



House of Representatives

General Assembly

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Substitute House Bill No. 6946

House of Representatives, April 8, 2015

The Committee on Human Services reported through REP. ABERCROMBIE of the 83rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING HUSKY PROGRAMS.

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

1 Section 1. Subsection (d) of section 4-66e of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective from*
3 *passage*):

4 (d) The self-sufficiency measurement shall not be used to: (1)
5 Analyze the success or failure of any program; (2) determine or
6 establish eligibility or benefit levels for any state or federal public
7 assistance program, including, but not limited to, temporary family
8 assistance, child care assistance, medical assistance, state-administered
9 general assistance, supplemental nutrition assistance or eligibility for
10 the HUSKY [plan] Health program; (3) determine whether a person
11 subject to time-limited benefits under the temporary family assistance
12 program qualifies for an extension of benefits under such program; or
13 (4) supplement the amount of benefits awarded under the temporary
14 family assistance program.

15 Sec. 2. Subsection (c) of section 10-223h of the general statutes is
16 repealed and the following is substituted in lieu thereof (*Effective from*
17 *passage*):

18 (c) Following the establishment of a turnaround committee, the
19 Department of Education shall conduct, in consultation with the local
20 or regional board of education for a school selected to participate in the
21 commissioner's network of schools, the school governance council for
22 such school and such turnaround committee, an operations and
23 instructional audit, as described in subparagraph (A) of subdivision (2)
24 of subsection (e) of section 10-223e, for such school. Such operations
25 and instructional audit shall be conducted pursuant to guidelines
26 issued by the department and shall determine the extent to which the
27 school (1) has established a strong family and community connection
28 to the school; (2) has a positive school environment, as evidenced by a
29 culture of high expectations, a safe and orderly workplace, and that
30 address other nonacademic factors that impact student achievement,
31 such as students' social, emotional, arts, cultural, recreational and
32 health needs; (3) has effective leadership, as evidenced by the school
33 principal's performance appraisals, track record in improving student
34 achievement, ability to lead turnaround efforts, and managerial skills
35 and authority in the areas of scheduling, staff management,
36 curriculum implementation and budgeting; (4) has effective teachers
37 and support staff as evidenced by performance evaluations, policies to
38 retain staff determined to be effective and who have the ability to be
39 successful in the turnaround effort, policies to prevent ineffective
40 teachers from transferring to the schools, and job-embedded, ongoing
41 professional development informed by the teacher evaluation and
42 support programs that are tied to teacher and student needs; (5) uses
43 time effectively as evidenced by the redesign of the school day, week,
44 or year to include additional time for student learning and teacher
45 collaboration; (6) has a curriculum and instructional program that is
46 based on student needs, is research-based, rigorous and aligned with
47 state academic content standards, and serves all children, including
48 students at every achievement level; and (7) uses evidence to inform
49 decision-making and for continuous improvement, including by

50 providing time for collaboration on the use of data. Such operations
51 and instructional audit shall be informed by an inventory of the
52 following: (A) Before and after school programs, (B) any school-based
53 health centers, family resource centers or other community services
54 offered at the school, including, but not limited to, social services,
55 mental health services and parenting support programs, (C) whether
56 scientific research-based interventions are being fully implemented at
57 the school, (D) resources for scientific research-based interventions
58 during the school year and summer school programs, (E) resources for
59 gifted and talented students, (F) the length of the school day and the
60 school year, (G) summer school programs, (H) the alternative high
61 school, if any, available to students at the school, (I) the number of
62 teachers employed at the school and the number of teachers who have
63 left the school in each of the previous three school years, (J) student
64 mobility, including the number of students who have been enrolled in
65 and left the school, (K) the number of students whose primary
66 language is not English, (L) the number of students receiving special
67 education services, (M) the number of truants, (N) the number of
68 students who are eligible for free or reduced price lunches, (O) the
69 number of students who are eligible for HUSKY [Plan, Part] A, (P) the
70 curricula used at the school, (Q) the reading curricula and programs
71 for kindergarten to grade three, inclusive, if any, at the school, (R) arts
72 and music programs offered at the school, (S) physical education
73 programs offered and periods for recess or physical activity, (T) the
74 number of school psychologists at the school and the ratio of school
75 psychologists to students at the school, (U) the number of social
76 workers at the school and the ratio of social workers to students at the
77 school, (V) the teacher and administrator performance evaluation
78 program, including the frequency of performance evaluations, how
79 such evaluations are conducted and by whom, the standards for
80 performance ratings and follow-up and remediation plans and the
81 aggregate results of teacher performance evaluation ratings conducted
82 pursuant to section 10-151b and any other available measures of
83 teacher effectiveness, (W) professional development activities and
84 programs, (X) teacher and student access to technology inside and

