



# House of Representatives

General Assembly

**File No. 779**

January Session, 2013

Substitute House Bill No. 6367

*House of Representatives, May 9, 2013*

The Committee on Appropriations reported through REP. WALKER of the 93rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

***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2 repealed and the following is substituted in lieu thereof (*Effective July*  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) There is established, within the Department of Rehabilitation  
135 Services, the Connecticut Tech Act Project. In accordance with the  
136 provisions of 29 USC 3001, the project may provide assistive  
137 technology evaluation and training services upon the request of any  
138 person or any public or private entity, to the extent persons who  
139 provide assistive technology services are available. The project may  
140 charge a fee to any person or entity receiving such assistive technology  
141 evaluation and training services to reimburse the department for its  
142 costs. The Commissioner of Rehabilitation Services shall establish fees  
143 at reasonable rates that will cover the department's direct and indirect  
144 costs.

145 Sec. 3. Subdivision (4) of subsection (f) of section 17b-340 of the  
146 general statutes is repealed and the following is substituted in lieu  
147 thereof (*Effective July 1, 2013*):

148 (4) For the fiscal year ending June 30, 1992, (A) no facility shall  
149 receive a rate that is less than the rate it received for the rate year  
150 ending June 30, 1991; (B) no facility whose rate, if determined pursuant  
151 to this subsection, would exceed one hundred twenty per cent of the  
152 state-wide median rate, as determined pursuant to this subsection,  
153 shall receive a rate which is five and one-half per cent more than the  
154 rate it received for the rate year ending June 30, 1991; and (C) no  
155 facility whose rate, if determined pursuant to this subsection, would be  
156 less than one hundred twenty per cent of the state-wide median rate,  
157 as determined pursuant to this subsection, shall receive a rate which is  
158 six and one-half per cent more than the rate it received for the rate year  
159 ending June 30, 1991. For the fiscal year ending June 30, 1993, no  
160 facility shall receive a rate that is less than the rate it received for the  
161 rate year ending June 30, 1992, or six per cent more than the rate it  
162 received for the rate year ending June 30, 1992. For the fiscal year  
163 ending June 30, 1994, no facility shall receive a rate that is less than the  
164 rate it received for the rate year ending June 30, 1993, or six per cent  
165 more than the rate it received for the rate year ending June 30, 1993.  
166 For the fiscal year ending June 30, 1995, no facility shall receive a rate  
167 that is more than five per cent less than the rate it received for the rate  
168 year ending June 30, 1994, or six per cent more than the rate it received  
169 for the rate year ending June 30, 1994. For the fiscal years ending June  
170 30, 1996, and June 30, 1997, no facility shall receive a rate that is more  
171 than three per cent more than the rate it received for the prior rate  
172 year. For the fiscal year ending June 30, 1998, a facility shall receive a  
173 rate increase that is not more than two per cent more than the rate that  
174 the facility received in the prior year. For the fiscal year ending June  
175 30, 1999, a facility shall receive a rate increase that is not more than  
176 three per cent more than the rate that the facility received in the prior  
177 year and that is not less than one per cent more than the rate that the  
178 facility received in the prior year, exclusive of rate increases associated  
179 with a wage, benefit and staffing enhancement rate adjustment added  
180 for the period from April 1, 1999, to June 30, 1999, inclusive. For the  
181 fiscal year ending June 30, 2000, each facility, except a facility with an  
182 interim rate or replaced interim rate for the fiscal year ending June 30,

183 1999, and a facility having a certificate of need or other agreement  
184 specifying rate adjustments for the fiscal year ending June 30, 2000,  
185 shall receive a rate increase equal to one per cent applied to the rate the  
186 facility received for the fiscal year ending June 30, 1999, exclusive of  
187 the facility's wage, benefit and staffing enhancement rate adjustment.  
188 For the fiscal year ending June 30, 2000, no facility with an interim rate,  
189 replaced interim rate or scheduled rate adjustment specified in a  
190 certificate of need or other agreement for the fiscal year ending June  
191 30, 2000, shall receive a rate increase that is more than one per cent  
192 more than the rate the facility received in the fiscal year ending June  
193 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a  
194 facility with an interim rate or replaced interim rate for the fiscal year  
195 ending June 30, 2000, and a facility having a certificate of need or other  
196 agreement specifying rate adjustments for the fiscal year ending June  
197 30, 2001, shall receive a rate increase equal to two per cent applied to  
198 the rate the facility received for the fiscal year ending June 30, 2000,  
199 subject to verification of wage enhancement adjustments pursuant to  
200 subdivision (14) of this subsection. For the fiscal year ending June 30,  
201 2001, no facility with an interim rate, replaced interim rate or  
202 scheduled rate adjustment specified in a certificate of need or other  
203 agreement for the fiscal year ending June 30, 2001, shall receive a rate  
204 increase that is more than two per cent more than the rate the facility  
205 received for the fiscal year ending June 30, 2000. For the fiscal year  
206 ending June 30, 2002, each facility shall receive a rate that is two and  
207 one-half per cent more than the rate the facility received in the prior  
208 fiscal year. For the fiscal year ending June 30, 2003, each facility shall  
209 receive a rate that is two per cent more than the rate the facility  
210 received in the prior fiscal year, except that such increase shall be  
211 effective January 1, 2003, and such facility rate in effect for the fiscal  
212 year ending June 30, 2002, shall be paid for services provided until  
213 December 31, 2002, except any facility that would have been issued a  
214 lower rate effective July 1, 2002, than for the fiscal year ending June 30,  
215 2002, due to interim rate status or agreement with the department shall  
216 be issued such lower rate effective July 1, 2002, and have such rate  
217 increased two per cent effective June 1, 2003. For the fiscal year ending

218 June 30, 2004, rates in effect for the period ending June 30, 2003, shall  
219 remain in effect, except any facility that would have been issued a  
220 lower rate effective July 1, 2003, than for the fiscal year ending June 30,  
221 2003, due to interim rate status or agreement with the department shall  
222 be issued such lower rate effective July 1, 2003. For the fiscal year  
223 ending June 30, 2005, rates in effect for the period ending June 30, 2004,  
224 shall remain in effect until December 31, 2004, except any facility that  
225 would have been issued a lower rate effective July 1, 2004, than for the  
226 fiscal year ending June 30, 2004, due to interim rate status or  
227 agreement with the department shall be issued such lower rate  
228 effective July 1, 2004. Effective January 1, 2005, each facility shall  
229 receive a rate that is one per cent greater than the rate in effect  
230 December 31, 2004. Effective upon receipt of all the necessary federal  
231 approvals to secure federal financial participation matching funds  
232 associated with the rate increase provided in this subdivision, but in  
233 no event earlier than July 1, 2005, and provided the user fee imposed  
234 under section 17b-320 is required to be collected, for the fiscal year  
235 ending June 30, 2006, the department shall compute the rate for each  
236 facility based upon its 2003 cost report filing or a subsequent cost year  
237 filing for facilities having an interim rate for the period ending June 30,  
238 2005, as provided under section 17-311-55 of the regulations of  
239 Connecticut state agencies. For each facility not having an interim rate  
240 for the period ending June 30, 2005, the rate for the period ending June  
241 30, 2006, shall be determined beginning with the higher of the  
242 computed rate based upon its 2003 cost report filing or the rate in  
243 effect for the period ending June 30, 2005. Such rate shall then be  
244 increased by eleven dollars and eighty cents per day except that in no  
245 event shall the rate for the period ending June 30, 2006, be thirty-two  
246 dollars more than the rate in effect for the period ending June 30, 2005,  
247 and for any facility with a rate below one hundred ninety-five dollars  
248 per day for the period ending June 30, 2005, such rate for the period  
249 ending June 30, 2006, shall not be greater than two hundred seventeen  
250 dollars and forty-three cents per day and for any facility with a rate  
251 equal to or greater than one hundred ninety-five dollars per day for  
252 the period ending June 30, 2005, such rate for the period ending June

253 30, 2006, shall not exceed the rate in effect for the period ending June  
254 30, 2005, increased by eleven and one-half per cent. For each facility  
255 with an interim rate for the period ending June 30, 2005, the interim  
256 replacement rate for the period ending June 30, 2006, shall not exceed  
257 the rate in effect for the period ending June 30, 2005, increased by  
258 eleven dollars and eighty cents per day plus the per day cost of the  
259 user fee payments made pursuant to section 17b-320 divided by  
260 annual resident service days, except for any facility with an interim  
261 rate below one hundred ninety-five dollars per day for the period  
262 ending June 30, 2005, the interim replacement rate for the period  
263 ending June 30, 2006, shall not be greater than two hundred seventeen  
264 dollars and forty-three cents per day and for any facility with an  
265 interim rate equal to or greater than one hundred ninety-five dollars  
266 per day for the period ending June 30, 2005, the interim replacement  
267 rate for the period ending June 30, 2006, shall not exceed the rate in  
268 effect for the period ending June 30, 2005, increased by eleven and one-  
269 half per cent. Such July 1, 2005, rate adjustments shall remain in effect  
270 unless (i) the federal financial participation matching funds associated  
271 with the rate increase are no longer available; or (ii) the user fee  
272 created pursuant to section 17b-320 is not in effect. For the fiscal year  
273 ending June 30, 2007, each facility shall receive a rate that is three per  
274 cent greater than the rate in effect for the period ending June 30, 2006,  
275 except any facility that would have been issued a lower rate effective  
276 July 1, 2006, than for the rate period ending June 30, 2006, due to  
277 interim rate status or agreement with the department, shall be issued  
278 such lower rate effective July 1, 2006. For the fiscal year ending June  
279 30, 2008, each facility shall receive a rate that is two and nine-tenths  
280 per cent greater than the rate in effect for the period ending June 30,  
281 2007, except any facility that would have been issued a lower rate  
282 effective July 1, 2007, than for the rate period ending June 30, 2007, due  
283 to interim rate status or agreement with the department, shall be  
284 issued such lower rate effective July 1, 2007. For the fiscal year ending  
285 June 30, 2009, rates in effect for the period ending June 30, 2008, shall  
286 remain in effect until June 30, 2009, except any facility that would have  
287 been issued a lower rate for the fiscal year ending June 30, 2009, due to

288 interim rate status or agreement with the department shall be issued  
289 such lower rate. For the fiscal years ending June 30, 2010, and June 30,  
290 2011, rates in effect for the period ending June 30, 2009, shall remain in  
291 effect until June 30, 2011, except any facility that would have been  
292 issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal  
293 year ending June 30, 2011, due to interim rate status or agreement with  
294 the department, shall be issued such lower rate. For the fiscal years  
295 ending June 30, 2012, and June 30, 2013, rates in effect for the period  
296 ending June 30, 2011, shall remain in effect until June 30, 2013, except  
297 any facility that would have been issued a lower rate for the fiscal year  
298 ending June 30, 2012, or the fiscal year ending June 30, 2013, due to  
299 interim rate status or agreement with the department, shall be issued  
300 such lower rate. For the fiscal years ending June 30, 2014, and June 30,  
301 2015, rates shall not exceed those in effect for the period ending June  
302 30, 2013. Any facility that would have been issued a lower rate for the  
303 fiscal year ending June 30, 2014, or the fiscal year ending June 30, 2015,  
304 due to rebasing, available appropriations, interim rate status or  
305 agreement with the department, shall be issued such lower rate. The  
306 Commissioner of Social Services shall add fair rent increases to any  
307 other rate increases established pursuant to this subdivision for a  
308 facility which has undergone a material change in circumstances  
309 related to fair rent, except for the fiscal years ending June 30, 2010, June  
310 30, 2011, and June 30, 2012, such fair rent increases shall only be  
311 provided to facilities with an approved certificate of need pursuant to  
312 section 17b-352, 17b-353, 17b-354 or 17b-355. For the fiscal year ending  
313 June 30, 2013, the commissioner may, within available appropriations,  
314 provide pro rata fair rent increases for facilities which have undergone  
315 a material change in circumstances related to fair rent additions placed  
316 in service in cost report years ending September 30, 2008, to September  
317 30, 2011, inclusive, and not otherwise included in rates issued. For the  
318 fiscal year ending June 30, 2013, the commissioner shall add fair rent  
319 increases associated with an approved certificate of need pursuant to  
320 section 17b-352, 17b-353, 17b-354 or 17b-355. Interim rates may take  
321 into account reasonable costs incurred by a facility, including wages  
322 and benefits. Notwithstanding the provisions of this section, the

323 Commissioner of Social Services may, [within] subject to available  
324 appropriations, increase or decrease rates issued to licensed chronic  
325 and convalescent nursing homes and licensed rest homes with nursing  
326 supervision.

