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SUMMARY OF HB 6367

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You asked for a summary of HB 6367, *An Act Implementing the Governor's Budget Recommendations for Human Services Programs*.

This bill makes several changes to human services programs, services, and grants. It also eliminates some programs, including ConnPACE, the Charter Oak Health Plan (COHP), and the Family Support Grant Program. And it eliminates Medicaid (HUSKY A) coverage for caretaker relatives with incomes higher than 133% of the federal poverty level (FPL).

We provide a section-by-section analysis of the bill below. The bill has various effective dates ranging from upon passage for a provision regarding Medicaid coverage for customized wheelchairs to January 1, 2014 for the elimination of the HUSKY A adult coverage for higher income caretaker relatives.

§ 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 being the employment of state employee teachers of the visually impaired and providing specialized books, equipment, and materials.

Under current law, if there are remaining funds after DORS exhausts spending under the priority categories, it must use them to cover the pro-rated share of the actual cost (including benefits) that school districts use to hire directly instead of using DORS teachers. And if there are still funds left, they must 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. The bill eliminates these two funding priorities for any remaining funds.

EFFECTIVE DATE: July 1, 2013

§ 2 — DEPARTMENT OF REHABILITATIVE SERVICES

PA 11-44 created a new Bureau of Rehabilitative Services (renamed the Department of Rehabilitation Services, or 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 the Bureau of Rehabilitation Services (BRS), which was previously within DSS.

Assistive Technology Revolving Fund

The bill conforms law to practice by authorizing the rehabilitation services 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 the commissioner to use the fund to make loans to persons with disabilities for the purchase of 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 a fixed rate of up to 6%. (Under current law, the State Bond Commission determines the loan interest rate.) It is unclear who will set the interest rate and how the rate will be determined under the bill.

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 costs by charging a reasonable fee that the rehabilitation services commissioner establishes.

EFFECTIVE DATE: July 1, 2013

§§ 3-5 — "CHILD" DEFINITION

The bill modifies the definition of a child to reflect current Department of Children and Families (DCF) practices by including a person under age 18 and a person age 18 to 20 who was committed to DCF before turning 18 and is:

1. enrolled full-time, or part-time in the commissioner's discretion, in an approved secondary education or GED program;

2. enrolled full-time, or part-time in the commissioner's discretion, in an institution that provides post-secondary or vocational education; or

3. participating in a program or activity approved by the commissioner that is designed to promote or remove employment barriers.

Under current law, the general definition of a child is a person under age 18 who has not been legally emancipated, with certain exceptions for delinquency matters and proceedings. The child welfare statutes define a child as a person under age 18, except as otherwise specified, or under age 21 if a full time student in a school or state accredited job training program.

EFFECTIVE DATE: July 1, 2013

§ 6 — NURSING HOME RATES

For FYs 14 and 15, the bill freezes at FY 13 levels the rates DSS pays nursing homes for their Medicaid-covered residents. Under current law, homes that would have received lower rates because DSS has issued them an interim rate receive that lower rate. The bill extends this same exception to the freeze, but also 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 rebased, 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 makes it clear 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

§ 7 — INTERMEDIATE CARE FACILITIES FOR PEOPLE WITH INTELLECTUAL DISABILTIES (ICF-MR)

The bill freezes the rates DSS pays ICF-MRs (group homes) for FYs 14 and 15. But it allows for higher rates if (1) a capital improvement is made to the home during either year for the residents' health or safety and the Department of Developmental Services (DDS) approved it, in consultation with DSS and (2) there is funding available to do so. Facilities that would have received lower rates due to their interim rate status or some other agreement with DSS must receive a lower rate.

The bill also extends DSS' authority for the next two years to pay a fair rent increase to an ICF-MR that has (1) undergone a material change in circumstances related to fair rent and (2) an approved certificate of need for the change.

As it does for nursing homes above, the bill makes it clear that DSS may decrease, as well as increase, rates issued to ICF-MRs regardless of any other contrary law. But it appears to limit this authority to (1) re-based rates or (2) budget reductions, subject to any maximum increase or decrease the DSS commissioner determines.

EFFECTIVE DATE: July 1, 2013

§ 8 — LICENSED PRIVATE RESIDENTIAL FACILITY REIMBURSEMENT RATES

For FYs 14 and 15, the bill freezes DSS reimbursement rates at the FY 13 level for licensed private residential facilities and similar facilities operated by regional educational service centers that provide vocational or functional services for severely handicapped individuals.

Any facility that would have gotten a lower rate during either year due to interim rate status or an agreement with DSS gets the lower rate.