85 outside of the classroom, (Y) student access to and enrollment in
86 mastery test preparation programs, (Z) the availability of textbooks,
87 learning materials and other supplies, (AA) student demographics,
88 including race, gender and ethnicity, (BB) chronic absenteeism, and
89 (CC) preexisting school improvement plans, for the purpose of (i)
90 determining why such school improvement plans have not improved
91 student academic performance, and (ii) identifying governance, legal,
92 operational, staffing or resource constraints that contributed to the lack
93 of student academic performance at such school and should be
94 addressed, modified or removed for such school to improve student
95 academic performance.

96 Sec. 3. Subsection (b) of section 10-265f of the general statutes is
97 repealed and the following is substituted in lieu thereof (*Effective from*
98 *passage*):

99 (b) (1) In the case of proposals for full-day kindergarten programs,
100 the plan shall include: (A) Information on the number of full-day
101 kindergarten classes that will be offered initially and the number of
102 children to be enrolled in such classes; (B) how the board anticipates
103 expanding the number of full-day kindergarten programs in future
104 school years; (C) the number of additional teachers needed and any
105 additional equipment needed for purposes of such programs; (D) a
106 description of any proposed school building project that is related to
107 the need for additional space for full-day kindergarten programs,
108 including an analysis of the different options available to meet such
109 need, such as relocatable classrooms, the division of existing
110 classrooms, an addition to a building or new construction; (E)
111 information on the curriculum for the full-day kindergarten program
112 pursuant to subdivision (2) of this subsection; (F) information on
113 coordination between the full-day kindergarten program and school
114 readiness programs for the purpose of providing (i) information
115 concerning transition from preschool to kindergarten, including the
116 child's preschool records, and (ii) before and after school child care for
117 children attending the full-day kindergarten program; and (G) any
118 additional information the commissioner deems relevant.

119 (2) A full-day kindergarten program that receives funding pursuant
120 to this subsection shall: (A) Include language development and
121 appropriate reading readiness experiences; (B) provide for the
122 assessment of a student's progress; (C) include a professional
123 development component in the teaching of reading and reading
124 readiness and assessment of reading competency for kindergarten
125 teachers; (D) provide for parental involvement; and (E) refer eligible
126 children who do not have health insurance to the HUSKY Health
127 program.

128 Sec. 4. Subsection (b) of section 10a-132e of the general statutes is
129 repealed and the following is substituted in lieu thereof (*Effective from*
130 *passage*):

131 (b) The program established pursuant to subsection (a) of this
132 section shall: (1) Arrange for licensed physicians, pharmacists and
133 nurses to conduct in person educational visits with prescribing
134 practitioners, utilizing evidence-based materials, borrowing methods
135 from behavioral science and educational theory and, when
136 appropriate, utilizing pharmaceutical industry data and outreach
137 techniques; (2) inform prescribing practitioners about drug marketing
138 that is designed to prevent competition to brand name drugs from
139 generic or other therapeutically-equivalent pharmaceutical alternatives
140 or other evidence-based treatment options; and (3) provide outreach
141 and education to licensed physicians and other health care
142 practitioners who are participating providers in state-funded health
143 care programs, including, but not limited to, Medicaid, the HUSKY
144 [Plan, Parts A and B] Health program, the Department of Correction
145 inmate health services program and the state employees' health
146 insurance plan.

147 Sec. 5. Subdivision (4) of subsection (b) of section 12-202a of the
148 general statutes is repealed and the following is substituted in lieu
149 thereof (*Effective from passage*):

150 (4) Any new or renewal contract or policy entered into with the state
151 on or after April 1, 1998, to provide health care coverage to eligible

152 beneficiaries under the HUSKY [Plan, Part A, HUSKY Plan, Part B]
153 Health program, or HUSKY Plus [programs] program, each as defined
154 in section 17b-290, as amended by this act;

155 Sec. 6. Subsection (b) of section 12-202b of the general statutes is
156 repealed and the following is substituted in lieu thereof (*Effective from*
157 *passage*):

158 (b) The amount of credit allowed shall be equal to fifty-five dollars
159 multiplied by the sum of the number of persons provided health care
160 coverage by the taxpayer under the HUSKY [Plan, Part A, HUSKY
161 Plan, Part B] Health program or the HUSKY Plus [programs] program,
162 each as defined in section 17b-290, as amended by this act, on the first
163 day of each month of the income year for which the credit is taken,
164 divided by twelve.