327 Sec. 4. Subdivision (1) of subsection (h) of section 17b-340 of the  
328 general statutes is repealed and the following is substituted in lieu  
329 thereof (*Effective July 1, 2013*):

330 (h) (1) For the fiscal year ending June 30, 1993, any residential care  
331 home with an operating cost component of its rate in excess of one  
332 hundred thirty per cent of the median of operating cost components of  
333 rates in effect January 1, 1992, shall not receive an operating cost  
334 component increase. For the fiscal year ending June 30, 1993, any  
335 residential care home with an operating cost component of its rate that  
336 is less than one hundred thirty per cent of the median of operating cost  
337 components of rates in effect January 1, 1992, shall have an allowance  
338 for real wage growth equal to sixty-five per cent of the increase  
339 determined in accordance with subsection (q) of section 17-311-52 of  
340 the regulations of Connecticut state agencies, provided such operating  
341 cost component shall not exceed one hundred thirty per cent of the  
342 median of operating cost components in effect January 1, 1992.  
343 Beginning with the fiscal year ending June 30, 1993, for the purpose of  
344 determining allowable fair rent, a residential care home with allowable  
345 fair rent less than the twenty-fifth percentile of the state-wide  
346 allowable fair rent shall be reimbursed as having allowable fair rent  
347 equal to the twenty-fifth percentile of the state-wide allowable fair  
348 rent. Beginning with the fiscal year ending June 30, 1997, a residential  
349 care home with allowable fair rent less than three dollars and ten cents  
350 per day shall be reimbursed as having allowable fair rent equal to  
351 three dollars and ten cents per day. Property additions placed in  
352 service during the cost year ending September 30, 1996, or any  
353 succeeding cost year shall receive a fair rent allowance for such  
354 additions as an addition to three dollars and ten cents per day if the  
355 fair rent for the facility for property placed in service prior to  
356 September 30, 1995, is less than or equal to three dollars and ten cents

357 per day. For the fiscal year ending June 30, 1996, and any succeeding  
358 fiscal year, the allowance for real wage growth, as determined in  
359 accordance with subsection (q) of section 17-311-52 of the regulations  
360 of Connecticut state agencies, shall not be applied. For the fiscal year  
361 ending June 30, 1996, and any succeeding fiscal year, the inflation  
362 adjustment made in accordance with subsection (p) of section 17-311-  
363 52 of the regulations of Connecticut state agencies shall not be applied  
364 to real property costs. Beginning with the fiscal year ending June 30,  
365 1997, minimum allowable patient days for rate computation purposes  
366 for a residential care home with twenty-five beds or less shall be  
367 eighty-five per cent of licensed capacity. Beginning with the fiscal year  
368 ending June 30, 2002, for the purposes of determining the allowable  
369 salary of an administrator of a residential care home with sixty beds or  
370 less the department shall revise the allowable base salary to thirty-  
371 seven thousand dollars to be annually inflated thereafter in accordance  
372 with section 17-311-52 of the regulations of Connecticut state agencies.  
373 The rates for the fiscal year ending June 30, 2002, shall be based upon  
374 the increased allowable salary of an administrator, regardless of  
375 whether such amount was expended in the 2000 cost report period  
376 upon which the rates are based. Beginning with the fiscal year ending  
377 June 30, 2000, and until the fiscal year ending June 30, 2009, inclusive,  
378 the inflation adjustment for rates made in accordance with subsection  
379 (p) of section 17-311-52 of the regulations of Connecticut state agencies  
380 shall be increased by two per cent, and beginning with the fiscal year  
381 ending June 30, 2002, the inflation adjustment for rates made in  
382 accordance with subsection (c) of said section shall be increased by one  
383 per cent. Beginning with the fiscal year ending June 30, 1999, for the  
384 purpose of determining the allowable salary of a related party, the  
385 department shall revise the maximum salary to twenty-seven  
386 thousand eight hundred fifty-six dollars to be annually inflated  
387 thereafter in accordance with section 17-311-52 of the regulations of  
388 Connecticut state agencies and beginning with the fiscal year ending  
389 June 30, 2001, such allowable salary shall be computed on an hourly  
390 basis and the maximum number of hours allowed for a related party  
391 other than the proprietor shall be increased from forty hours to forty-

392 eight hours per work week. For the fiscal year ending June 30, 2005,  
393 each facility shall receive a rate that is two and one-quarter per cent  
394 more than the rate the facility received in the prior fiscal year, except  
395 any facility that would have been issued a lower rate effective July 1,  
396 2004, than for the fiscal year ending June 30, 2004, due to interim rate  
397 status or agreement with the department shall be issued such lower  
398 rate effective July 1, 2004. Effective upon receipt of all the necessary  
399 federal approvals to secure federal financial participation matching  
400 funds associated with the rate increase provided in subdivision (4) of  
401 subsection (f) of this section, but in no event earlier than October 1,  
402 2005, and provided the user fee imposed under section 17b-320 is  
403 required to be collected, each facility shall receive a rate that is  
404 determined in accordance with applicable law and subject to  
405 appropriations, except any facility that would have been issued a  
406 lower rate effective October 1, 2005, than for the fiscal year ending June  
407 30, 2005, due to interim rate status or agreement with the department,  
408 shall be issued such lower rate effective October 1, 2005. Such rate  
409 increase shall remain in effect unless: (A) The federal financial  
410 participation matching funds associated with the rate increase are no  
411 longer available; or (B) the user fee created pursuant to section 17b-320  
412 is not in effect. For the fiscal year ending June 30, 2007, rates in effect  
413 for the period ending June 30, 2006, shall remain in effect until  
414 September 30, 2006, except any facility that would have been issued a  
415 lower rate effective July 1, 2006, than for the fiscal year ending June 30,  
416 2006, due to interim rate status or agreement with the department,  
417 shall be issued such lower rate effective July 1, 2006. Effective October  
418 1, 2006, no facility shall receive a rate that is more than four per cent  
419 greater than the rate in effect for the facility on September 30, 2006,  
420 except for any facility that would have been issued a lower rate  
421 effective October 1, 2006, due to interim rate status or agreement with  
422 the department, shall be issued such lower rate effective October 1,  
423 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates  
424 in effect for the period ending June 30, 2009, shall remain in effect until  
425 June 30, 2011, except any facility that would have been issued a lower  
426 rate for the fiscal year ending June 30, 2010, or the fiscal year ending

427 June 30, 2011, due to interim rate status or agreement with the  
428 department, shall be issued such lower rate, except (i) any facility that  
429 would have been issued a lower rate for the fiscal year ending June 30,  
430 2010, or the fiscal year ending June 30, 2011, due to interim rate status  
431 or agreement with the Commissioner of Social Services shall be issued  
432 such lower rate; and (ii) the commissioner may increase a facility's rate  
433 for reasonable costs associated with such facility's compliance with the  
434 provisions of section 19a-495a concerning the administration of  
435 medication by unlicensed personnel. For the fiscal year ending June 30,  
436 2012, rates in effect for the period ending June 30, 2011, shall remain in  
437 effect until June 30, 2012, except that (I) any facility that would have  
438 been issued a lower rate for the fiscal year ending June 30, 2012, due to  
439 interim rate status or agreement with the Commissioner of Social  
440 Services shall be issued such lower rate; and (II) the commissioner may  
441 increase a facility's rate for reasonable costs associated with such  
442 facility's compliance with the provisions of section 19a-495a  
443 concerning the administration of medication by unlicensed personnel.  
444 For the fiscal year ending June 30, 2013, the Commissioner of Social  
445 Services may, within available appropriations, provide a rate increase  
446 to a residential care home. Any facility that would have been issued a  
447 lower rate for the fiscal year ending June 30, 2013, due to interim rate  
448 status or agreement with the Commissioner of Social Services shall be  
449 issued such lower rate. For the fiscal years ending June 30, 2012, and  
450 June 30, 2013, the Commissioner of Social Services may provide fair  
451 rent increases to any facility that has undergone a material change in  
452 circumstances related to fair rent and has an approved certificate of  
453 need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. Any  
454 facility that would have been issued a lower rate for the fiscal year  
455 ending June 30, 2014, or the fiscal year ending June 30, 2015, due to  
456 interim rate status or agreement with the commissioner, shall be issued  
457 such lower rate. The department may, within available appropriations,  
458 increase or decrease residential care home rates to reflect the rebasing  
459 of facility costs as provided in subsection (a) of this section.

460 Sec. 5. (NEW) (Effective October 1, 2014) The Commissioner of Social  
461 Services shall implement the tenth revision of the International

462 Statistical Classification of Diseases and Related Health Problems for  
463 the purposes of all medical assistance programs administered by the  
464 Department of Social Services. The Commissioner of Social Services  
465 may implement policies and procedures necessary to carry out the  
466 provisions of this section while in the process of adopting the policies  
467 and procedures as regulations, provided notice of intent to adopt the  
468 regulations is published in the Connecticut Law Journal not later than  
469 twenty days after the date of implementation.

470 Sec. 6. Section 17b-239 of the general statutes is repealed and the  
471 following is substituted in lieu thereof (*Effective July 1, 2013*):

472 (a) [The rate to be paid by the state to hospitals receiving  
473 appropriations granted by the General Assembly and to freestanding  
474 chronic disease hospitals, providing services to persons aided or cared  
475 for by the state for routine services furnished to state patients, shall be  
476 based upon reasonable cost to such hospital, or the charge to the  
477 general public for ward services or the lowest charge for semiprivate  
478 services if the hospital has no ward facilities, imposed by such  
479 hospital, whichever is lowest, except to the extent, if any, that the  
480 commissioner determines that a greater amount is appropriate in the  
481 case of hospitals serving a disproportionate share of indigent patients.  
482 Such rate shall be promulgated annually by the Commissioner of  
483 Social Services.] On and after July 1, 2013, Medicaid rates paid to acute  
484 care and children's hospitals shall be based on diagnosis-related  
485 groups established and periodically rebased by the Commissioner of  
486 Social Services, provided the Department of Social Services completes  
487 a fiscal analysis of the impact of such rate payment system on each  
488 hospital. The Commissioner of Social Services shall, in accordance with  
489 the provisions of section 11-4a, file a report on the results of the fiscal  
490 analysis not later than December 31, 2013, with the joint standing  
491 committees of the General Assembly having cognizance of matters  
492 relating to human services and appropriations and the budgets of state  
493 agencies. The Commissioner of Social Services shall annually  
494 determine inpatient rates for each hospital by multiplying diagnostic-  
495 related group relative weights by a base rate. Within available

496 appropriations, the commissioner may, in his or her discretion, make  
497 additional payments to hospitals based on criteria to be determined by  
498 the commissioner. Nothing contained in this section shall authorize [a]  
499 Medicaid payment by the state [for such services] to any such hospital  
500 in excess of the charges made by such hospital for comparable services  
501 to the general public. [Notwithstanding the provisions of this section,  
502 for the rate period beginning July 1, 2000, rates paid to freestanding  
503 chronic disease hospitals and freestanding psychiatric hospitals shall  
504 be increased by three per cent. For the rate period beginning July 1,  
505 2001, a freestanding chronic disease hospital or freestanding  
506 psychiatric hospital shall receive a rate that is two and one-half per  
507 cent more than the rate it received in the prior fiscal year and such rate  
508 shall remain effective until December 31, 2002. Effective January 1,  
509 2003, a freestanding chronic disease hospital or freestanding  
510 psychiatric hospital shall receive a rate that is two per cent more than  
511 the rate it received in the prior fiscal year. Notwithstanding the  
512 provisions of this subsection, for the period commencing July 1, 2001,  
513 and ending June 30, 2003, the commissioner may pay an additional  
514 total of no more than three hundred thousand dollars annually for  
515 services provided to long-term ventilator patients. For purposes of this  
516 subsection, "long-term ventilator patient" means any patient at a  
517 freestanding chronic disease hospital on a ventilator for a total of sixty  
518 days or more in any consecutive twelve-month period. Effective July 1,  
519 2007, each freestanding chronic disease hospital shall receive a rate  
520 that is four per cent more than the rate it received in the prior fiscal  
521 year.]

522 (b) Effective October 1, 1991, the rate to be paid by the state for the  
523 cost of special services rendered by such hospitals shall be established  
524 annually by the commissioner for each such hospital based on the  
525 reasonable cost to each hospital of such services furnished to state  
526 patients. Nothing contained in this subsection shall authorize a  
527 payment by the state for such services to any such hospital in excess of  
528 the charges made by such hospital for comparable services to the  
529 general public.

530 (c) The term "reasonable cost" as used in this section means the cost  
531 of care furnished such patients by an efficient and economically  
532 operated facility, computed in accordance with accepted principles of  
533 hospital cost reimbursement. The commissioner may adjust the rate of  
534 payment established under the provisions of this section for the year  
535 during which services are furnished to reflect fluctuations in hospital  
536 costs. Such adjustment may be made prospectively to cover anticipated  
537 fluctuations or may be made retroactive to any date subsequent to the  
538 date of the initial rate determination for such year or in such other  
539 manner as may be determined by the commissioner. In determining  
540 "reasonable cost" the commissioner may give due consideration to  
541 allowances for fully or partially unpaid bills, reasonable costs  
542 mandated by collective bargaining agreements with certified collective  
543 bargaining agents or other agreements between the employer and  
544 employees, provided "employees" shall not include persons employed  
545 as managers or chief administrators, requirements for working capital  
546 and cost of development of new services, including additions to and  
547 replacement of facilities and equipment. The commissioner shall not  
548 give consideration to amounts paid by the facilities to employees as  
549 salary, or to attorneys or consultants as fees, where the responsibility  
550 of the employees, attorneys or consultants is to persuade or seek to  
551 persuade the other employees of the facility to support or oppose  
552 unionization. Nothing in this subsection shall prohibit the  
553 commissioner from considering amounts paid for legal counsel related  
554 to the negotiation of collective bargaining agreements, the settlement  
555 of grievances or normal administration of labor relations.

