed physicians and other health care

1658 practitioners who are participating providers in state-funded health
1659 care programs, including, but not limited to, Medicaid, the HUSKY
1660 Plan, Parts A and B, [the Charter Oak Health Plan, the ConnPACE
1661 program,] the Department of Correction inmate health services
1662 program and the state employees' health insurance plan.

1663 Sec. 33. Subsection (a) of section 17a-22f of the general statutes is
1664 repealed and the following is substituted in lieu thereof (*Effective*
1665 *January 1, 2014*):

1666 (a) The Commissioner of Social Services may, with regard to the
1667 provision of behavioral health services provided pursuant to a state
1668 plan under Title XIX or Title XXI of the Social Security Act; [, or under
1669 the Charter Oak Health Plan:] (1) Contract with one or more
1670 administrative services organizations to provide clinical management,
1671 provider network development and other administrative services; (2)
1672 delegate responsibility to the Department of Children and Families for
1673 the clinical management portion of such administrative contract or
1674 contracts that pertain to HUSKY Plan Parts A and B, and other
1675 children, adolescents and families served by the Department of
1676 Children and Families; and (3) delegate responsibility to the
1677 Department of Mental Health and Addiction Services for the clinical
1678 management portion of such administrative contract or contracts that
1679 pertain to Medicaid recipients who are not enrolled in HUSKY Plan
1680 Part A. [and recipients enrolled in the Charter Oak Health Plan.]

1681 Sec. 34. Subsection (a) of section 17a-22h of the general statutes, as
1682 amended by section 26 of this act, is repealed and the following is
1683 substituted in lieu thereof (*Effective January 1, 2014*):

1684 (a) The Commissioners of Social Services, Children and Families,
1685 and Mental Health and Addiction Services shall develop and
1686 implement an integrated behavioral health service system for
1687 Medicaid and HUSKY Plan Part B members and children enrolled in
1688 the voluntary services program operated by the Department of
1689 Children and Families and may, at the discretion of the commissioners,

1690 include [:(1) Other] other children, adolescents and families served by
1691 the Department of Children and Families or the Court Support
1692 Services Division of the Judicial Branch. [; and (2) Charter Oak Health
1693 Plan members.] The integrated behavioral health service system shall
1694 be known as the Behavioral Health Partnership. The Behavioral Health
1695 Partnership shall seek to increase access to quality behavioral health
1696 services by: (A) Expanding individualized, family-centered and
1697 community-based services; (B) maximizing federal revenue to fund
1698 behavioral health services; (C) reducing unnecessary use of
1699 institutional and residential services for children and adults; (D)
1700 capturing and investing enhanced federal revenue and savings derived
1701 from reduced residential services and increased community-based
1702 services for HUSKY Plan Parts A and B recipients; (E) improving
1703 administrative oversight and efficiencies; and (F) monitoring
1704 individual outcomes and provider performance, taking into
1705 consideration the acuity of the patients served by each provider, and
1706 overall program performance.

1707 Sec. 35. Subsection (a) of section 17b-28 of the general statutes is
1708 repealed and the following is substituted in lieu thereof (*Effective*
1709 *January 1, 2014*):

1710 (a) There is established a Council on Medical Assistance Program
1711 Oversight which shall advise the Commissioner of Social Services on
1712 the planning and implementation of the health care delivery system
1713 for the following health care programs: The HUSKY Plan, Parts A and
1714 B [, the Charter Oak Health Plan] and the Medicaid program,
1715 including, but not limited to, the portions of the program serving low
1716 income adults, the aged, blind and disabled individuals, individuals
1717 who are dually eligible for Medicaid and Medicare and individuals
1718 with preexisting medical conditions. The council shall monitor
1719 planning and implementation of matters related to Medicaid care
1720 management initiatives including, but not limited to, (1) eligibility
1721 standards, (2) benefits, (3) access, (4) quality assurance, (5) outcome
1722 measures, and (6) the issuance of any request for proposal by the

1723 Department of Social Services for utilization of an administrative
1724 services organization in connection with such initiatives.