165 Sec. 7. Subsection (b) of section 12-202c of the general statutes is
166 repealed and the following is substituted in lieu thereof (*Effective from*
167 *passage*):

168 (b) For the fiscal year ending June 30, 2003, any company that
169 received a payment under subsection (a) of this section shall be
170 entitled to an additional supplemental payment equal to thirty-six
171 dollars and seventy-five cents multiplied by the sum of the number of
172 persons provided health care coverage by the taxpayer under the
173 HUSKY [Plan, Part A, HUSKY Plan, Part B] Health program or the
174 HUSKY Plus [programs] program, each as defined in section 17b-290,
175 as amended by this act, on the first day of each month, January to June,
176 inclusive, of 2002, divided by six.

177 Sec. 8. Subsection (f) of section 17a-4a of the general statutes is
178 repealed and the following is substituted in lieu thereof (*Effective from*
179 *passage*):

180 (f) Not later than October first of each odd-numbered year, the
181 advisory committee shall submit recommendations concerning the
182 provision of behavioral health services for all children in the state to

183 the Commissioner of Children and Families and the State Advisory
184 Council on Children and Families. The recommendations shall
185 address, but shall not be limited to, the following: (1) The target
186 population for children with behavioral health needs, and assessment
187 and benefit options for children with such needs; (2) the
188 appropriateness and quality of care for children with behavioral health
189 needs; (3) the coordination of behavioral health services provided
190 under the HUSKY [Plan] Health program with services provided by
191 other publicly-funded programs; (4) performance standards for
192 preventive services, family supports and emergency service training
193 programs; (5) assessments of community-based and residential care
194 programs; (6) outcome measurements by reviewing provider practice;
195 and (7) a medication protocol and standards for the monitoring of
196 medication and after-care programs.

197 Sec. 9. Section 17a-22a of the general statutes is repealed and the
198 following is substituted in lieu thereof (*Effective from passage*):

199 (a) The Commissioner of Social Services and the Commissioner of
200 Children and Families shall, within available appropriations, develop
201 and administer an integrated behavioral health service delivery system
202 to be known as Connecticut Community KidCare. Said system shall
203 provide services to children and youths with behavioral health needs
204 who are in the custody of the Department of Children and Families,
205 who are eligible to receive services from [the HUSKY Plan, Part]
206 HUSKY A or the federally subsidized portion of [Part] HUSKY B, or
207 receive services under the voluntary services program operated by the
208 Department of Children and Families. All necessary changes to the IV-
209 E, Title XIX and Title XXI state plans shall be made to maximize federal
210 financial participation. The Commissioner of Social Services may
211 amend the state Medicaid plan to facilitate the claiming of federal
212 reimbursement for private nonmedical institutions as defined in the
213 Social Security Act. The Commissioner of Social Services may
214 implement policies and procedures necessary to provide
215 reimbursement for the services provided by private nonmedical
216 institutions, as defined in 42 CFR Part 434, while in the process of

217 adopting such policies and procedures in regulation form, provided
218 the commissioner [prints] publishes notice of intention to adopt the
219 regulations [in the Connecticut Law Journal] on the Department of
220 Social Services' Internet web site and the eRegulations System within
221 twenty days of implementing such policies and procedures. Policies
222 and procedures implemented pursuant to this subsection shall be valid
223 until the time such regulations are effective.

224 (b) Connecticut Community KidCare shall, within available
225 appropriations, provide a comprehensive benefit package of
226 behavioral health specialty services. The HUSKY [Plan] Health
227 program shall continue to provide primary behavioral health services
228 and may provide additional behavioral health services to be
229 determined by the Department of Social Services and shall assure an
230 integration of such services with the behavioral health services
231 provided by Connecticut Community KidCare.