556 (d) [The state shall also pay to such hospitals for each outpatient  
557 clinic and emergency room visit a reasonable rate to be established  
558 annually by the commissioner for each hospital, such rate to be  
559 determined by the reasonable cost of such services. The emergency  
560 room visit rates in effect June 30, 1991, shall remain in effect through  
561 June 30, 1993, except those which would have been decreased effective  
562 July 1, 1991, or July 1, 1992, shall be decreased.] On or after July 1,  
563 2013, hospitals shall be paid for outpatient and emergency room  
564 episodes of care based on prospective rates established by the

565 commissioner in accordance with the Medicare ambulatory payment  
566 classification system in conjunction with a state conversion factor,  
567 provided the Department of Social Services completes a fiscal analysis  
568 of the impact of such rate payment system on each hospital. The  
569 Commissioner of Social Services shall, in accordance with the  
570 provisions of section 11-4a, file a report on the results of the fiscal  
571 analysis not later than December 31, 2013, with the joint standing  
572 committees of the General Assembly having cognizance of matters  
573 relating to human services and appropriations and the budgets of state  
574 agencies. The Medicare ambulatory payment classification system  
575 shall be modified to provide payment for services not generally  
576 covered by Medicare, including, but not limited to, pediatric, obstetric,  
577 neonatal and perinatal services. Nothing contained in this subsection  
578 shall authorize a payment by the state for such [services] episodes of  
579 care to any hospital in excess of the charges made by such hospital for  
580 comparable services to the general public. [For those] Those outpatient  
581 hospital services that do not have an established Ambulatory Payment  
582 Classification code shall be paid on the basis of a ratio of cost to  
583 charges, [the ratios] or the fixed fee in effect [June 30, 1991, shall be  
584 reduced effective July 1, 1991, by the most recent annual increase in the  
585 consumer price index for medical care. For those outpatient hospital  
586 services paid on the basis of a ratio of cost to charges, the ratios  
587 computed to be effective July 1, 1994, shall be reduced by the most  
588 recent annual increase in the consumer price index for medical care.  
589 The emergency room visit rates in effect June 30, 1994, shall remain in  
590 effect through December 31, 1994] as of July 1, 2014. The  
591 Commissioner of Social Services shall establish a fee schedule for  
592 outpatient hospital services to be effective on and after January 1, 1995,  
593 and may annually modify such fee schedule if such modification is  
594 needed to ensure that the conversion to an administrative services  
595 organization is cost neutral to hospitals in the aggregate and ensures  
596 patient access. Utilization may be a factor in determining cost  
597 neutrality. [for the fiscal year ending June 30, 2013. Except with respect  
598 to the rate periods beginning July 1, 1999, and July 1, 2000, such fee  
599 schedule shall be adjusted annually beginning July 1, 1996, to reflect

600 necessary increases in the cost of services. Notwithstanding the  
601 provisions of this subsection, the fee schedule for the rate period  
602 beginning July 1, 2000, shall be increased by ten and one-half per cent,  
603 effective June 1, 2001. Notwithstanding the provisions of this  
604 subsection, outpatient rates in effect as of June 30, 2003, shall remain in  
605 effect through June 30, 2005. Effective July 1, 2006, subject to available  
606 appropriations, the commissioner shall increase outpatient service fees  
607 for services that may include clinic, emergency room, magnetic  
608 resonance imaging, and computerized axial tomography.]

609 (e) The commissioner shall adopt regulations, in accordance with  
610 the provisions of chapter 54, establishing criteria for defining  
611 emergency and nonemergency visits to hospital emergency rooms. All  
612 nonemergency visits to hospital emergency rooms shall be paid at the  
613 hospital's outpatient clinic services rate. Nothing contained in this  
614 subsection or the regulations adopted [hereunder] under this section  
615 shall authorize a payment by the state for such services to any hospital  
616 in excess of the charges made by such hospital for comparable services  
617 to the general public.

618 (f) [On and after October 1, 1984, the state shall pay to an acute care  
619 general hospital for the inpatient care of a patient who no longer  
620 requires acute care a rate determined by the following schedule: For  
621 the first seven days following certification that the patient no longer  
622 requires acute care the state shall pay the hospital at a rate of fifty per  
623 cent of the hospital's actual cost; for the second seven-day period  
624 following certification that the patient no longer requires acute care the  
625 state shall pay seventy-five per cent of the hospital's actual cost; for the  
626 third seven-day period following certification that the patient no  
627 longer requires acute care and for any period of time thereafter, the  
628 state shall pay the hospital at a rate of one hundred per cent of the  
629 hospital's actual cost.] On and after July 1, 1995, no payment shall be  
630 made by the state to an acute care general hospital for the inpatient  
631 care of a patient who no longer requires acute care and is eligible for  
632 Medicare unless the hospital does not obtain reimbursement from  
633 Medicare for that stay.

634 (g) The Commissioner of Social Services may implement policies  
635 and procedures necessary to carry out the provisions of this section  
636 while in the process of adopting the policies and procedures as  
637 regulations, provided notice of intent to adopt the regulations is  
638 published in the Connecticut Law Journal not later than twenty days  
639 after the date of implementation.

640 Sec. 7. Subsection (b) of section 17b-239e of the general statutes is  
641 repealed and the following is substituted in lieu thereof (*Effective July*  
642 *1, 2013*):

643 (b) The commissioner may establish a blended in-patient hospital  
644 case rate that includes services provided to all Medicaid recipients and  
645 may exclude certain diagnoses, as determined by the commissioner, if  
646 the establishment of such rates is needed to ensure that the conversion  
647 to an administrative services organization is cost neutral to hospitals in  
648 the aggregate and ensures patient access. Utilization may be a factor in  
649 determining cost neutrality. [for the fiscal year ending June 30, 2013.]

650 Sec. 8. Subsection (a) of section 17b-242 of the general statutes is  
651 repealed and the following is substituted in lieu thereof (*Effective July*  
652 *1, 2013*):

653 (a) The Department of Social Services shall determine the rates to be  
654 paid to home health care agencies and homemaker-home health aide  
655 agencies by the state or any town in the state for persons aided or  
656 cared for by the state or any such town. For the period from February  
657 1, 1991, to January 31, 1992, inclusive, payment for each service to the  
658 state shall be based upon the rate for such service as determined by the  
659 Office of Health Care Access, except that for those providers whose  
660 Medicaid rates for the year ending January 31, 1991, exceed the median  
661 rate, no increase shall be allowed. For those providers whose rates for  
662 the year ending January 31, 1991, are below the median rate, increases  
663 shall not exceed the lower of the prior rate increased by the most  
664 recent annual increase in the consumer price index for urban  
665 consumers or the median rate. In no case shall any such rate exceed the  
666 eightieth percentile of rates in effect January 31, 1991, nor shall any rate

667 exceed the charge to the general public for similar services. Rates  
668 effective February 1, 1992, shall be based upon rates as determined by  
669 the Office of Health Care Access, except that increases shall not exceed  
670 the prior year's rate increased by the most recent annual increase in the  
671 consumer price index for urban consumers and rates effective  
672 February 1, 1992, shall remain in effect through June 30, 1993. Rates  
673 effective July 1, 1993, shall be based upon rates as determined by the  
674 Office of Health Care Access except if the Medicaid rates for any  
675 service for the period ending June 30, 1993, exceed the median rate for  
676 such service, the increase effective July 1, 1993, shall not exceed one  
677 per cent. If the Medicaid rate for any service for the period ending June  
678 30, 1993, is below the median rate, the increase effective July 1, 1993,  
679 shall not exceed the lower of the prior rate increased by one and one-  
680 half times the most recent annual increase in the consumer price index  
681 for urban consumers or the median rate plus one per cent. The  
682 Commissioner of Social Services shall establish a fee schedule for home  
683 health services to be effective on and after July 1, 1994. The  
684 commissioner may annually modify such fee schedule if such  
685 modification is needed to ensure that the conversion to an  
686 administrative services organization is cost neutral to home health care  
687 agencies and homemaker-home health aide agencies in the aggregate  
688 and ensures patient access. Utilization may be a factor in determining  
689 cost neutrality. [for the fiscal year ending June 30, 2013.] The  
690 commissioner shall increase the fee schedule for home health services  
691 provided under the Connecticut home-care program for the elderly  
692 established under section 17b-342, effective July 1, 2000, by two per  
693 cent over the fee schedule for home health services for the previous  
694 year. The commissioner may increase any fee payable to a home health  
695 care agency or homemaker-home health aide agency upon the  
696 application of such an agency evidencing extraordinary costs related to  
697 (1) serving persons with AIDS; (2) high-risk maternal and child health  
698 care; (3) escort services; or (4) extended hour services. In no case shall  
699 any rate or fee exceed the charge to the general public for similar  
700 services. A home health care agency or homemaker-home health aide  
701 agency which, due to any material change in circumstances, is

702 aggrieved by a rate determined pursuant to this subsection may,  
703 within ten days of receipt of written notice of such rate from the  
704 Commissioner of Social Services, request in writing a hearing on all  
705 items of aggrievement. The commissioner shall, upon the receipt of all  
706 documentation necessary to evaluate the request, determine whether  
707 there has been such a change in circumstances and shall conduct a  
708 hearing if appropriate. The Commissioner of Social Services shall  
709 adopt regulations, in accordance with chapter 54, to implement the  
710 provisions of this subsection. The commissioner may implement  
711 policies and procedures to carry out the provisions of this subsection  
712 while in the process of adopting regulations, provided notice of intent  
713 to adopt the regulations is published in the Connecticut Law Journal  
714 [within] not later than twenty days after the date of implementing the  
715 policies and procedures. Such policies and procedures shall be valid  
716 for not longer than nine months.

717 Sec. 9. Subsection (a) of section 17b-261m of the general statutes is  
718 repealed and the following is substituted in lieu thereof (*Effective July*  
719 *1, 2013*):

720 (a) The Commissioner of Social Services may contract with one or  
721 more administrative services organizations to provide care  
722 coordination, utilization management, disease management, customer  
723 service and review of grievances for recipients of assistance under  
724 Medicaid, HUSKY Plan, Parts A and B, and the Charter Oak Health  
725 Plan. Such organization may also provide network management,  
726 credentialing of providers, monitoring of copayments and premiums  
727 and other services as required by the commissioner. Subject to  
728 approval by applicable federal authority, the Department of Social  
729 Services shall utilize the contracted organization's provider network  
730 and billing systems in the administration of the program. In order to  
731 implement the provisions of this section, the commissioner may  
732 establish rates of payment to providers of medical services under this  
733 section if the establishment of such rates is required to ensure that any  
734 contract entered into with an administrative services organization  
735 pursuant to this section is cost neutral to such providers in the

736 aggregate and ensures patient access. Utilization may be a factor in  
737 determining cost neutrality. [for the fiscal year ending June 30, 2013.]

738 Sec. 10. Subsection (a) of section 17b-239c of the general statutes is  
739 repealed and the following is substituted in lieu thereof (*Effective July*  
740 *1, 2013*):

741 (a) Notwithstanding any provision of the general statutes, on and  
742 after July 1, 2011, the Department of Social Services may, within  
743 available appropriations, make interim [monthly] quarterly medical  
744 assistance disproportionate share payments to short-term general  
745 hospitals. The total amount of interim payments made to such  
746 hospitals individually and in the aggregate shall maximize federal  
747 matching payments under the medical assistance program as  
748 determined by the Department of Social Services, in consultation with  
749 the Office of Policy and Management. No payments shall be made  
750 under this section to (1) any hospital which, on July 1, 2011, is within  
751 the class of hospitals licensed by the Department of Public Health as a  
752 children's general hospital, or (2) a short-term acute hospital operated  
753 exclusively by the state other than a short-term acute hospital operated  
754 by the state as a receiver pursuant to chapter 920. The [monthly]  
755 quarterly interim payment amount for each hospital shall be  
756 determined by the Commissioner of Social Services based upon the  
757 information submitted by the hospital pursuant to Section 1001(d) of  
758 Public Law 108-173, the Medicare Prescription Drug, Improvement,  
759 and Modernization Act of 2003.

760 Sec. 11. Section 17b-28e of the general statutes is repealed and the  
761 following is substituted in lieu thereof (*Effective July 1, 2013*):

762 (a) The Commissioner of Social Services shall amend the Medicaid  
763 state plan to include, on and after January 1, 2009, hospice services as  
764 optional services covered under the Medicaid program. Said state plan  
765 amendment shall supersede any regulations of Connecticut state  
766 agencies concerning such optional services. [From January 1, 2013, to  
767 June 30, 2013, inclusive, hospice] Hospice services covered under the  
768 Medicaid program for individuals who are residents in long-term care

769 facilities shall be paid at a rate that is ninety-five per cent of the  
770 facility's per diem rate.

771 [(b) Effective July 1, 2013, the Commissioner of Social Services shall  
772 amend the Medicaid state plan to include foreign language interpreter  
773 services provided to any beneficiary with limited English proficiency  
774 as a covered service under the Medicaid program. Not later than July  
775 1, 2013, the commissioner shall develop and implement the use of  
776 medical billing codes for foreign language interpreter services.

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

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

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

788 Sec. 12. Section 17b-261 of the general statutes is amended by  
789 adding subsection (k) as follows (*Effective January 1, 2014*):

790 (NEW) (k) In addition to persons eligible for medical assistance  
791 under the provisions of subsections (a) to (j), inclusive, of this section,  
792 on and after January 1, 2014, medical assistance shall be provided  
793 without an asset test to low-income adults whose income does not  
794 exceed one hundred thirty-three per cent of the federal poverty level,  
795 in accordance with Section 1902(a)(10)(A)(i)(VIII) of the Social Security  
796 Act. In determining eligibility, the commissioner shall not consider as  
797 income Aid and Attendance pension benefits granted to a veteran, as  
798 defined in section 27-103, or the surviving spouse of such veteran.

799 Sec. 13. Section 17b-256f of the general statutes is repealed and the

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

801 [Beginning March 1, 2012, and annually thereafter, the] The  
802 Commissioner of Social Services shall increase income disregards used  
803 to determine eligibility by the Department of Social Services for the  
804 federal [Specified Low-Income Medicare Beneficiary, the] Qualified  
805 Medicare Beneficiary, the Specified Low-Income Medicare Beneficiary  
806 and the Qualifying Individual [Programs] programs, administered in  
807 accordance with the provisions of 42 USC 1396d(p), by [an amount that  
808 equalizes the income levels and deductions used to determine  
809 eligibility for said programs with income levels and deductions used  
810 to determine eligibility for the ConnPACE program under subsection  
811 (a) of section 17b-492] such amounts that shall result in persons with  
812 income that is (1) less than two hundred eleven per cent of the federal  
813 poverty level qualifying for the Qualified Medicare Beneficiary  
814 program, (2) at or above two hundred eleven per cent of the federal  
815 poverty level but less than two hundred thirty-one per cent of the  
816 federal poverty level qualifying for the Specified Low-Income  
817 Medicare Beneficiary program, and (3) at or above two hundred thirty-  
818 one per cent of the federal poverty level but less than two hundred  
819 forty-six per cent of the federal poverty level qualifying for the  
820 Qualifying Individual program. The commissioner shall not apply an  
821 asset test for eligibility under the Medicare Savings Program. The  
822 commissioner shall not consider as income Aid and Attendance  
823 pension benefits granted to a veteran, as defined in section 27-103, or  
824 the surviving spouse of such veteran. The Commissioner of Social  
825 Services, pursuant to section 17b-10, may implement policies and  
826 procedures to administer the provisions of this section while in the  
827 process of adopting such policies and procedures in regulation form,  
828 provided the commissioner prints notice of the intent to adopt the  
829 regulations in the Connecticut Law Journal not later than twenty days  
830 after the date of implementation. Such policies and procedures shall be  
831 valid until the time final regulations are adopted.