1725 Sec. 36. Subsection (a) of section 17b-261m of the general statutes, as
1726 amended by section 14 of this act, is repealed and the following is
1727 substituted in lieu thereof (*Effective January 1, 2014*):

1728 (a) The Commissioner of Social Services may contract with one or
1729 more administrative services organizations to provide care
1730 coordination, utilization management, disease management, customer
1731 service and review of grievances for recipients of assistance under
1732 Medicaid [] and HUSKY Plan, Parts A and B, [, and the Charter Oak
1733 Health Plan.] Such organization may also provide network
1734 management, credentialing of providers, monitoring of copayments
1735 and premiums and other services as required by the commissioner.
1736 Subject to approval by applicable federal authority, the Department of
1737 Social Services shall utilize the contracted organization's provider
1738 network and billing systems in the administration of the program. In
1739 order to implement the provisions of this section, the commissioner
1740 may establish rates of payment to providers of medical services under
1741 this section if the establishment of such rates is required to ensure that
1742 any contract entered into with an administrative services organization
1743 pursuant to this section is cost neutral to such providers in the
1744 aggregate and ensures patient access. Utilization may be a factor in
1745 determining cost neutrality, provided the Department of Social
1746 Services completes a fiscal analysis prior to implementation of the
1747 impact on each such provider of considering utilization as a factor.

1748 Sec. 37. Section 17b-274 of the general statutes is repealed and the
1749 following is substituted in lieu thereof (*Effective January 1, 2014*):

1750 (a) The Division of Criminal Justice shall periodically investigate
1751 pharmacies to ensure that the state is not billed for a brand name drug
1752 product when a less expensive generic substitute drug product is
1753 dispensed to a Medicaid recipient. The Commissioner of Social
1754 Services shall cooperate and provide information as requested by such

1755 division.

1756 (b) A licensed medical practitioner may specify in writing or by a
1757 telephonic or electronic communication that there shall be no
1758 substitution for the specified brand name drug product in any
1759 prescription for a Medicaid [or ConnPACE] recipient, provided (1) the
1760 practitioner specifies the basis on which the brand name drug product
1761 and dosage form is medically necessary in comparison to a chemically
1762 equivalent generic drug product substitution, and (2) the phrase
1763 "brand medically necessary" shall be in the practitioner's handwriting
1764 on the prescription form or, if the prohibition was communicated by
1765 telephonic communication, in the pharmacist's handwriting on such
1766 form, and shall not be preprinted or stamped or initialed on such form.
1767 If the practitioner specifies by telephonic communication that there
1768 shall be no substitution for the specified brand name drug product in
1769 any prescription for a Medicaid [or ConnPACE] recipient, written
1770 certification in the practitioner's handwriting bearing the phrase
1771 "brand medically necessary" shall be sent to the dispensing pharmacy
1772 within ten days. A pharmacist shall dispense a generically equivalent
1773 drug product for any drug listed in accordance with the Code of
1774 Federal Regulations Title 42 Part 447.332 for a drug prescribed for a
1775 Medicaid, or state-administered general assistance [, or ConnPACE]
1776 recipient unless the phrase "brand medically necessary" is ordered in
1777 accordance with this subsection and such pharmacist has received
1778 approval to dispense the brand name drug product in accordance with
1779 subsection (c) of this section.

1780 (c) The Commissioner of Social Services shall implement a
1781 procedure by which a pharmacist shall obtain approval from an
1782 independent pharmacy consultant acting on behalf of the Department
1783 of Social Services, under an administrative services only contract,
1784 whenever the pharmacist dispenses a brand name drug product to a
1785 Medicaid [or ConnPACE] recipient and a chemically equivalent
1786 generic drug product substitution is available. The length of
1787 authorization for brand name drugs shall be in accordance with section

1788 17b-491a. In cases where the brand name drug is less costly than the
1789 chemically equivalent generic drug when factoring in manufacturers'
1790 rebates, the pharmacist shall dispense the brand name drug. If such
1791 approval is not granted or denied within two hours of receipt by the
1792 commissioner of the request for approval, it shall be deemed granted.
1793 Notwithstanding any provision of this section, a pharmacist shall not
1794 dispense any initial maintenance drug prescription for which there is a
1795 chemically equivalent generic substitution that is for less than fifteen
1796 days without the department's granting of prior authorization,
1797 provided prior authorization shall not otherwise be required for
1798 atypical antipsychotic drugs if the individual is currently taking such
1799 drug at the time the pharmacist receives the prescription. The
1800 pharmacist may appeal a denial of reimbursement to the department
1801 based on the failure of such pharmacist to substitute a generic drug
1802 product in accordance with this section.