232 (c) Connecticut Community KidCare shall include: (1) A system of
233 care model in which service planning is based on the needs and
234 preferences of the child or youth and his or her family and that places
235 an emphasis on early identification, prevention and treatment; (2) a
236 comprehensive behavioral health program with a flexible benefit
237 package that shall include clinically necessary and appropriate home
238 and community-based treatment services and comprehensive support
239 services in the least restrictive setting; (3) community-based care
240 planning and service delivery, including services and supports for
241 children from birth through early childhood that link Connecticut
242 Community KidCare to the early childhood community and promote
243 emotional wellness; (4) comprehensive children and youth behavioral
244 health training for agency and system staff and interested parents and
245 guardians; (5) an efficient balance of local participation and state-wide
246 administration; (6) integration of agency funding to support the benefit
247 package; (7) a performance measurement system for monitoring
248 quality and access; (8) accountability for quality, access and cost; (9)
249 elimination of the major gaps in services and barriers to access
250 services; (10) a system of care that is family-focused with respect for

251 the legal rights of the child or youth and his or her parents and
252 provides training, support and family advocacy services; (11)
253 assurances of timely payment of service claims; (12) assurances that no
254 child or youth shall be disenrolled or inappropriately discharged due
255 to behavioral health care needs; and (13) identification of youths in
256 need of transition services to adult systems.

257 (d) The Commissioner of Social Services and the Commissioner of
258 Children and Families shall enter into a memorandum of
259 understanding for the purpose of the joint administration of
260 Connecticut Community KidCare. Such memorandum of
261 understanding shall establish mechanisms to administer funding for,
262 establish standards for and monitor implementation of Connecticut
263 Community KidCare and specify that (1) the Department of Social
264 Services, which is the agency designated as the single state agency for
265 the administration of the Medicaid program pursuant to Title XIX of
266 the Social Security Act and is the agency responsible for the
267 administration of [the HUSKY Plan, Part] HUSKY B under Title XXI of
268 the Social Security Act, manage all Medicaid and HUSKY [Plan]
269 Health program modifications, waiver amendments, federal reporting
270 and claims processing and provide financial management, and (2) the
271 Department of Children and Families, which is the state agency
272 responsible for administering and evaluating a comprehensive and
273 integrated state-wide program of services for children and youths with
274 behavioral health needs, define the services to be included in the
275 continuum of care and develop state-wide training programs for
276 providers, families and other persons.

277 (e) Said commissioners shall consult with the Commissioner of
278 Mental Health and Addiction Services, the Commissioner of
279 Developmental Services, the Commissioner of Public Health and the
280 Commissioner of Education during the development of Connecticut
281 Community KidCare in order to (1) ensure coordination of a delivery
282 system of behavioral health services across the life span of children,
283 youths and adults with behavioral health needs, (2) maximize federal
284 reimbursement and revenue, and (3) ensure the coordination of care

285 and funding among agencies.

286 (f) The Commissioner of Social Services and the Commissioner of
287 Children and Families may apply for any federal waivers or waiver
288 amendments necessary to implement the provisions of this section.

289 Sec. 10. Section 17a-22f of the general statutes is repealed and the
290 following is substituted in lieu thereof (*Effective from passage*):

291 (a) The Commissioner of Social Services may, with regard to the
292 provision of behavioral health services provided pursuant to a state
293 plan under Title XIX or Title XXI of the Social Security Act: (1) Contract
294 with one or more administrative services organizations to provide
295 clinical management, provider network development and other
296 administrative services; (2) delegate responsibility to the Department
297 of Children and Families for the clinical management portion of such
298 administrative contract or contracts that pertain to HUSKY [Plan Parts]
299 A and B, and other children, adolescents and families served by the
300 Department of Children and Families; and (3) delegate responsibility
301 to the Department of Mental Health and Addiction Services for the
302 clinical management portion of such administrative contract or
303 contracts that pertain to Medicaid recipients who are not enrolled in
304 HUSKY [Plan Part] A.

305 (b) For purposes of this section, the term "clinical management"
306 describes the process of evaluating and determining the
307 appropriateness of the utilization of behavioral health services and
308 providing assistance to clinicians or beneficiaries to ensure appropriate
309 use of resources and may include, but is not limited to, authorization,
310 concurrent and retrospective review, discharge review, quality
311 management, provider certification and provider performance
312 enhancement. The Commissioners of Social Services, Children and
313 Families, and Mental Health and Addiction Services shall jointly
314 develop clinical management policies and procedures. The
315 Department of Social Services may implement policies and procedures
316 necessary to carry out the purposes of this section, including any
317 necessary changes to existing behavioral health policies and

318 procedures concerning utilization management, while in the process of
319 adopting such policies and procedures in regulation form, provided
320 the Commissioner of Social Services publishes notice of intention to
321 adopt the regulations [in the Connecticut Law Journal] on the
322 department's Internet web site and the eRegulations System within
323 twenty days of implementing such policies and procedures. Policies
324 and procedures implemented pursuant to this subsection shall be valid
325 until the time such regulations are adopted.