832 Sec. 14. Section 17b-551 of the general statutes is repealed and the  
833 following is substituted in lieu thereof (*Effective January 1, 2014*):

834 Eligibility for participation in the program shall be limited to a  
835 resident who is enrolled in Medicare Part B whose annual income does  
836 not exceed [one hundred sixty-five per cent of the qualifying income  
837 level established in the ConnPACE program, pursuant to subsection  
838 (a) of section 17b-492] forty-three thousand five hundred sixty dollars  
839 or if such resident has a spouse, the combined income of such resident  
840 and his spouse does not exceed [one hundred sixty-five per cent of the  
841 qualifying income level established in the ConnPACE program,  
842 pursuant to subsection (a) of section 17b-492] fifty-eight thousand  
843 seven hundred forty dollars. On January 1, 2014, and annually  
844 thereafter, the commissioner shall increase the income limit established  
845 under this subsection over that of the previous fiscal year to reflect the  
846 annual inflation adjustment in Social Security income, if any. Each  
847 such adjustment shall be determined to the nearest one hundred  
848 dollars.

849 Sec. 15. Section 17b-552 of the general statutes is repealed and the  
850 following is substituted in lieu thereof (*Effective January 1, 2014*):

851 (a) A health care provider shall limit charges for care, treatment,  
852 service or equipment covered by Medicare Part B under Title XVIII of  
853 the Social Security Act, as amended, provided to a Medicare  
854 beneficiary who meets the eligibility requirements specified in section  
855 17b-551, as amended by this act, to the reasonable charge for the care,  
856 treatment, service or equipment provided as determined by the United  
857 States Secretary of Health and Human Services. No health care  
858 provider shall collect from such qualified beneficiary any amount in  
859 excess of the approved reasonable charge. Any violation of this  
860 subsection shall constitute grounds for the assessment of a civil  
861 penalty in accordance with subdivision (6) of subsection (a) of section  
862 19a-17. Any complaint alleging a violation of this section shall be made  
863 to the Department of Public Health or the appropriate professional  
864 licensing board or commission.

865 (b) The Commissioner of Social Services shall adopt regulations in  
866 accordance with the provisions of chapter 54, necessary to administer

867 the program and to determine eligibility in accordance with the  
868 provisions of section 17b-551, as amended by this act.

869 [(c) All health care providers shall accept the identification card  
870 issued for the ConnPACE program pursuant to sections 17b-490 to  
871 17b-498, inclusive, as a substitute for a Medicare assignment card.]

872 Sec. 16. Subsection (a) of section 17b-278i of the general statutes is  
873 repealed and the following is substituted in lieu thereof (*Effective from*  
874 *passage*):

875 (a) Customized wheelchairs shall be covered under the Medicaid  
876 program only when a standard wheelchair [will] does not meet an  
877 individual's needs as determined by the Department of Social Services.  
878 [Assessment of the need for a customized wheelchair may be  
879 performed by a vendor or nursing facility only if specifically requested  
880 by the department.] Wheelchair repairs and parts replacements may be  
881 subject to review and approval by the department. Refurbished  
882 wheelchairs, parts and components shall be utilized whenever  
883 practicable.

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

887 (a) The Commissioner of Social Services may, upon the request of a  
888 nursing facility providing services eligible for payment under the  
889 medical assistance program, [and after consultation with the Secretary  
890 of the Office of Policy and Management,] make a payment to such  
891 nursing facility in advance of normal bill payment processing. Except  
892 as provided in subsection (b) of this section, (1) such advance shall not  
893 exceed estimated amounts due to such nursing facility for services  
894 provided to eligible recipients over the most recent two-month period,  
895 and (2) the commissioner shall recover such payment through  
896 reductions to payments due to such nursing facility or cash receipt not  
897 later than ninety days after issuance of such payment. The  
898 commissioner shall take prudent measures to assure that such advance

899 payments are not provided to any nursing facility that is at risk of  
900 bankruptcy or insolvency, and may execute agreements appropriate  
901 for the security of repayment.

902 Sec. 18. Section 17a-22h of the general statutes is repealed and the  
903 following is substituted in lieu thereof (*Effective July 1, 2013*):

904 (a) The Commissioners of Social Services, Children and Families,  
905 and Mental Health and Addiction Services shall develop and  
906 implement an integrated behavioral health service system for  
907 Medicaid and HUSKY Plan [Parts A and] Part B members and children  
908 enrolled in the voluntary services program operated by the  
909 Department of Children and Families and may, at the discretion of the  
910 commissioners, include: (1) Other children, adolescents and families  
911 served by the Department of Children and Families or the Court  
912 Support Services Division of the Judicial Branch; and (2) [Medicaid  
913 recipients who are not enrolled in HUSKY Plan Part A; and (3)]  
914 Charter Oak Health Plan members. The integrated behavioral health  
915 service system shall be known as the Behavioral Health Partnership.  
916 The Behavioral Health Partnership shall seek to increase access to  
917 quality behavioral health services by: (A) Expanding individualized,  
918 family-centered and community-based services; (B) maximizing  
919 federal revenue to fund behavioral health services; (C) reducing  
920 unnecessary use of institutional and residential services for children  
921 and adults; (D) capturing and investing enhanced federal revenue and  
922 savings derived from reduced residential services and increased  
923 community-based services for HUSKY Plan Parts A and B recipients;  
924 (E) improving administrative oversight and efficiencies; and (F)  
925 monitoring individual outcomes and provider performance, taking  
926 into consideration the acuity of the patients served by each provider,  
927 and overall program performance.

928 (b) The Behavioral Health Partnership shall operate in accordance  
929 with the financial requirements specified in this subsection. Prior to the  
930 conversion of any grant-funded services to a rate-based, fee-for-service  
931 payment system, the Department of Social Services, the Department of

932 Children and Families and the Department of Mental Health and  
933 Addiction Services shall submit documentation verifying that the  
934 proposed rates seek to cover the reasonable cost of providing services  
935 to the Behavioral Health Partnership Oversight Council, established  
936 pursuant to section 17a-22j, as amended by this act.

937 Sec. 19. Section 17a-22p of the general statutes is repealed and the  
938 following is substituted in lieu thereof (*Effective July 1, 2013*):

939 (a) The Departments of Children and Families, Social Services and  
940 Mental Health and Addiction Services shall enter into one or more  
941 joint contracts or agreements with an administrative services  
942 organization or organizations to perform eligibility verification,  
943 utilization management, intensive care management, quality  
944 management, coordination of medical and behavioral health services,  
945 provider network development and management, recipient and  
946 provider services and reporting.

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

952 (c) [Administrative services organizations] An administrative  
953 services organization shall authorize services, based solely on medical  
954 necessity, as defined in section 17b-259b. Such organization shall use  
955 guidelines established by the clinical management committee,  
956 established pursuant to section 17a-22k, [Administrative services  
957 organizations may make exceptions to the guidelines when requested  
958 by a member, or the member's legal guardian or service provider, and  
959 determined by the administrative services organization to be in the  
960 best interest of the member] provided such guidelines may only be  
961 used as a basis for expeditiously approving a request for services. If a  
962 request for services does not meet such guidelines, an administrative  
963 services organization may deny the request based solely on the request  
964 not being deemed medically necessary, as defined in section 17b-259b.

965 Decisions regarding the interpretation of such guidelines shall be  
966 made by the Departments of Children and Families, Social Services  
967 and Mental Health and Addiction Services. No administrative services  
968 organization shall have any financial incentive to approve, deny or  
969 reduce services. Administrative services organizations shall ensure  
970 that service providers and persons seeking services have timely access  
971 to program information and timely responses to inquiries, including  
972 inquiries concerning the clinical guidelines for services.

973 (d) [The] An administrative services organization for Medicaid and  
974 HUSKY Plan [Parts A and] Part B shall provide or arrange for on-site  
975 assistance to facilitate the appropriate placement, as soon as  
976 practicable, of children with behavioral health diagnoses who the  
977 administrative services organization knows to have been in an  
978 emergency department for over forty-eight hours. The administrative  
979 services organization shall provide or arrange for on-site assistance to  
980 arrange for the discharge or appropriate placement, as soon as  
981 practicable, for children who the administrative services organization  
982 knows to have remained in an inpatient hospital unit for more than  
983 five days longer than is medically necessary, as agreed by the  
984 administrative services organization and the hospital.

985 (e) The Departments of Children and Families, Social Services and  
986 Mental Health and Addiction Services shall develop, in consultation  
987 with the Behavioral Health Partnership, a comprehensive plan for  
988 monitoring the performance of administrative services organizations  
989 which shall include data on service authorizations, individual  
990 outcomes, appeals, outreach and accessibility, comments from  
991 program participants compiled from written surveys and face-to-face  
992 interviews.

993 (f) The Behavioral Health Partnership shall establish policies to  
994 coordinate benefits received under the partnership with other benefits  
995 received under Medicaid. Such policies shall specify a coordinated  
996 delivery of both physical and behavioral health care. The policies shall  
997 be submitted to the Behavioral Health Partnership Oversight Council

998 for review and comment.

999 Sec. 20. Section 17b-10a of the general statutes is repealed and the  
1000 following is substituted in lieu thereof (*Effective January 1, 2014*):

1001 The Commissioner of Social Services, pursuant to section 17b-10,  
1002 may implement policies and procedures necessary to administer  
1003 section 17b-197, subsection (d) of section 17b-266, section 17b-280a [,]  
1004 and subsection (a) of section 17b-295, [and subsection (c) of section  
1005 17b-311,] while in the process of adopting such policies and procedures  
1006 as regulation, provided the commissioner prints notice of intent to  
1007 adopt regulations in the Connecticut Law Journal not later than twenty  
1008 days after the date of implementation. Policies and procedures  
1009 implemented pursuant to this section shall be valid until the time final  
1010 regulations are adopted.

1011 Sec. 21. Subsection (b) of section 38a-556a of the general statutes is  
1012 repealed and the following is substituted in lieu thereof (*Effective*  
1013 *January 1, 2014*):

1014 (b) Said association shall, in consultation with the Insurance  
1015 Commissioner and the Healthcare Advocate, develop, within available  
1016 appropriations, a web site, telephone number or other method to serve  
1017 as a clearinghouse for information about individual and small  
1018 employer health insurance policies and health care plans that are  
1019 available to consumers in this state, including, but not limited to, the  
1020 Medicaid program, the HUSKY Plan, [the Charter Oak Health Plan set  
1021 forth in section 17b-311,] the Municipal Employee Health Insurance  
1022 Plan set forth in subsection (i) of section 5-259, and any individual or  
1023 small employer health insurance policies or health care plans an  
1024 insurer, health care center or other entity chooses to list with the  
1025 Connecticut Clearinghouse.

1026 Sec. 22. Subsection (a) of section 29-1s of the general statutes is  
1027 repealed and the following is substituted in lieu thereof (*Effective*  
1028 *January 1, 2014*):

1029 (a) (1) Wherever the term "Department of Public Safety" is used in  
1030 the following general statutes, the term "Department of Emergency  
1031 Services and Public Protection" shall be substituted in lieu thereof; and  
1032 (2) wherever the term "Commissioner of Public Safety" is used in the  
1033 following general statutes, the term "Commissioner of Emergency  
1034 Services and Public Protection" shall be substituted in lieu thereof: 1-  
1035 24, 1-84b, 1-217, 2-90b, 3-2b, 4-68m, 4a-2a, 4a-18, 4a-67d, 4b-1, 4b-130, 5-  
1036 142, 5-146, 5-149, 5-150, 5-169, 5-173, 5-192f, 5-192t, 5-246, 6-32g, 7-169,  
1037 7-285, 7-294f to 7-294h, inclusive, 7-294l, 7-294n, 7-294y, 7-425, 9-7a, 10-  
1038 233h, 12-562, 12-564a, 12-586f, 12-586g, 13a-123, 13b-69, 13b-376, 14-10,  
1039 14-64, 14-67m, 14-67w, 14-103, 14-108a, 14-138, 14-152, 14-163c, 14-211a,  
1040 14-212a, 14-212f, 14-219c, 14-227a, 14-227c, 14-267a, 14-270c to 14-270f,  
1041 inclusive, 14-283, 14-291, 14-298, 14-315, 15-98, 15-140r, 15-140u, 16-  
1042 256g, 16a-103, 17a-105a, 17a-106a, 17a-500, 17b-90, as amended by this  
1043 act, 17b-137, 17b-192, 17b-225, 17b-279, [17b-490,] 18-87k, 19a-112a, 19a-  
1044 112f, 19a-179b, 19a-409, 19a-904, 20-12c, 20-327b, 21a-36, 21a-283, 22a-2,  
1045 23-8b, 23-18, 26-5, 26-67b, 27-19a, 27-107, 28-25b, 28-27, 28-27a, 28-30a,  
1046 29-1c, 29-1e to 29-1h, inclusive, 29-1q, 29-1zz, 29-2, 29-2a, 29-2b, 29-3a,  
1047 29-4a, 29-6a, 29-7, 29-7b, 29-7c, 29-7h, 29-7m, 29-7n, 29-8, 29-10, 29-10a,  
1048 29-10c, 29-11, 29-12, 29-17a, 29-17b, 29-17c, 29-18 to 29-23a, inclusive,  
1049 29-25, 29-26, 29-28, 29-28a, 29-30 to 29-32, inclusive, 29-32b, 29-33, 29-  
1050 36f to 29-36i, inclusive, 29-36k, 29-36m, 29-36n, 29-37a, 29-37f, 29-38b,  
1051 29-38e, 29-38f, 29-108b, 29-143i, 29-143j, 29-145 to 29-151, inclusive, 29-  
1052 152f to 29-152j, inclusive, 29-152m, 29-152o, 29-152u, 29-153, 29-155d,  
1053 29-156a, 29-161g to 29-161i, inclusive, 29-161k to 29-161m, inclusive, 29-  
1054 161o to 29-161t, inclusive, 29-161v to 29-161z, inclusive, 29-163, 29-  
1055 164g, 29-166, 29-176 to 29-179, inclusive, 29-179f to 29-179h, 31-275,  
1056 38a-18, 38a-356, 45a-63, 46a-4b, 46a-170, 46b-15a, 46b-38d, 46b-38f, 51-  
1057 5c, 51-10c, 51-51o, 51-277a, 52-11, 53-39a, 53-134, 53-199, 53-202, 53-  
1058 202b, 53-202c, 53-202g, 53-202l, 53-202n, 53-202o, 53-278c, 53-341b, 53a-  
1059 3, 53a-30, 53a-54b, 53a-130, 53a-130a, 54-1f, 54-1l, 54-36e, 54-36i, 54-36n,  
1060 54-47aa, 54-63c, 54-76l, 54-86k, 54-102g to 54-102j, inclusive, 54-102m,  
1061 54-102pp, 54-142j, 54-222a, 54-240, 54-240m, 54-250 to 54-258, inclusive,  
1062 54-259a, 54-260b, and 54-300.