1803 (d) A licensed medical practitioner shall disclose to the Department
1804 of Social Services or such consultant, upon request, the basis on which
1805 the brand name drug product and dosage form is medically necessary
1806 in comparison to a chemically equivalent generic drug product
1807 substitution. The Commissioner of Social Services shall establish a
1808 procedure by which such a practitioner may appeal a determination
1809 that a chemically equivalent generic drug product substitution is
1810 required for a Medicaid [or ConnPACE] recipient.

1811 Sec. 38. Section 17b-274a of the general statutes is repealed and the
1812 following is substituted in lieu thereof (*Effective January 1, 2014*):

1813 The Commissioner of Social Services may establish maximum
1814 allowable costs to be paid under the Medicaid [, ConnPACE] and
1815 Connecticut AIDS drug assistance programs for generic prescription
1816 drugs based on, but not limited to, actual acquisition costs. The
1817 department shall implement and maintain a procedure to review and
1818 update the maximum allowable cost list at least annually, and shall
1819 report annually to the joint standing committee of the General
1820 Assembly having cognizance of matters relating to appropriations and

1821 the budgets of state agencies on its activities pursuant to this section.

1822 Sec. 39. Subsection (a) of section 17b-274c of the general statutes is
1823 repealed and the following is substituted in lieu thereof (*Effective*
1824 *January 1, 2014*):

1825 (a) The Commissioner of Social Services may establish a voluntary
1826 mail order option for any maintenance prescription drug covered
1827 under the Medicaid [ConnPACE] or Connecticut AIDS drug
1828 assistance programs.

1829 Sec. 40. Subsection (e) of section 17b-274d of the general statutes is
1830 repealed and the following is substituted in lieu thereof (*Effective*
1831 *January 1, 2014*):

1832 (e) The Department of Social Services, in consultation with the
1833 Pharmaceutical and Therapeutics Committee, may adopt a preferred
1834 drug [lists] list for use in the Medicaid [and ConnPACE programs]
1835 program. To the extent feasible, the department shall review all drugs
1836 included on the preferred drug [lists] list at least every twelve months,
1837 and may recommend additions to, and deletions from, the preferred
1838 drug [lists] list, to ensure that the preferred drug [lists provide] list
1839 provides for medically appropriate drug therapies for Medicaid [and
1840 ConnPACE] patients. [For the fiscal year ending June 30, 2004, such
1841 drug lists shall be limited to use in the Medicaid and ConnPACE
1842 programs and cover three classes of drugs, including proton pump
1843 inhibitors and two other classes of drugs determined by the
1844 Commissioner of Social Services. Not later than June 30, 2005, the] The
1845 Department of Social Services, in consultation with the Pharmaceutical
1846 and [Therapeutic] Therapeutics Committee, shall expand such drug
1847 [lists] list to include other classes of drugs, except as provided in
1848 subsection (f) of this section, in order to achieve savings reflected in the
1849 amounts appropriated to the department, for the various components
1850 of the program, in the state budget act.

1851 Sec. 41. Section 17b-274e of the general statutes is repealed and the

1852 following is substituted in lieu thereof (*Effective January 1, 2014*):

1853 A pharmacist, when filling a prescription under the Medicaid [,
1854 ConnPACE] or Connecticut AIDS drug assistance programs, shall fill
1855 such prescription utilizing the most cost-efficient dosage, consistent
1856 with the prescription of a prescribing practitioner as defined in section
1857 20-571, unless such pharmacist receives permission to do otherwise
1858 pursuant to the prior authorization requirements set forth in sections
1859 17b-274, as amended by this act, and 17b-491a.