326 Sec. 11. Section 17a-22f of the general statutes, as amended by
327 section 4 of public act 14-62, is repealed and the following is
328 substituted in lieu thereof (*Effective July 1, 2016*):

329 (a) The Commissioner of Social Services may, with regard to the
330 provision of behavioral health services provided pursuant to a state
331 plan under Title XIX or Title XXI of the Social Security Act: (1) Contract
332 with one or more administrative services organizations to provide
333 clinical management, intensive case management, provider network
334 development and other administrative services; (2) delegate
335 responsibility to the Department of Children and Families for the
336 clinical management portion of such administrative contract or
337 contracts that pertain to HUSKY [Plan Parts] A and B, and other
338 children, adolescents and families served by the Department of
339 Children and Families; and (3) delegate responsibility to the
340 Department of Mental Health and Addiction Services for the clinical
341 management portion of such administrative contract or contracts that
342 pertain to Medicaid recipients who are not enrolled in HUSKY [Plan
343 Part] A.

344 (b) For purposes of this section, the term "clinical management"
345 describes the process of evaluating and determining the
346 appropriateness of the utilization of behavioral health services and
347 providing assistance to clinicians or beneficiaries to ensure appropriate
348 use of resources and may include, but is not limited to, authorization,
349 concurrent and retrospective review, discharge review, quality
350 management, provider certification and provider performance

351 enhancement. The Commissioners of Social Services, Children and
352 Families, and Mental Health and Addiction Services shall jointly
353 develop clinical management policies and procedures.

354 (c) The Commissioners of Social Services, Children and Families,
355 and Mental Health and Addiction Services shall require that
356 administrative services organizations managing behavioral health
357 services for Medicaid clients develop intensive case management that
358 includes, but is not limited to: (1) The identification by the
359 administrative services organization of hospital emergency
360 departments which may benefit from intensive case management
361 based on the number of Medicaid clients who are frequent users of
362 such emergency departments; (2) the creation of regional intensive
363 case management teams to work with emergency department doctors
364 to (A) identify Medicaid clients who would benefit from intensive case
365 management, (B) create care plans for such Medicaid clients, and (C)
366 monitor progress of such Medicaid clients; and (3) the assignment of at
367 least one staff member from a regional intensive case management
368 team to participating hospital emergency departments during hours
369 when Medicaid clients who are frequent users visit the most and when
370 emergency department use is at its highest.

371 (d) The Commissioners of Social Services, Children and Families,
372 and Mental Health and Addiction Services shall ensure that any
373 contracts entered into with an administrative services organization
374 require such organization to (1) conduct assessments of behavioral
375 health providers and specialists to determine patient ease of access to
376 services, including, but not limited to, the wait times for appointments
377 and whether the provider is accepting new Medicaid clients; and (2)
378 perform outreach to Medicaid clients to (A) inform them of the
379 advantages of receiving care from a behavioral health provider, (B)
380 help to connect such clients with behavioral health providers soon
381 after they are enrolled in Medicaid, and (C) for frequent users of
382 emergency departments, help to arrange visits by Medicaid clients
383 with behavioral health providers after such clients are treated at an
384 emergency department.

385 (e) The Commissioners of Social Services, Children and Families,
386 and Mental Health and Addiction Services, in consultation with the
387 Secretary of the Office of Policy and Management, shall ensure that all
388 expenditures for intensive case management eligible for Medicaid
389 reimbursement are submitted to the Centers for Medicare and
390 Medicaid Services.

391 (f) The Department of Social Services may implement policies and
392 procedures necessary to carry out the purposes of this section,
393 including any necessary changes to procedures relating to the
394 provision of behavioral health services and utilization management,
395 while in the process of adopting such policies and procedures in
396 regulation form, provided the Commissioner of Social Services
397 publishes notice of intention to adopt the regulations in accordance
398 with the provisions of section 17b-10 not later than twenty days after
399 implementing such policies and procedures. Policies and procedures
400 implemented pursuant to this subsection shall be valid until the time
401 such regulations are adopted.