1063 Sec. 23. Subsection (e) of section 12-746 of the general statutes is

1064 repealed and the following is substituted in lieu thereof (*Effective*  
1065 *January 1, 2014*):

1066 (e) Amounts rebated pursuant to this section shall not be considered  
1067 income for purposes of sections 8-119l, 12-170d, 12-170aa, [17b-490,]  
1068 17b-550, 17b-812, 47-88d and 47-287.

1069 Sec. 24. Subsection (b) of section 10a-132e of the general statutes is  
1070 repealed and the following is substituted in lieu thereof (*Effective*  
1071 *January 1, 2014*):

1072 (b) The program established pursuant to subsection (a) of this  
1073 section shall: (1) Arrange for licensed physicians, pharmacists and  
1074 nurses to conduct in person educational visits with prescribing  
1075 practitioners, utilizing evidence-based materials, borrowing methods  
1076 from behavioral science and educational theory and, when  
1077 appropriate, utilizing pharmaceutical industry data and outreach  
1078 techniques; (2) inform prescribing practitioners about drug marketing  
1079 that is designed to prevent competition to brand name drugs from  
1080 generic or other therapeutically-equivalent pharmaceutical alternatives  
1081 or other evidence-based treatment options; and (3) provide outreach  
1082 and education to licensed physicians and other health care  
1083 practitioners who are participating providers in state-funded health  
1084 care programs, including, but not limited to, Medicaid, the HUSKY  
1085 Plan, Parts A and B, [the Charter Oak Health Plan, the ConnPACE  
1086 program,] the Department of Correction inmate health services  
1087 program and the state employees' health insurance plan.

1088 Sec. 25. Subsection (a) of section 17a-22f of the general statutes is  
1089 repealed and the following is substituted in lieu thereof (*Effective*  
1090 *January 1, 2014*):

1091 (a) The Commissioner of Social Services may, with regard to the  
1092 provision of behavioral health services provided pursuant to a state  
1093 plan under Title XIX or Title XXI of the Social Security Act; [, or under  
1094 the Charter Oak Health Plan:] (1) Contract with one or more  
1095 administrative services organizations to provide clinical management,

1096 provider network development and other administrative services; (2)  
1097 delegate responsibility to the Department of Children and Families for  
1098 the clinical management portion of such administrative contract or  
1099 contracts that pertain to HUSKY Plan Parts A and B, and other  
1100 children, adolescents and families served by the Department of  
1101 Children and Families; and (3) delegate responsibility to the  
1102 Department of Mental Health and Addiction Services for the clinical  
1103 management portion of such administrative contract or contracts that  
1104 pertain to Medicaid recipients who are not enrolled in HUSKY Plan  
1105 Part A. [and recipients enrolled in the Charter Oak Health Plan.]

1106 Sec. 26. Subsection (a) of section 17a-22h of the general statutes, as  
1107 amended by section 18 of this act, is repealed and the following is  
1108 substituted in lieu thereof (*Effective January 1, 2014*):

1109 (a) The Commissioners of Social Services, Children and Families,  
1110 and Mental Health and Addiction Services shall develop and  
1111 implement an integrated behavioral health service system for  
1112 Medicaid and HUSKY Plan Part B members and children enrolled in  
1113 the voluntary services program operated by the Department of  
1114 Children and Families and may, at the discretion of the commissioners,  
1115 include [:(1) Other] other children, adolescents and families served by  
1116 the Department of Children and Families or the Court Support  
1117 Services Division of the Judicial Branch. [; and (2) Charter Oak Health  
1118 Plan members.] The integrated behavioral health service system shall  
1119 be known as the Behavioral Health Partnership. The Behavioral Health  
1120 Partnership shall seek to increase access to quality behavioral health  
1121 services by: (A) Expanding individualized, family-centered and  
1122 community-based services; (B) maximizing federal revenue to fund  
1123 behavioral health services; (C) reducing unnecessary use of  
1124 institutional and residential services for children and adults; (D)  
1125 capturing and investing enhanced federal revenue and savings derived  
1126 from reduced residential services and increased community-based  
1127 services for HUSKY Plan Parts A and B recipients; (E) improving  
1128 administrative oversight and efficiencies; and (F) monitoring  
1129 individual outcomes and provider performance, taking into

1130 consideration the acuity of the patients served by each provider, and  
1131 overall program performance.

1132 Sec. 27. Subsection (a) of section 17b-28 of the general statutes is  
1133 repealed and the following is substituted in lieu thereof (*Effective*  
1134 *January 1, 2014*):

1135 (a) There is established a Council on Medical Assistance Program  
1136 Oversight which shall advise the Commissioner of Social Services on  
1137 the planning and implementation of the health care delivery system  
1138 for the following health care programs: The HUSKY Plan, Parts A and  
1139 B [, the Charter Oak Health Plan] and the Medicaid program,  
1140 including, but not limited to, the portions of the program serving low  
1141 income adults, the aged, blind and disabled individuals, individuals  
1142 who are dually eligible for Medicaid and Medicare and individuals  
1143 with preexisting medical conditions. The council shall monitor  
1144 planning and implementation of matters related to Medicaid care  
1145 management initiatives including, but not limited to, (1) eligibility  
1146 standards, (2) benefits, (3) access, (4) quality assurance, (5) outcome  
1147 measures, and (6) the issuance of any request for proposal by the  
1148 Department of Social Services for utilization of an administrative  
1149 services organization in connection with such initiatives.

1150 Sec. 28. Subsection (a) of section 17b-261m of the general statutes, as  
1151 amended by section 9 of this act, is repealed and the following is  
1152 substituted in lieu thereof (*Effective January 1, 2014*):

1153 (a) The Commissioner of Social Services may contract with one or  
1154 more administrative services organizations to provide care  
1155 coordination, utilization management, disease management, customer  
1156 service and review of grievances for recipients of assistance under  
1157 Medicaid [.] and HUSKY Plan, Parts A and B. [, and the Charter Oak  
1158 Health Plan.] Such organization may also provide network  
1159 management, credentialing of providers, monitoring of copayments  
1160 and premiums and other services as required by the commissioner.  
1161 Subject to approval by applicable federal authority, the Department of  
1162 Social Services shall utilize the contracted organization's provider

1163 network and billing systems in the administration of the program. In  
1164 order to implement the provisions of this section, the commissioner  
1165 may establish rates of payment to providers of medical services under  
1166 this section if the establishment of such rates is required to ensure that  
1167 any contract entered into with an administrative services organization  
1168 pursuant to this section is cost neutral to such providers in the  
1169 aggregate and ensures patient access. Utilization may be a factor in  
1170 determining cost neutrality.

1171 Sec. 29. Section 17b-274 of the general statutes is repealed and the  
1172 following is substituted in lieu thereof (*Effective January 1, 2014*):

1173 (a) The Division of Criminal Justice shall periodically investigate  
1174 pharmacies to ensure that the state is not billed for a brand name drug  
1175 product when a less expensive generic substitute drug product is  
1176 dispensed to a Medicaid recipient. The Commissioner of Social  
1177 Services shall cooperate and provide information as requested by such  
1178 division.

1179 (b) A licensed medical practitioner may specify in writing or by a  
1180 telephonic or electronic communication that there shall be no  
1181 substitution for the specified brand name drug product in any  
1182 prescription for a Medicaid [or ConnPACE] recipient, provided (1) the  
1183 practitioner specifies the basis on which the brand name drug product  
1184 and dosage form is medically necessary in comparison to a chemically  
1185 equivalent generic drug product substitution, and (2) the phrase  
1186 "brand medically necessary" shall be in the practitioner's handwriting  
1187 on the prescription form or, if the prohibition was communicated by  
1188 telephonic communication, in the pharmacist's handwriting on such  
1189 form, and shall not be preprinted or stamped or initialed on such form.  
1190 If the practitioner specifies by telephonic communication that there  
1191 shall be no substitution for the specified brand name drug product in  
1192 any prescription for a Medicaid [or ConnPACE] recipient, written  
1193 certification in the practitioner's handwriting bearing the phrase  
1194 "brand medically necessary" shall be sent to the dispensing pharmacy  
1195 within ten days. A pharmacist shall dispense a generically equivalent

1196 drug product for any drug listed in accordance with the Code of  
1197 Federal Regulations Title 42 Part 447.332 for a drug prescribed for a  
1198 Medicaid, or state-administered general assistance [, or ConnPACE]  
1199 recipient unless the phrase "brand medically necessary" is ordered in  
1200 accordance with this subsection and such pharmacist has received  
1201 approval to dispense the brand name drug product in accordance with  
1202 subsection (c) of this section.

1203 (c) The Commissioner of Social Services shall implement a  
1204 procedure by which a pharmacist shall obtain approval from an  
1205 independent pharmacy consultant acting on behalf of the Department  
1206 of Social Services, under an administrative services only contract,  
1207 whenever the pharmacist dispenses a brand name drug product to a  
1208 Medicaid [or ConnPACE] recipient and a chemically equivalent  
1209 generic drug product substitution is available. The length of  
1210 authorization for brand name drugs shall be in accordance with section  
1211 17b-491a. In cases where the brand name drug is less costly than the  
1212 chemically equivalent generic drug when factoring in manufacturers'  
1213 rebates, the pharmacist shall dispense the brand name drug. If such  
1214 approval is not granted or denied within two hours of receipt by the  
1215 commissioner of the request for approval, it shall be deemed granted.  
1216 Notwithstanding any provision of this section, a pharmacist shall not  
1217 dispense any initial maintenance drug prescription for which there is a  
1218 chemically equivalent generic substitution that is for less than fifteen  
1219 days without the department's granting of prior authorization,  
1220 provided prior authorization shall not otherwise be required for  
1221 atypical antipsychotic drugs if the individual is currently taking such  
1222 drug at the time the pharmacist receives the prescription. The  
1223 pharmacist may appeal a denial of reimbursement to the department  
1224 based on the failure of such pharmacist to substitute a generic drug  
1225 product in accordance with this section.

1226 (d) A licensed medical practitioner shall disclose to the Department  
1227 of Social Services or such consultant, upon request, the basis on which  
1228 the brand name drug product and dosage form is medically necessary  
1229 in comparison to a chemically equivalent generic drug product

1230 substitution. The Commissioner of Social Services shall establish a  
1231 procedure by which such a practitioner may appeal a determination  
1232 that a chemically equivalent generic drug product substitution is  
1233 required for a Medicaid [or ConnPACE] recipient.

1234 Sec. 30. Section 17b-274a of the general statutes is repealed and the  
1235 following is substituted in lieu thereof (*Effective January 1, 2014*):

1236 The Commissioner of Social Services may establish maximum  
1237 allowable costs to be paid under the Medicaid [, ConnPACE] and  
1238 Connecticut AIDS drug assistance programs for generic prescription  
1239 drugs based on, but not limited to, actual acquisition costs. The  
1240 department shall implement and maintain a procedure to review and  
1241 update the maximum allowable cost list at least annually, and shall  
1242 report annually to the joint standing committee of the General  
1243 Assembly having cognizance of matters relating to appropriations and  
1244 the budgets of state agencies on its activities pursuant to this section.

1245 Sec. 31. Subsection (a) of section 17b-274c of the general statutes is  
1246 repealed and the following is substituted in lieu thereof (*Effective*  
1247 *January 1, 2014*):

1248 (a) The Commissioner of Social Services may establish a voluntary  
1249 mail order option for any maintenance prescription drug covered  
1250 under the Medicaid [, ConnPACE] or Connecticut AIDS drug  
1251 assistance programs.

1252 Sec. 32. Subsection (e) of section 17b-274d of the general statutes is  
1253 repealed and the following is substituted in lieu thereof (*Effective*  
1254 *January 1, 2014*):

1255 (e) The Department of Social Services, in consultation with the  
1256 Pharmaceutical and Therapeutics Committee, may adopt a preferred  
1257 drug [lists] list for use in the Medicaid [and ConnPACE programs]  
1258 program. To the extent feasible, the department shall review all drugs  
1259 included on the preferred drug [lists] list at least every twelve months,  
1260 and may recommend additions to, and deletions from, the preferred

1261 drug [lists] list, to ensure that the preferred drug [lists provide] list  
1262 provides for medically appropriate drug therapies for Medicaid [and  
1263 ConnPACE] patients. [For the fiscal year ending June 30, 2004, such  
1264 drug lists shall be limited to use in the Medicaid and ConnPACE  
1265 programs and cover three classes of drugs, including proton pump  
1266 inhibitors and two other classes of drugs determined by the  
1267 Commissioner of Social Services. Not later than June 30, 2005, the] The  
1268 Department of Social Services, in consultation with the Pharmaceutical  
1269 and [Therapeutic] Therapeutics Committee, shall expand such drug  
1270 [lists] list to include other classes of drugs, except as provided in  
1271 subsection (f) of this section, in order to achieve savings reflected in the  
1272 amounts appropriated to the department, for the various components  
1273 of the program, in the state budget act.