The rate may be higher if the facility makes a capital improvement in FY 14 or 15 required by the DDS commissioner for resident health and safety.

EFFECTIVE DATE: July 1, 2013

§ 9 — RESIDENTIAL CARE HOMES (RCH)

As it does for the other facilities, the bill freezes for the next two fiscal years the rates DSS pays RCHs, except that homes scheduled to receive lower rates, either due to an interim rate status or other agreement with DSS during these years receive the lower rates.

The bill permits DSS, within available appropriations, to increase or decrease RCH rates to reflect cost re-basing, subject to a maximum increase (but not decrease) that the DSS commissioner determines.

EFFECTIVE DATE: July 1, 2013

§ 10 — MEDICAL CODE STANDARDS

In 2009, the 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 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

§ 11, 12 — 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 "rebases." DSS must annually determine the 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 acuity of the each patient's illness.

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

Under current law, 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 day per Medicaid patient.

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. This apparently is obsolete given the bill's shift to a DRG-based reimbursement system.

The bill removes obsolete language.

Medicare Ambulatory Payment Classification—Outpatient and Emergency Room Rates

The bill likewise requires DSS, beginning July 1, 2013, to pay hospitals for outpatient episodes of care based on prospective rates that DSS 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.

Under current law, DSS pays for outpatient services based on a ratio of costs to charges and must 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.

The bill also makes a technical, conforming change.

DSS Authorization to Implement Before Regulations Final

The bill permits the DSS commissioner to implement policies and procedures necessary to carry out these provisions while in the process of adopting them in regulation, provided he publishes notice of intent 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 is needed to ensure that its conversion from a managed care to an administrative services organization service delivery model is cost neutral to hospitals in the aggregate and ensures patient access. The bill makes permanent a provision in law 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

§ 13 — 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 is required to ensure that any contract with an administrative services organization (ASO)(see BACKGROUND) is cost neutral to home health care agencies and homemaker-home health aide agencies in the aggregate and ensures patient access. It also permits the commissioner to take into account how often a particular service was provided (utilization)

when determining cost neutrality in FY 13 only. The bill allows the commissioner to always take utilization into account for cost-neutrality determination.

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.

§ 14 — MEDICAL SERVICE PROVIDER PAYMENT RATES

The law authorizes the DSS commissioner to establish payment rates for medical service providers if establishing the rates is required to ensure that any contract it maintains with an ASO is cost neutral to hospitals in the aggregate and ensures patient access. It also permits the commissioner to take utilization into account when determining cost neutrality in FY 13. The bill allows the commissioner to take utilization into account for cost-neutrality determination purposes each year.

EFFECTIVE DATE: July 1, 2013

§ 15 — DISPROPORTIONATE SHARE PAYMENTS

Under federal and state law, Medicaid provides additional reimbursement to short-term hospitals that serve a disproportionate share (DSH) of low-income patients. (By state law, CCMC 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 requires that these interim payments be made on a quarterly instead of monthly basis, thus conforming law to current practice.

EFFECTIVE DATE: July 1, 2013

§ 16 — HOSPICE CARE AND INTERPRETER SERVICES

Hospice Care Reimbursement Rates

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 would otherwise have been.

PA 12-1, December Special Session, imposes a temporary 5% reduction on Medicaid reimbursement rates (from 100% to 95%) for long-term care facility residents receiving only hospice care. It requires DSS to pay facilities the lower per diem from January 1, 2013 through June 30, 2013. The bill makes this reimbursement rate reduction permanent.

Foreign Language Interpreter Services

Federal Medicaid law allows states to receive federal matching funds for limited English proficiency interpreters, either by designating them as a covered state plan service or an administrative cost.

State law requires DSS to amend the Medicaid state plan, by July 1, 2013, to include foreign language interpreter services as a "covered service" to any beneficiary with limited English proficiency. DSS was supposed to establish billing codes for interpreter services provided under the Medicaid program. The law also requires DSS to report semi-annually to the Council on Medical Assistance Program Oversight on the foreign language interpreter services provided under this program. The bill eliminates the foreign language interpreter services and associated reporting requirements.

The Medicaid ASO, Community Health Network of Connecticut, Inc., currently provides foreign language interpreter services for Connecticut Medicaid recipients.

EFFECTIVE DATE: July 1, 2013

§ 17 — REIMBURSEMENT FOR PRESCRIPTION DRUGS

The bill reduces from $1.70 to $1.40 the fee DSS pays pharmacies for dispensing drugs to patients covered by any of DSS' medical assistance programs.

The bill eliminates the requirement for DSS, contingent upon federal approval, to reimburse independent pharmacies at a higher rate than chain pharmacies. DSS never implemented this provision.