1860 Sec. 42. Subsection (a) of section 17b-280 of the general statutes is
1861 repealed and the following is substituted in lieu thereof (*Effective*
1862 *January 1, 2014*):

1863 (a) The state shall reimburse for all legend drugs provided under
1864 medical assistance programs administered by the Department of Social
1865 Services at the lower of (1) the rate established by the Centers for
1866 Medicare and Medicaid Services as the federal acquisition cost, (2) the
1867 average wholesale price minus sixteen per cent, or (3) an equivalent
1868 percentage as established under the Medicaid state plan.
1869 Notwithstanding the provisions of this section, contingent upon
1870 federal approval, on and after October 1, 2012, for independent
1871 pharmacies, the state shall reimburse for such legend drugs at the
1872 lower of (A) the rate established by the Centers for Medicare and
1873 Medicaid Services as the federal acquisition cost, (B) the average
1874 wholesale price minus fifteen per cent, or (C) an equivalent percentage
1875 as established under the Medicaid state plan. The state shall pay a
1876 professional fee of one dollar and seventy cents to licensed pharmacies
1877 for each prescription dispensed to a recipient of benefits under a
1878 medical assistance program administered by the Department of Social
1879 Services in accordance with federal regulations. On and after
1880 September 4, 1991, payment for legend and nonlegend drugs provided
1881 to Medicaid recipients shall be based upon the actual package size
1882 dispensed. Effective October 1, 1991, reimbursement for over-the-
1883 counter drugs for such recipients shall be limited to those over-the-
1884 counter drugs and products published in the Connecticut Formulary,

1885 or the cross reference list, issued by the commissioner. The cost of all
1886 over-the-counter drugs and products provided to residents of nursing
1887 facilities, chronic disease hospitals, and intermediate care facilities for
1888 the mentally retarded shall be included in the facilities' per diem rate.
1889 Notwithstanding the provisions of this subsection, no dispensing fee
1890 shall be issued for a prescription drug dispensed to a [ConnPACE or]
1891 Medicaid recipient who is a Medicare Part D beneficiary when the
1892 prescription drug is a Medicare Part D drug, as defined in Public Law
1893 108-173, the Medicare Prescription Drug, Improvement, and
1894 Modernization Act of 2003.

1895 Sec. 43. Section 17b-429 of the general statutes is repealed and the
1896 following is substituted in lieu thereof (*Effective January 1, 2014*):

1897 The Commissioner of Social Services shall, within available
1898 appropriations, make information available to senior citizens and
1899 disabled persons concerning any pharmaceutical company's drug
1900 program for indigent persons by utilizing the [ConnPACE program,
1901 the] CHOICES health insurance assistance program, as defined in
1902 section 17b-427, and Infoline of Connecticut to deliver such
1903 information.

1904 Sec. 44. Section 17b-491b of the general statutes is repealed and the
1905 following is substituted in lieu thereof (*Effective January 1, 2014*):

1906 The maximum allowable cost paid for Factor VIII pharmaceuticals
1907 under the Medicaid [and ConnPACE programs] program shall be the
1908 actual acquisition cost plus eight per cent. The Commissioner of Social
1909 Services may designate specific suppliers of Factor VIII
1910 pharmaceuticals from which a dispensing pharmacy shall order the
1911 prescription to be delivered to the pharmacy and billed by the supplier
1912 to the Department of Social Services. If the commissioner so designates
1913 specific suppliers of Factor VIII pharmaceuticals, the department shall
1914 pay the dispensing pharmacy a handling fee equal to eight per cent of
1915 the actual acquisition cost for such prescription.

1916 Sec. 45. Subsection (c) of section 20-619 of the general statutes is
1917 repealed and the following is substituted in lieu thereof (*Effective*
1918 *January 1, 2014*):

1919 (c) A prescribing practitioner may specify in writing or by a
1920 telephonic or other electronic communication that there shall be no
1921 substitution for the specified brand name drug product in any
1922 prescription, provided (1) in any prescription for a Medicaid [or
1923 ConnPACE] recipient, such practitioner specifies the basis on which
1924 the brand name drug product and dosage form is medically necessary
1925 in comparison to a chemically equivalent generic name drug product
1926 substitution, and (2) the phrase "BRAND MEDICALLY NECESSARY",
1927 shall be in the practitioner's handwriting on the prescription form or
1928 on an electronically produced copy of the prescription form or, if the
1929 prohibition was communicated by telephonic or other electronic
1930 communication that did not reproduce the practitioner's handwriting,
1931 a statement to that effect appears on the form. The phrase "BRAND
1932 MEDICALLY NECESSARY" shall not be preprinted or stamped or
1933 initialed on the form. If the practitioner specifies by telephonic or other
1934 electronic communication that did not reproduce the practitioner's
1935 handwriting that there shall be no substitution for the specified brand
1936 name drug product in any prescription for a Medicaid [or ConnPACE]
1937 recipient, written certification in the practitioner's handwriting bearing
1938 the phrase "BRAND MEDICALLY NECESSARY" shall be sent to the
1939 dispensing pharmacy not later than ten days after the date of such
1940 communication.