1274 Sec. 33. Section 17b-274e of the general statutes is repealed and the  
1275 following is substituted in lieu thereof (*Effective January 1, 2014*):

1276 A pharmacist, when filling a prescription under the Medicaid [,  
1277 ConnPACE] or Connecticut AIDS drug assistance programs, shall fill  
1278 such prescription utilizing the most cost-efficient dosage, consistent  
1279 with the prescription of a prescribing practitioner as defined in section  
1280 20-571, unless such pharmacist receives permission to do otherwise  
1281 pursuant to the prior authorization requirements set forth in sections  
1282 17b-274, as amended by this act, and 17b-491a.

1283 Sec. 34. Subsection (a) of section 17b-280 of the general statutes is  
1284 repealed and the following is substituted in lieu thereof (*Effective*  
1285 *January 1, 2014*):

1286 (a) The state shall reimburse for all legend drugs provided under  
1287 medical assistance programs administered by the Department of Social  
1288 Services at the lower of (1) the rate established by the Centers for  
1289 Medicare and Medicaid Services as the federal acquisition cost, (2) the  
1290 average wholesale price minus sixteen per cent, or (3) an equivalent  
1291 percentage as established under the Medicaid state plan.  
1292 Notwithstanding the provisions of this section, contingent upon  
1293 federal approval, on and after October 1, 2012, for independent

1294 pharmacies, the state shall reimburse for such legend drugs at the  
1295 lower of (A) the rate established by the Centers for Medicare and  
1296 Medicaid Services as the federal acquisition cost, (B) the average  
1297 wholesale price minus fifteen per cent, or (C) an equivalent percentage  
1298 as established under the Medicaid state plan. The state shall pay a  
1299 professional fee of one dollar and seventy cents to licensed pharmacies  
1300 for each prescription dispensed to a recipient of benefits under a  
1301 medical assistance program administered by the Department of Social  
1302 Services in accordance with federal regulations. On and after  
1303 September 4, 1991, payment for legend and nonlegend drugs provided  
1304 to Medicaid recipients shall be based upon the actual package size  
1305 dispensed. Effective October 1, 1991, reimbursement for over-the-  
1306 counter drugs for such recipients shall be limited to those over-the-  
1307 counter drugs and products published in the Connecticut Formulary,  
1308 or the cross reference list, issued by the commissioner. The cost of all  
1309 over-the-counter drugs and products provided to residents of nursing  
1310 facilities, chronic disease hospitals, and intermediate care facilities for  
1311 the mentally retarded shall be included in the facilities' per diem rate.  
1312 Notwithstanding the provisions of this subsection, no dispensing fee  
1313 shall be issued for a prescription drug dispensed to a [ConnPACE or]  
1314 Medicaid recipient who is a Medicare Part D beneficiary when the  
1315 prescription drug is a Medicare Part D drug, as defined in Public Law  
1316 108-173, the Medicare Prescription Drug, Improvement, and  
1317 Modernization Act of 2003.

1318 Sec. 35. Section 17b-429 of the general statutes is repealed and the  
1319 following is substituted in lieu thereof (*Effective January 1, 2014*):

1320 The Commissioner of Social Services shall, within available  
1321 appropriations, make information available to senior citizens and  
1322 disabled persons concerning any pharmaceutical company's drug  
1323 program for indigent persons by utilizing the [ConnPACE program,  
1324 the] CHOICES health insurance assistance program, as defined in  
1325 section 17b-427, and Infoline of Connecticut to deliver such  
1326 information.

1327 Sec. 36. Section 17b-491b of the general statutes is repealed and the  
1328 following is substituted in lieu thereof (*Effective January 1, 2014*):

1329 The maximum allowable cost paid for Factor VIII pharmaceuticals  
1330 under the Medicaid [and ConnPACE programs] program shall be the  
1331 actual acquisition cost plus eight per cent. The Commissioner of Social  
1332 Services may designate specific suppliers of Factor VIII  
1333 pharmaceuticals from which a dispensing pharmacy shall order the  
1334 prescription to be delivered to the pharmacy and billed by the supplier  
1335 to the Department of Social Services. If the commissioner so designates  
1336 specific suppliers of Factor VIII pharmaceuticals, the department shall  
1337 pay the dispensing pharmacy a handling fee equal to eight per cent of  
1338 the actual acquisition cost for such prescription.

1339 Sec. 37. Subsection (c) of section 20-619 of the general statutes is  
1340 repealed and the following is substituted in lieu thereof (*Effective*  
1341 *January 1, 2014*):

1342 (c) A prescribing practitioner may specify in writing or by a  
1343 telephonic or other electronic communication that there shall be no  
1344 substitution for the specified brand name drug product in any  
1345 prescription, provided (1) in any prescription for a Medicaid [or  
1346 ConnPACE] recipient, such practitioner specifies the basis on which  
1347 the brand name drug product and dosage form is medically necessary  
1348 in comparison to a chemically equivalent generic name drug product  
1349 substitution, and (2) the phrase "BRAND MEDICALLY NECESSARY",  
1350 shall be in the practitioner's handwriting on the prescription form or  
1351 on an electronically produced copy of the prescription form or, if the  
1352 prohibition was communicated by telephonic or other electronic  
1353 communication that did not reproduce the practitioner's handwriting,  
1354 a statement to that effect appears on the form. The phrase "BRAND  
1355 MEDICALLY NECESSARY" shall not be preprinted or stamped or  
1356 initialed on the form. If the practitioner specifies by telephonic or other  
1357 electronic communication that did not reproduce the practitioner's  
1358 handwriting that there shall be no substitution for the specified brand  
1359 name drug product in any prescription for a Medicaid [or ConnPACE]

1360 recipient, written certification in the practitioner's handwriting bearing  
1361 the phrase "BRAND MEDICALLY NECESSARY" shall be sent to the  
1362 dispensing pharmacy not later than ten days after the date of such  
1363 communication.

1364 Sec. 38. Subdivision (11) of subsection (b) of section 17a-22j of the  
1365 general statutes is repealed and the following is substituted in lieu  
1366 thereof (*Effective January 1, 2014*):

1367 (11) One representative from each administrative services  
1368 organization under contract with the Department of Social Services to  
1369 provide such services for recipients of assistance under Medicaid [ ]  
1370 and HUSKY Plan, [Part A and Part B and the Charter Oak Health  
1371 Plan,] Part B to be nonvoting ex-officio members.

1372 Sec. 39. Subsection (b) of section 17b-90 of the general statutes is  
1373 repealed and the following is substituted in lieu thereof (*Effective*  
1374 *January 1, 2014*):

1375 (b) No person shall, except for purposes directly connected with the  
1376 administration of programs of the Department of Social Services and in  
1377 accordance with the regulations of the commissioner, solicit, disclose,  
1378 receive or make use of, or authorize, knowingly permit, participate in  
1379 or acquiesce in the use of, any list of the names of, or any information  
1380 concerning, persons applying for or receiving assistance from the  
1381 Department of Social Services or persons participating in a program  
1382 administered by said department, directly or indirectly derived from  
1383 the records, papers, files or communications of the state or its  
1384 subdivisions or agencies, or acquired in the course of the performance  
1385 of official duties. The Commissioner of Social Services shall disclose (1)  
1386 to any authorized representative of the Labor Commissioner such  
1387 information directly related to unemployment compensation,  
1388 administered pursuant to chapter 567 or information necessary for  
1389 implementation of sections 17b-688b, 17b-688c and 17b-688h and  
1390 section 122 of public act 97-2 of the June 18 special session, (2) to any  
1391 authorized representative of the Commissioner of Mental Health and  
1392 Addiction Services any information necessary for the implementation

1393 and operation of the basic needs supplement program, or the Medicaid  
1394 program for low-income adults, [established] administered pursuant  
1395 to section [17b-261n] 17b-261, as amended by this act, (3) to any  
1396 authorized representative of the Commissioner of Administrative  
1397 Services or the Commissioner of Emergency Services and Public  
1398 Protection such information as the Commissioner of Social Services  
1399 determines is directly related to and necessary for the Department of  
1400 Administrative Services or the Department of Emergency Services and  
1401 Public Protection for purposes of performing their functions of  
1402 collecting social services recoveries and overpayments or amounts due  
1403 as support in social services cases, investigating social services fraud or  
1404 locating absent parents of public assistance recipients, (4) to any  
1405 authorized representative of the Commissioner of Children and  
1406 Families necessary information concerning a child or the immediate  
1407 family of a child receiving services from the Department of Social  
1408 Services, including safety net services, if the Commissioner of Children  
1409 and Families or the Commissioner of Social Services has determined  
1410 that imminent danger to such child's health, safety or welfare exists to  
1411 target the services of the family services programs administered by the  
1412 Department of Children and Families, (5) to a town official or other  
1413 contractor or authorized representative of the Labor Commissioner  
1414 such information concerning an applicant for or a recipient of  
1415 assistance under state-administered general assistance deemed  
1416 necessary by the Commissioner of Social Services and the Labor  
1417 Commissioner to carry out their respective responsibilities to serve  
1418 such persons under the programs administered by the Labor  
1419 Department that are designed to serve applicants for or recipients of  
1420 state-administered general assistance, (6) to any authorized  
1421 representative of the Commissioner of Mental Health and Addiction  
1422 Services for the purposes of the behavioral health managed care  
1423 program established by section 17a-453, (7) to any authorized  
1424 representative of the Commissioner of Public Health to carry out his or  
1425 her respective responsibilities under programs that regulate child day  
1426 care services or youth camps, (8) to a health insurance provider, in IV-  
1427 D support cases, as defined in subdivision (13) of subsection (b) of

1428 section 46b-231, information concerning a child and the custodial  
1429 parent of such child that is necessary to enroll such child in a health  
1430 insurance plan available through such provider when the noncustodial  
1431 parent of such child is under court order to provide health insurance  
1432 coverage but is unable to provide such information, provided the  
1433 Commissioner of Social Services determines, after providing prior  
1434 notice of the disclosure to such custodial parent and an opportunity for  
1435 such parent to object, that such disclosure is in the best interests of the  
1436 child, (9) to any authorized representative of the Department of  
1437 Correction, in IV-D support cases, as defined in subdivision (13) of  
1438 subsection (b) of section 46b-231, information concerning noncustodial  
1439 parents that is necessary to identify inmates or parolees with IV-D  
1440 support cases who may benefit from Department of Correction  
1441 educational, training, skill building, work or rehabilitation  
1442 programming that will significantly increase an inmate's or parolee's  
1443 ability to fulfill such inmate's support obligation, (10) to any  
1444 authorized representative of the Judicial Branch, in IV-D support cases,  
1445 as defined in subdivision (13) of subsection (b) of section 46b-231,  
1446 information concerning noncustodial parents that is necessary to: (A)  
1447 Identify noncustodial parents with IV-D support cases who may  
1448 benefit from educational, training, skill building, work or  
1449 rehabilitation programming that will significantly increase such  
1450 parent's ability to fulfill such parent's support obligation, (B) assist in  
1451 the administration of the Title IV-D child support program, or (C)  
1452 assist in the identification of cases involving family violence, or (11) to  
1453 any authorized representative of the State Treasurer, in IV-D support  
1454 cases, as defined in subdivision (13) of subsection (b) of section 46b-  
1455 231, information that is necessary to identify child support obligors  
1456 who owe overdue child support prior to the Treasurer's payment of  
1457 such obligors' claim for any property unclaimed or presumed  
1458 abandoned under part III of chapter 32. No such representative shall  
1459 disclose any information obtained pursuant to this section, except as  
1460 specified in this section. Any applicant for assistance provided through  
1461 said department shall be notified that, if and when such applicant  
1462 receives benefits, the department will be providing law enforcement

1463 officials with the address of such applicant upon the request of any  
1464 such official pursuant to section 17b-16a.