EFFECTIVE DATE: July 1, 2013

§ 18 — TEMPORARY FAMILY ASSISTANCE (TFA) AND STATE-ADMINISTERED GENERAL ASSISTANCE (SAGA) PAYMENT STANDARDS

The TFA and SAGA payment standards have been frozen at the FY 09 rate for the past four years. The bill extends the freeze at FY 09 rates for the next two fiscal years (FY 14 and FY 15). It retains the existing formula for calculating increases for future years.

EFFECTIVE DATE: July 1, 2013

§ 19 — FREEZE IN STATE SUPPLEMENT PAYMENTS

DSS provides cash assistance to low-income individuals who are aged, blind, or disabled and in most cases, receiving federal disability benefits. Under this program (State Supplement), the amount of the benefit is determined based on the living arrangement of the recipients (e.g., community, residential care home). The bill freezes for the next two fiscal years State Supplement payments at their current level.

When determining State Supplement benefits, DSS looks at the applicant's income and needs. If income is less than need, the difference is the benefit. When calculating income, DSS deducts a portion of the applicant's unearned income. The amount of this deduction or "disregard" is increased each year based on any increase in the federal SSI benefits. The bill eliminates this automatic indexing. For calendar year 2013, the COLA was 1.7%.

EFFECTIVE DATE: July 1, 2013

§ 20 — MEDICAID FOR LOW-INCOME ADULTS

The state's Medicaid for Low-Income Adults program (HUSKY D) 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. 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 lower income limit.

And it eliminates what appears to be obsolete provisions concerning (1) a $150 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. Currently, there is no asset test, parental resources are not counted, and there are no service limits. DSS applied for the waiver and it is still pending with the federal Medicaid agency.

EFFECTIVE DATE: January 1, 2014

§ 21 — ELIMINATION OF HUSKY A COVERAGE FOR CARETAKER RELATIVES WITH INCOMES ABOVE 133% OF THE FPL

Currently, children under age 19 and their caretaker relatives qualify for HUSKY A (Medicaid) if their income is under 185% of the FPL. The bill eliminates this coverage for parents and needy caretaker adults of HUSKY A children with incomes above 133% of the FPL. These adults may be eligible to receive 12 months of "transitional" medical assistance when their coverage ends (CGS § 17b-261(f)). (The bill seems to create a second category of children under age 19 who qualify for Medicaid with income under 185% of the FPL.)

EFFECTIVE DATE: January 1, 2014

§ 22, 24 — MEDICARE SAVINGS PROGRAM AND CONNPACE

MSP Eligibility

Current law requires DSS, when determining an individual's eligibility for the Medicare Savings Program (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 up to (1) 231% of the federal poverty level (FPL) will qualify for Specified Low-Income Medicare Beneficiary program coverage, (2) 211% FPL will qualify for the Qualified Medicare Beneficiary program and (3) 246% 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.

ConnPACE ID Cards

The bill eliminates the requirement that health care providers must accept a ConnPACE identification card as a substitute for a Medicare assignment card (see BACKGROUND).

EFFECTIVE DATE: January 1, 2014

BACKGROUND

ConnPACE and the Medicare Savings Program

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 bill appears to eliminate the ConnPACE program altogether (see § 35, et. seq.)

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. Qualified 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 during the year instead of having to wait for the Medicare Part D open enrollment period.

§ 23 — 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 freezes 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, so there is no legal effect).

EFFECTIVE DATE: January 1, 2014

BACKGROUND

The Connecticut Medicare Assignment Program (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.)

§ 25 — 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 limitation on when assessments may be performed.

EFFECTIVE DATE: Upon passage

§ 26 — NURSING HOME ADVANCE PAYMENTS

The bill eliminates a requirement for the DSS commissioner to 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

§§ 27-31, 53 — BEHAVIORAL HEALTH PARTNERSHIP OVERSIGHT COUNCIL

The Behavioral Health Partnership (BHP) is an integrated behavioral health system currently operated by the DCF, 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 the commissioners to implement the BHP for all Medicaid recipients, not just those in HUSKY Plan Part A. (Currently, the law permits the commissioners to do so at their discretion.) In practice, the BHP already provides assistance to all Medicaid recipients and Charter Oak Health Plan members.

Currently, the BHP Oversight Council advises DCF, DMHAS, and DSS on the BHP's planning and administration. The bill eliminates the council. It requires the Council on Medical Assistance Program Oversight (MAPOC) to monitor, as well as make recommendations concerning, the BHP including periodic review of BHP reports on program activities, finances, and outcomes and achievement of service delivery system goals.