1941 Sec. 46. Section 17b-260d of the general statutes is repealed. (*Effective*
1942 *July 1, 2013*)

1943 Sec. 47. Sections 17b-261n, 17b-311, 17b-490, 17b-491, 17b-492 and
1944 17b-493 to 17b-498, inclusive, of the general statutes are repealed.
1945 (*Effective January 1, 2014*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2013</i>	10-295(b)
Sec. 2	<i>July 1, 2013</i>	17b-607
Sec. 3	<i>July 1, 2013</i>	17a-1(5)
Sec. 4	<i>July 1, 2013</i>	17a-93(a)
Sec. 5	<i>July 1, 2013</i>	46b-120(1)
Sec. 6	<i>July 1, 2013</i>	17b-340(f)(4)
Sec. 7	<i>July 1, 2013</i>	17b-340(g)
Sec. 8	<i>July 1, 2013</i>	17b-244(a)
Sec. 9	<i>July 1, 2013</i>	17b-340(h)(1)
Sec. 10	<i>October 1, 2014</i>	New section
Sec. 11	<i>July 1, 2013</i>	17b-239
Sec. 12	<i>July 1, 2013</i>	17b-239e(b)
Sec. 13	<i>July 1, 2013</i>	17b-242(a)
Sec. 14	<i>July 1, 2013</i>	17b-261m(a)
Sec. 15	<i>July 1, 2013</i>	17b-239c(a)
Sec. 16	<i>July 1, 2013</i>	17b-28e
Sec. 17	<i>July 1, 2013</i>	17b-104(b)
Sec. 18	<i>July 1, 2013</i>	17b-106(a)
Sec. 19	<i>January 1, 2014</i>	17b-90(b)
Sec. 20	<i>January 1, 2014</i>	17b-261
Sec. 21	<i>January 1, 2014</i>	17b-256f
Sec. 22	<i>January 1, 2014</i>	17b-551
Sec. 23	<i>January 1, 2014</i>	17b-552
Sec. 24	<i>from passage</i>	17b-278i(a)
Sec. 25	<i>from passage</i>	17b-340c(a)
Sec. 26	<i>July 1, 2013</i>	17a-22h
Sec. 27	<i>July 1, 2013</i>	17a-22p
Sec. 28	<i>January 1, 2014</i>	17b-10a
Sec. 29	<i>January 1, 2014</i>	38a-556a(b)
Sec. 30	<i>January 1, 2014</i>	29-1s(a)
Sec. 31	<i>January 1, 2014</i>	12-746(e)
Sec. 32	<i>January 1, 2014</i>	10a-132e(b)
Sec. 33	<i>January 1, 2014</i>	17a-22f(a)
Sec. 34	<i>January 1, 2014</i>	17a-22h(a)
Sec. 35	<i>January 1, 2014</i>	17b-28(a)
Sec. 36	<i>January 1, 2014</i>	17b-261m(a)

Sec. 37	<i>January 1, 2014</i>	17b-274
Sec. 38	<i>January 1, 2014</i>	17b-274a
Sec. 39	<i>January 1, 2014</i>	17b-274c(a)
Sec. 40	<i>January 1, 2014</i>	17b-274d(e)
Sec. 41	<i>January 1, 2014</i>	17b-274e
Sec. 42	<i>January 1, 2014</i>	17b-280(a)
Sec. 43	<i>January 1, 2014</i>	17b-429
Sec. 44	<i>January 1, 2014</i>	17b-491b
Sec. 45	<i>January 1, 2014</i>	20-619(c)
Sec. 46	<i>July 1, 2013</i>	Repealer section
Sec. 47	<i>January 1, 2014</i>	Repealer section

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Joint Favorable Subst. C/R

APP