1465 Sec. 40. Section 17b-260d of the general statutes is repealed. (*Effective*  
1466 *July 1, 2013*)

1467 Sec. 41. Sections 17b-261n, 17b-311, 17b-490, 17b-491, 17b-492 and  
1468 17b-493 to 17b-498, inclusive, of the general statutes are repealed.  
1469 (*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>	17b-340(f)(4)
Sec. 4	<i>July 1, 2013</i>	17b-340(h)(1)
Sec. 5	<i>October 1, 2014</i>	New section
Sec. 6	<i>July 1, 2013</i>	17b-239
Sec. 7	<i>July 1, 2013</i>	17b-239e(b)
Sec. 8	<i>July 1, 2013</i>	17b-242(a)
Sec. 9	<i>July 1, 2013</i>	17b-261m(a)
Sec. 10	<i>July 1, 2013</i>	17b-239c(a)
Sec. 11	<i>July 1, 2013</i>	17b-28e
Sec. 12	<i>January 1, 2014</i>	17b-261
Sec. 13	<i>January 1, 2014</i>	17b-256f
Sec. 14	<i>January 1, 2014</i>	17b-551
Sec. 15	<i>January 1, 2014</i>	17b-552
Sec. 16	<i>from passage</i>	17b-278i(a)
Sec. 17	<i>from passage</i>	17b-340c(a)
Sec. 18	<i>July 1, 2013</i>	17a-22h
Sec. 19	<i>July 1, 2013</i>	17a-22p
Sec. 20	<i>January 1, 2014</i>	17b-10a
Sec. 21	<i>January 1, 2014</i>	38a-556a(b)
Sec. 22	<i>January 1, 2014</i>	29-1s(a)
Sec. 23	<i>January 1, 2014</i>	12-746(e)
Sec. 24	<i>January 1, 2014</i>	10a-132e(b)
Sec. 25	<i>January 1, 2014</i>	17a-22f(a)
Sec. 26	<i>January 1, 2014</i>	17a-22h(a)
Sec. 27	<i>January 1, 2014</i>	17b-28(a)

Sec. 28	January 1, 2014	17b-261m(a)
Sec. 29	January 1, 2014	17b-274
Sec. 30	January 1, 2014	17b-274a
Sec. 31	January 1, 2014	17b-274c(a)
Sec. 32	January 1, 2014	17b-274d(e)
Sec. 33	January 1, 2014	17b-274e
Sec. 34	January 1, 2014	17b-280(a)
Sec. 35	January 1, 2014	17b-429
Sec. 36	January 1, 2014	17b-491b
Sec. 37	January 1, 2014	20-619(c)
Sec. 38	January 1, 2014	17a-22j(b)(11)
Sec. 39	January 1, 2014	17b-90(b)
Sec. 40	July 1, 2013	Repealer section
Sec. 41	January 1, 2014	Repealer section

**Statement of Legislative Commissioners:**

In section 2(c), language was redrafted to conform with the style of the general statutes; in section 13, new language was redrafted for clarity and consistency with federal law; in section 28(a), the phrase "provided the Department of Social Services completes a fiscal analysis prior to implementation of the impact on each such provider of considering utilization as a factor" was deleted after the word "neutrality" for accuracy and consistency with section 9; and sections 38 and 39 were added to delete references to statutes being repealed in section 41.

**HS**            *Joint Favorable Subst. C/R*

APP

**APP**            *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

**OFA Fiscal Note**

**State Impact:**

Agency Affected	Fund-Effect	FY 14 \$	FY 15 \$
Various State Agencies	GF - See Below	See Below	See Below

**Municipal Impact:**

Municipalities	Effect	FY 14 \$	FY 15 \$
Various Municipalities	See Below	See Below	See Below

**Explanation**

The bill makes various changes which result in the fiscal impact described below.

**Section 1** implements the savings in the Department of Rehabilitation Services (DORS) budget (sHB 6350, the FY 14 and FY 15 budget bill, as favorably reported by the Appropriations Committee) from eliminating the reimbursement to towns for their costs associated with teachers for the visually impaired. The towns are able to use DORS teachers for their visually impaired students at no cost to themselves. This results in a reduction of \$1.1 million in FY 14 and FY 15 in the Educational Aid for Blind and Visually Handicapped Children account.

**Section 2** makes technical changes and allows the DORS to charge a fee related to the Connecticut Tech Act project which is anticipated to result in nominal revenue to the agency.

**Section 3** requires the Department of Social Services (DSS) to freeze nursing home statutory rate increases in both years of the biennium.

Approximately \$53.4 million in FY 14 and \$81.0 million in FY 15, of the savings identified in the bill are included in sHB 6350, the FY 14 and FY 15 budget bill, as favorably reported by the Appropriations Committee.

**Section 4** allows the DSS to rebase residential care home rates based on changes in the facility's costs. Current statute freezes residential care home rates and therefore precludes the DSS from achieving savings when a facility's costs are decreased which otherwise result in a reduced reimbursement rate. The FY 14 and FY 15 budget bill, as favorably reported by the Appropriations Committee, appropriates \$458,333 in FY 14 and \$500,000 in FY 15 for residential care home rate increases.

**Section 5** does not result in a fiscal impact. The section requires the DSS to adopt the 10<sup>th</sup> revision of the International Statistical Classifications of Diseases and Related Health Problems medical code.

**Section 6** is not anticipated to result in a fiscal impact. The section requires the DSS to modify reimbursement rates for hospitals which is not anticipated to change the DSS' aggregate hospital expenditures.

**Sections 7 through 9** eliminate transitional supplemental payments related to the conversion from managed care to an administrative services organization (ASO). Approximately \$23.5 million in FY 14 and FY 15, of the savings identified in the bill are included in sHB 6350, the FY 14 and FY 15 budget bill, as favorably reported by the Appropriations Committee.

**Section 10** makes a technical change which does not result in a fiscal impact.

**Section 11** makes the following changes to the DSS: 1) reduces the facility per diem hospice rate, and 2) eliminates interpreter and chiropractic services as covered benefits. Approximately \$9.5 million in FY 14 and \$10.3 million in FY 15, of the savings identified in the bill are included in sHB 6350, the FY 14 and FY 15 budget bill, as favorably

reported by the Appropriations Committee.

**Sections 12 and 39** codify the Medicaid for Low Income Adults expansion under the Patient Protection and Affordable Care Act. sHB 6350, the FY 14 and FY 15 budget bill, as favorably reported by the Appropriations Committee, appropriated \$51.6 million in FY 14 and \$301 million in FY 15 to the DSS and the Department of Mental Health and Addiction Services for this purpose. The costs of the Medicaid expansion will be 100% reimbursed by the federal government through 2016, after which the reimbursement rate will be adjusted incrementally downward to 90% by 2020.

**Sections 13 - 15 and 20 - 38** eliminate references to the CONNPACE and Charter Oak Health Programs which do not result in a fiscal impact.

**Sections 16 and 17** make technical changes which do not result in a fiscal impact.

**Sections 18 and 19** do not result in a fiscal impact. These sections make various technical changes to the Behavioral Health Partnership.

**Section 40** eliminates the HIV/AIDS waiver which has not been implemented. Approximately \$1.3 million in FY 14 and \$2.2 million in FY 15, of the savings identified in the bill are included in sHB 6350, the FY 14 and FY 15 budget bill, as favorably reported by the Appropriations Committee.

**Section 41** repeals various sections of statute which result in the following fiscal impacts: 1) CGS section 17b-491 which established the CONNPACE program is repealed and results in a savings of \$162,000 in FY 14 and \$340,900 in FY 15, 2) CGS section 17b-311 which established the Charter Oak Health Program is repealed and results in a savings of \$3.7 million in FY 14 and approximately \$7.0 million savings in FY 15, 3) CGS section 17b-261n repeals the Medicaid for Low Income Adults Wavier which does not result in a fiscal impact. The other sections of statute are repealed as they relate to the

eliminated programs. The savings identified in the bill are included in sHB 6350, the FY 14 and FY 15 budget bill, as favorably reported by the Appropriations Committee.

***The Out Years***

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

**OLR Bill Analysis****sHB 6367****AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES PROGRAMS.****SUMMARY:**

This bill makes several changes to human services programs, many of which the Department of Social Services (DSS) administers. These include:

1. elimination, as of January 1, 2014, of the Charter Oak Health Plan, which serves residents who have been uninsured for at least six months;
2. elimination of the ConnPACE program, which serves elderly and disabled individuals who do not qualify for Medicare, as of January 1, 2014;
3. a freeze on nursing home rates in FYs 14 and 15;
4. creation of diagnosis-related groups to factor the severity of the patient's condition in determining Medicaid rates for inpatient hospital care; and
5. limits on the type of foreign language interpreter services available for Medicaid recipients.

The bill also makes technical changes.

EFFECTIVE DATE: Various; see below.

**§ 1 — EDUCATION OF BLIND AND VISUALLY IMPAIRED CHILDREN**

The Department of Rehabilitation Services (DORS) provides up to \$6,400 annually to local school districts for the educational needs of

each child who is blind or visually impaired. DORS pays for these services from the Educational Aid for Blind and Visually Handicapped Children Account. The law prioritizes how the funds may be spent, with the top two priorities being the use of state employee teachers of the visually impaired and providing specialized books, equipment, and materials.

The bill eliminates requirements that remaining funds after DORS exhausts spending under the priority categories (1) cover the pro-rated share of the actual cost (including benefits) that school districts use to hire teachers directly instead of using DORS teachers and (2) if there are still funds left, be distributed to school districts on a 2:1 credit ratio of Braille-learning to non-Braille-learning students based on the annual child count data.

EFFECTIVE DATE: July 1, 2013

## **§ 2 — DEPARTMENT OF REHABILITATIVE SERVICES**

[PA 11-44](#) created a new Bureau of Rehabilitative Services (renamed DORS in 2012) to provide services to individuals who are blind and visually impaired and deaf and hearing impaired. DORS took over all the functions of DSS' Bureau of Rehabilitation Services (BRS).

### ***Assistive Technology Revolving Fund***

The bill conforms law to practice by authorizing the DORS commissioner, rather than the DSS commissioner, to establish and administer the Assistive Technology Revolving Fund. In practice, BRS administered the fund when it was within DSS and DORS does so currently.

Current law requires that the fund be used to make loans to people with disabilities to purchase assistive equipment. The bill expands loan eligibility to include senior citizens or the family members of both groups. It eliminates loan use for assistive equipment and instead allows the loans to be used for assistive technology and adaptive equipment and services. It also extends terms of the loan from up to five years to up to ten years and caps the interest at no more than 6%.

The bill eliminates State Bond Commission authority to set the interest rate and conforms law to practice by allowing the DORS commissioner to set the rate.

### ***Connecticut Tech Act Project***

DORS currently administers the Connecticut Tech Act Project, which helps clients get the assistive technology they need for greater independence at work, school, or in the community. The bill allows the project to provide available assistive technology evaluation and training services upon request. It allows the project to recoup direct and indirect costs by charging a reasonable fee that the DORS commissioner establishes.

EFFECTIVE DATE: July 1, 2013

### **§ 3 — NURSING HOME RATES**

For FYs 14 and 15, the bill limits at FY 13 levels the rates DSS pays nursing homes for their Medicaid-covered residents. Under current law, homes that receive lower rates because DSS has issued them an interim rate receive that lower rate. The bill extends this same exception in FY 13 and FY 14 and extends it to homes whose rates would be lower due to (1) re-basing, (2) available appropriations, or (3) some other agreement with DSS.

By law, DSS must re-base nursing home rates no more frequently than every two years and at least once every four years. The DSS commissioner determines the frequency of the re-basing. When a nursing home has its rates re-based, DSS looks at the home's most recent cost report and bases the rate on those costs, rather than those from an earlier year.

Finally, the bill clarifies that DSS may decrease, as well as increase, nursing home rates regardless of any contrary provision in the nursing home rate setting law, as available appropriations permit.

EFFECTIVE DATE: July 1, 2013

---

**§ 4 — RESIDENTIAL CARE HOMES (RCH)**

The bill permits DSS, within available appropriations, to increase or decrease RCH rates to reflect cost re-basing. The bill provides that RCHs that are to be issued lower rates due to having an interim rate status or some other agreement with DSS must receive such lower rate in FYs 14 and 15.

EFFECTIVE DATE: July 1, 2013

**§ 5 — MEDICAL CODE STANDARDS**

In 2009, the federal Department of Health and Human Services (HHS) published a regulation (45 CFR 162.1002) setting the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) medical code as the new Health Insurance Portability and Accountability Act (HIPAA) standard. As HIPAA-covered entities, states must comply with this new standard on October 1, 2014.

The bill requires the DSS commissioner to convert all DSS medical assistance programs from ICD-9 to ICD-10 in compliance with the HHS regulation. It also allows the commissioner to implement necessary policies and procedures while in the process of adopting regulations if he publishes notice of his intent to adopt regulations in the *Connecticut Law Journal* within 20 days after implementing the interim policies and procedures.

EFFECTIVE DATE: October 1, 2014

**§§ 6 & 7 — HOSPITAL RATES*****Diagnostic-Related Groups—Inpatient Rates***

The bill requires DSS, beginning July 1, 2013, to reimburse acute care and children's hospitals for serving Medicaid recipients based on diagnostic-related groups (DRGs) that the DSS commissioner establishes and periodically re-bases. DSS must annually determine the inpatient rates by multiplying DRG relative weights by a base rate. The federal Medicare program uses a DRG-type system when setting the

rates it reimburses hospitals for serving Medicare patients. Such a system permits payment to be based on the severity of each patient's illness.

The bill permits the DSS commissioner, within available appropriations, to make additional payments to hospitals based on criteria he establishes.

The bill's provisions replace current law, under which hospitals (including chronic disease hospitals) are reimbursed based on the lower of (1) their reasonable costs or (2) the charge to the general public for ward services or the lowest charge for semiprivate rooms if the hospital has no wards. And it allows these hospitals to receive a higher amount for serving a disproportionate share of indigent patients. In practice, the hospitals receive a flat daily rate per Medicaid patient, along with a payment for serving a disproportionate share of indigent patients.

The bill eliminates a provision requiring DSS to pay hospitals a lower acute care inpatient rate for patients who no longer need an acute level of care. It eliminates obsolete provisions and makes technical changes.

By law, the reimbursement rates may not exceed those that the hospital charges to the general public.

***Medicare Ambulatory Payment Classification—Outpatient and Emergency Room Rates***

The bill requires DSS, beginning July 1, 2013, to pay hospitals for outpatient and emergency room care based on prospective rates that the DSS commissioner establishes in accordance with the Medicare Ambulatory Payment Classification (MAPC) system, in conjunction with a state conversion factor. The MAPC system must be modified to provide payment for services that Medicare does not normally cover, including pediatric, obstetric, neonatal, and perinatal services. By law and unchanged by the bill, these rates may not exceed those that the hospital charges to the general public.

The bill eliminates a requirement that DSS pay for these services based on a ratio of costs to charges and establish a fee schedule from which it pays hospitals based on the type of visit. Under the bill, those outpatient services that do not have an established MAPC “code” must be paid on the basis of either a cost to charges ratio or the fixed fee in effect as of July 1, 2014. It is unclear how services that do not have a code will be reimbursed in FY 13.

The bill also makes a technical, conforming change.

### ***Fiscal Impact Report***

The bill (1) requires the commissioner to determine the fiscal impact of the new DRG and MAPC systems on each hospital and (2) report his results to the Appropriations and Human Services committees by December 31, 2013.