The bill also eliminates the following requirements:

1. Prior to converting any BHP grant-funded services to a rate-based, fee-for-service payment system, DSS, DCF, and DMHAS must submit documentation to the Behavioral Health Partnership Oversight Council verifying that the proposed rates seek to cover the reasonable cost of providing services;
2. DCF, DSS, and DMHAS must develop consumer and provider appeal procedures and submit them to the BHP Oversight Council for review and comment; and
3. The BHP must establish policies to coordinate benefits received under the partnership with other benefits received under Medicaid and submit them to the BHP Oversight Council for review and comment.

Clinical Management Committee

The law establishes a committee to develop clinical management guidelines for the BHP and the ASO. Currently, the DCF, DSS, and DMHAS commissioner each select two committee members and the BHP Oversight Council selects two members. The bill requires the committee to advise DCF, DSS, and DMHAS on BHP guidelines instead of developing them itself. It also requires MAPOC, instead of the BHP Oversight Council, to select two committee members.

ASO Service Authorization

Currently, the ASO must authorize services based solely on the clinical management committee's guidelines. The bill requires the ASO to authorize services based solely on "medical necessity," as defined by statute (see BACKGROUND). The bill requires the ASO to use the clinical management committee guidelines to inform and guide the authorization decision. The bill retains current language allowing the ASO to make exceptions to the guidelines when the member or the member's legal guardian or service provider requests it and the ASO determines it to be in the member's best interest. It is unclear if this would allow the ASO to circumvent the bill's medical necessity requirement in such circumstances.

EFFECTIVE DATE: July 1, 2013

BACKGROUND

"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 least 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.

EFFECTIVE DATE: July 1, 2013

§ 32 & 53 — ELIMINATION OF FAMILY SUPPORT GRANT

The bill eliminates the DSS Family Support Grant program and a requirement that the Human Services Committee review it every 10 years beginning no later than July 1, 2015. The program provides a $250 monthly grant to help families pay the costs of caring for a child aged five to 18 with a developmental disability other than mental retardation. The grant can be used for ongoing costs such as medical expenses, special equipment, medical transportation, and special clothing. This program has a limited number of slots (25), all of which are presently filled. DSS currently maintains a waiting list of 40.

EFFECTIVE DATE: July 1, 2013

§§ 33-34, 39-43, 53 — CHARTER OAK HEALTH PLAN (COHP)

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

§§ 35-39, 44-52, 54 -— CONNPACE

The bill eliminates most references to the ConnPACE program, but leaves intact a provision that establishes the program (CGS § 17b-491 (a)).

The bill repeals two sections related to ConnPACE (CGS §§ 17b-494 and -497) but retains them in the body of the bill. The first section pertains to regulations for ConnPACE. The second pertains to fraud perpetrated by pharmacists or beneficiaries.

EFFECTIVE DATE: January 1, 2014

§§ 53 & 54 — REPEALERS

The bill repeals the following statutes:

5. CGS § 17a-22j—establishes the Behavioral Health Partnership (BHP) Oversight Council;

6. CGS § 17a-22m –requires the DCF, DMHAS, and DSS commissioners to annually evaluate the BHP and submit the evaluation to the appropriations, human services, and public health committees;

7. CGS § 17a-22n –requires DCF and DMHAS to monitor the BHP implementation and submit an annual report to the appropriations, human services, and public health committees;

8. CGS § 17a-220 –requires DCF, DMHAS, and DSS to submit all BHP rate change proposals to the BHP Oversight Council for review;

9. CGS § 17b-260d—requires the DSS commissioner to apply for a Medicaid home- and community-based services waiver for individuals with AIDS or HIV; DSS never applied for the waiver;

10. CGS § 17b-616—establishes the Family Support Grant Program in DSS;

11. CGS § 17b-311—establishes the Charter Oak Health Plan;

12. CGS § 17b-490—creates ConnPACE definitions;

13. CGS § 17b-492—establishes eligibility and other ConnPACE rules;

14. CGS § 17b-492a—already repealed in 2011;

15. CGS § 17b-493—requires generic substitution for ConnPACE recipients;

16. CGS § 17b-494—requires DSS to adopt regulations for both ConnPACE and prior authorization;

17. CGS § 17b-495—permits DSS to enter into a contract with a fiscal intermediary to administer ConnPACE;

18. CGS § 17b-496—gives individuals aggrieved by any ConnPace administrative action by DSS commissioner the right to a hearing;

19. CGS § 17b-497—imposes penalties on pharmacists and program beneficiaries who defraud or otherwise violate the ConnPACE program and prior authorization laws; and

20. CGS § 17b-498—directs DSS to undertake educational outreach on the ConnPACE program.

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