### ***DSS Authorization to Implement Before Regulations Finalized***

The bill permits the DSS commissioner to implement policies and procedures necessary to carry out the above hospital-related provisions while in the process of adopting them in regulation, provided he publishes notice of intent to adopt regulations in the *Connecticut Law Journal* within 20 days of implementation.

### ***Utilization and Cost Neutrality.***

By law, DSS can modify the outpatient fee schedule and establish a “blended” inpatient rate if such (1) is needed to ensure that its conversion from a managed care to an administrative services organization (ASO) service delivery model is cost neutral to hospitals in the aggregate and (2) ensures patient access. The bill makes permanent a provision that allows service utilization to be a factor in determining cost neutrality. Under current law, this provision expires on June 30, 2013.

EFFECTIVE DATE: July 1, 2013

## **§ 8 — HOME HEALTH CARE SERVICES FEE SCHEDULE**

The law authorizes the DSS commissioner to annually modify fee

schedules for home health care services if doing so (1) is required to ensure that any contract with an ASO (see BACKGROUND) is cost neutral to home health care agencies and homemaker-home health aide agencies in the aggregate and (2) ensures patient access. The bill makes permanent a provision that would have expired on June 30, 2013, which allows the commissioner to take utilization into account when determining cost neutrality.

EFFECTIVE DATE: July 1, 2013

### **§ 9 — HOSPITAL MEDICAL SERVICE PROVIDER PAYMENT RATES**

The law authorizes the DSS commissioner to establish payment rates for medical service providers if establishing the rates (1) is required to ensure that any contract it maintains with an ASO is cost neutral to hospitals in the aggregate and (2) ensures patient access. The bill makes permanent a provision that would have expired on June 30, 2013, which allows the commissioner to take utilization into account when determining cost neutrality.

EFFECTIVE DATE: July 1, 2013

### **§ 10 — DISPROPORTIONATE SHARE PAYMENTS**

Under federal and state law, Medicaid provides additional reimbursement to short-term general hospitals that serve a disproportionate share (DSH) of low-income patients. (By state law, Connecticut Children's Medical Center and UConn Health Center are not eligible for such payments.) Under current law, DSS, within available appropriations, can make interim DSH payments on a monthly basis in order to maximize federal Medicaid matching funds. The bill instead requires that these interim payments be made on a quarterly basis, thus conforming law to current practice.

EFFECTIVE DATE: July 1, 2013

### **§ 11 — HOSPICE CARE REIMBURSEMENT RATES**

[PA 12-1](#), December Special Session, imposed a 5% reduction on Medicaid reimbursement rates (from 100% to 95%) for long-term care facility residents receiving only hospice care from January 1, 2013 through June 30, 2013. The bill makes this reimbursement rate reduction permanent.

Some long-term care facility and hospice agency services provided to residents who have chosen hospice care overlap. In this situation, federal Medicaid law allows state programs to set a facility's per diem rates at 95% of what it otherwise would have been.

EFFECTIVE DATE: July 1, 2013

## **§ 11 — CHIROPRACTIC AND FOREIGN LANGUAGE INTERPRETER SERVICES FOR MEDICAID RECIPIENTS**

### ***Interpreter Services***

Federal Medicaid law requires states to provide foreign language interpreter services to individuals with limited English proficiency (LEPs). It allows states to receive federal matching funds for LEP interpreters, either by designating them as a covered state plan service or an administrative cost.

Currently, DSS must, by July 1, 2013 (1) amend the Medicaid state plan to include foreign language interpreter services as a “covered service” to any beneficiary with limited English proficiency, (2) establish billing codes for interpreter services provided under the Medicaid program, and (3) report semi-annually to the Council on Medical Assistance Program Oversight on the foreign language interpreter services provided under this program. The bill eliminates these requirements.

The Medicaid ASO, Community Health Network of Connecticut, Inc., currently provides foreign language interpreter services for Connecticut Medicaid recipients over the phone and in person upon request. Presumably, it will continue to do so as part of its administrative cost.

---

**Chiropractic Services**

The bill eliminates a requirement that the DSS commissioner amend the Medicaid state plan to limit chiropractic coverage only to the extent required by federal law.

Federal law provides that chiropractic coverage is an optional service for adult Medicaid recipients and the state does not currently cover this for adults if the service is provided by an independent chiropractor.

Federal law generally requires that children under age 21 be entitled to receive chiropractic coverage under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions if ordered by a medical professional to treat a condition that a screening reveals. The state reimburses independent chiropractors treating Medicaid-eligible children and provides some limited chiropractic services beyond those required by EPSDT. The bill will enable DSS to continue to provide those services.

EFFECTIVE DATE: July 1, 2013

**§§ 12, 39, & 41 — MEDICAID FOR LOW-INCOME ADULTS**

The state's Medicaid for Low-Income Adults program (LIA) provides Medicaid coverage to childless adults between the ages of 19 and 64 with income up to about 60% of the federal poverty level (FPL), or \$512.05 per month; there is no asset limit. Beginning January 1, 2014, the income limit rises under federal law (Affordable Care Act) to 133% of the FPL (plus an additional 5%), or about \$1,275 per month using 2013 federal poverty guidelines. To comply with federal law, the bill eliminates the 60% of FPL limit and, linking to federal eligibility requirements, establishes program eligibility by referring to the federal law.

The bill eliminates provisions concerning (1) a \$150 per-month disregard for earnings (which allows applicants to have a higher income and still qualify) and (2) a three-month extension of benefits for someone who loses eligibility solely due to earnings.

The bill also removes a requirement that DSS seek a federal waiver to (1) impose a \$10,000 liquid asset test on LIA applicants and recipients, (2) count parental income and assets, and (3) limit to 90 days the amount of nursing home care LIA recipients can have covered by the Medicaid program. The federal Medicaid agency denied a DSS waiver application earlier this year.

Finally, it removes a provision that permits DSS to offer an alternative, more limited benefit package to LIA recipients.

EFFECTIVE DATE: January 1, 2014

### **§ 13 — MEDICARE SAVINGS PROGRAM (MSP) ELIGIBILITY**

Current law requires DSS, when determining an individual's eligibility for MSP, to disregard the amount of income that equalizes the program's income limits with the ConnPACE income limits (see BACKGROUND).

The bill instead requires DSS to disregard the amount of income for each MSP sub-group so that a person with an income that is (1) less than 211% of the FPL will qualify for Qualified Medicare Beneficiary program coverage, (2) from 211% FPL to 230% FPL will qualify for the Specified Low-Income Medicare Beneficiary program, and (3) from 231% FPL up to 245% FPL will qualify for the Qualifying Individual program.

The bill does not change the MSP income limits but it does change the mechanism for providing cost of living adjustments.

EFFECTIVE DATE: January 1, 2014

### **§ 14 — CONNMAP ELIGIBILITY**

Currently, to be eligible for the Connecticut Medicare Assistance Program (ConnMAP, see BACKGROUND) a resident must be enrolled in Medicare Part B with an annual income of up to 165% of the ConnPACE qualifying income level (\$43,560 in 2013) or, if married, a combined income of up to 165% of the ConnPACE qualifying income

level (\$58,740 in 2013). The bill eliminates the formula for calculating ConnMAP income eligibility and sets the income limits at current levels (\$43,560 for an individual income and \$58,740 for a combined income). The bill requires the DSS commissioner, starting on January 1, 2014, to increase the income limits to the nearest hundred dollars to reflect the annual inflation adjustment in Social Security income. (ConnPACE currently uses the same mechanism to calculate income limit increases).

EFFECTIVE DATE: January 1, 2014

### **§ 16 — CUSTOMIZED WHEELCHAIRS FOR MEDICAID RECIPIENTS**

The law provides that customized wheelchairs must be covered under Medicaid only when (1) a standard wheelchair will not meet an individual's needs, as DSS determines, and (2) when DSS requests an assessment. (DSS regulations permit vendors or nursing homes to perform assessments to determine this need.) The bill removes the requirement that DSS request the assessment.

EFFECTIVE DATE: Upon passage

### **§ 17 — NURSING HOME ADVANCE PAYMENTS**

The bill eliminates a requirement that the DSS commissioner consult with the Office of Policy and Management secretary before providing advance payments to nursing homes that provide services eligible for payment under the medical assistance program.

EFFECTIVE DATE: Upon passage

### **§§ 18, 19, & 26 — BEHAVIORAL HEALTH PARTNERSHIP**

The Behavioral Health Partnership (BHP) is an integrated behavioral health system currently operated by the departments of children and families (DCF) and mental health and addiction services (DMHAS), and DSS. BHP's goal is to provide access to complete, coordinated, and effective community-based behavioral health services and supports. The partnership maintains a contract with an ASO,

ValueOptions.

The law requires the DCF, DMHAS and DSS commissioners to implement the BHP for HUSKY Plan A and B members and children enrolled in voluntary DCF services. The bill requires, instead of permits, the commissioners to implement the BHP for all Medicaid recipients, not just those in HUSKY Plan Part A. In practice, the BHP already provides assistance to all Medicaid recipients. The bill also eliminates BHP assistance for Charter Oak Health Plan (COHP) members on January 1, 2014 to conform with the provisions eliminating COHP (see below).

Currently, the ASO must authorize services based solely on the BHP clinical management committee's guidelines. It may make exceptions when a member or the member's legal guardian or service provider requests one and the ASO determines the exception to be in the member's best interest. The bill instead requires the ASO to authorize services based solely on "medical necessity," as defined by statute (see BACKGROUND) and use the clinical management committee guidelines only as a basis for expeditiously approving a service request. If the request for services does not meet the guidelines, the ASO may deny the request only if it is not medically necessary, as defined by statute.

EFFECTIVE DATE: July 1, 2013

**§§ 20-21, 24-28, 38, & 41 — CHARTER OAK HEALTH PLAN (COHP) ELIMINATED**

The bill eliminates COHP, effective January 1, 2014. COHP is for residents who have been uninsured for at least six months, including those with pre-existing medical conditions. Some individuals currently insured through COHP will be able to enroll in health insurance through the Connecticut Health Insurance Exchange starting in October 2013 and others will be eligible for Medicaid under the new federal income eligibility limits effective January 1, 2014.

EFFECTIVE DATE: January 1, 2014

**§§ 15, 22-24, 29-37, & 41 — CONNPACE ELIMINATED**

The bill eliminates the ConnPACE program, which serves people over age 65 and younger individuals with disabilities who do not qualify for Medicare. It makes numerous technical, conforming changes.

EFFECTIVE DATE: January 1, 2014

**§ 40 — REPEAL OF AIDS WAIVER**

The bill eliminates a requirement that the DSS commissioner apply for a Medicaid home- and community-based services waiver for individuals with AIDS or HIV. DSS has not applied for the waiver.

EFFECTIVE DATE: July 1, 2013

**BACKGROUND*****Converting Medicaid Program to ASO Model***

The law authorizes DSS to contract with one or more ASOs (currently, the Community Health Network of Connecticut, Inc.) to provide a variety of nonmedical services for Medicaid, HUSKY A and B, and Charter Oak Health Plan enrollees. DSS previously contracted with managed care organizations to perform most of these services, which they did as part of a risk-sharing capitation payment that covered medical services. The ASO performs the services for a set fee and does not share any risk for the provision of medical services.

***ConnPACE and MSP***

For over 25 years, the Connecticut Pharmaceutical Contract to the Elderly and Disabled (ConnPACE) program subsidized seniors' prescription drug costs. When Congress added prescription drug coverage to Medicare in 2006 (Part D), ConnPACE became a wrap-around program for seniors eligible for Medicare and helped with co-payments, premium assistance, the Part D coverage gap ("donut hole"), and coverage for drugs that were not in a participant's Part D plan's formulary. As of July 1, 2011, ConnPACE was eliminated for anyone eligible for Medicare, but these individuals can get drug

coverage by enrolling in the Medicare Savings Program (MSP).

The MSP is a mandatory Medicaid coverage group that essentially allows Medicare recipients who would not otherwise qualify for Medicaid to receive limited help with their Medicare Part A and B cost sharing. The MSP consists of three sub-groups:

1. Qualified Medicare Beneficiaries,
2. Specified Low-Income Medicare Beneficiaries, and
3. Qualifying Individuals.

Eligibility for MSP also makes individuals eligible for the Medicare Part D Low-Income Subsidy (LIS). The LIS reduces the co-payments seniors must pay and covers the Part D donut hole. People enrolled in the LIS can move from one Part D plan to another at any time of the year instead of having to wait for the Medicare Part D open enrollment period.

### **ConnMAP**

ConnMAP prohibits medical providers from billing enrollees for charges beyond what the federal Medicare program determines is a “reasonable and necessary” rate, of which Medicare pays 80% (a practice called “balance billing.”) Thus, any provider accepting Medicare patients may not balance bill ConnMAP enrollees beyond the 20% co-payment for the service. (Patients are also responsible for Medicare Part B premiums and deductibles.)

### **“Medical Necessity” Definition**

The law defines medical necessity as those health services required to prevent, identify, diagnose, treat, rehabilitate, or ameliorate a person’s medical condition, including mental illness, or its effects, in order to attain or maintain the person’s achievable health and independent functioning. The services must be consistent with generally-accepted medical practice standards that are based on (1) credible scientific evidence published in recognized peer-reviewed

medical literature, (2) physician-specialty society recommendations, (3) the views of physicians practicing in relevant clinical areas, and (4) any other relevant factors. The services must also be:

1. clinically appropriate in terms of type, frequency, timing, extent, and duration and considered effective for the person's illness, injury, or disease;
2. not primarily for the convenience of the person, the person's health care provider, or other health care providers;
3. not more costly than an alternative service or services at least as likely to produce equivalent therapeutic or diagnostic results for the person's illness, injury, or disease; and
4. based on an assessment of the person and his or her medical condition.

**COMMITTEE ACTION**

Appropriations Committee

Joint Favorable Substitute

Yea 35 Nay 17 (04/22/2013)