402 Sec. 12. Subsection (a) of section 17a-22h of the general statutes is
403 repealed and the following is substituted in lieu thereof (*Effective from*
404 *passage*):

405 (a) The Commissioners of Social Services, Children and Families,
406 and Mental Health and Addiction Services shall develop and
407 implement an integrated behavioral health service system for
408 [Medicaid and HUSKY Plan Part B] HUSKY Health program members
409 and children enrolled in the voluntary services program operated by
410 the Department of Children and Families and may, at the discretion of
411 the commissioners, include other children, adolescents and families
412 served by the Department of Children and Families or the Court
413 Support Services Division of the Judicial Branch. The integrated
414 behavioral health service system shall be known as the Behavioral
415 Health Partnership. The Behavioral Health Partnership shall seek to
416 increase access to quality behavioral health services by: (1) Expanding
417 individualized, family-centered and community-based services; (2)

418 maximizing federal revenue to fund behavioral health services; (3)
419 reducing unnecessary use of institutional and residential services for
420 children and adults; (4) capturing and investing enhanced federal
421 revenue and savings derived from reduced residential services and
422 increased community-based services for HUSKY [Plan Parts] A and B
423 recipients; (5) improving administrative oversight and efficiencies; and
424 (6) monitoring individual outcomes and provider performance, taking
425 into consideration the acuity of the patients served by each provider,
426 and overall program performance.

427 Sec. 13. Section 17a-22j of the general statutes is repealed and the
428 following is substituted in lieu thereof (*Effective from passage*):

429 (a) There is established a Behavioral Health Partnership Oversight
430 Council which shall advise the Commissioners of Children and
431 Families, Social Services and Mental Health and Addiction Services on
432 the planning and implementation of the Behavioral Health
433 Partnership.

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

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

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

445 (3) Two appointed by the majority leader of the House of
446 Representatives; one of whom is a primary care provider serving
447 adults or children in the Medicaid program; and one of whom is a
448 child psychiatrist serving children [pursuant to] in the HUSKY [Plan]

449 Health program;

450 (4) Two appointed by the majority leader of the Senate; one of
451 whom is an advocate for adults with substance use disorders; and one
452 of whom is a representative of school-based health clinics;

453 (5) Two appointed by the minority leader of the House of
454 Representatives; one of whom is a provider of community-based
455 psychiatric services for adults; and one of whom is a provider of
456 residential treatment for children;

457 (6) Two appointed by the minority leader of the Senate one of
458 whom is a provider of community-based services for children with
459 behavioral health problems and one of whom is a member of the
460 Council on Medical Assistance Program Oversight;

461 (7) Four appointed by the Governor; two of whom are
462 representatives of general or specialty psychiatric hospitals and two of
463 whom are parents of children who have a behavioral health disorder
464 or have received child protection or juvenile justice services from the
465 Department of Children and Families;

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

470 (9) Four appointed by the chairpersons of the Behavioral Health
471 Partnership Oversight Council; one of whom is a representative of a
472 home health care agency providing behavioral health services; one of
473 whom is a provider of substance use disorder treatment services; one
474 of whom is an adult in recovery from a psychiatric disability; and one
475 of whom is a parent or family member of an adult with a serious
476 behavioral health disorder;

477 (10) Eight nonvoting ex-officio members, one each appointed by the
478 Commissioner of Social Services, the Commissioner of Children and
479 Families, the Commissioner of Mental Health and Addiction Services,

480 the Commissioner of Developmental Services and the Commissioner
481 of Education to represent his or her department, one appointed by the
482 Chief Court Administrator of the Judicial Branch to represent the
483 Court Support Services Division and one each appointed by the State
484 Comptroller and the Secretary of the Office of Policy and Management
485 to represent said offices; and

486 (11) One representative from each administrative services
487 organization under contract with the Department of Social Services to
488 provide such services for recipients of assistance under [Medicaid and
489 HUSKY Plan, Part B] the HUSKY Health program to be nonvoting ex-
490 officio members.

491 (c) All appointments to the council shall be made no later than July
492 1, 2005. Any vacancy shall be filled by the appointing authority.

493 (d) On or after July 1, 2010, the members of the Behavioral Health
494 Partnership Oversight Council shall select the chairpersons of the
495 council from among the members of the council. Such chairpersons
496 shall convene the first meeting of the council, which shall be held not
497 later than August 1, 2005. The council shall meet not less than six times
498 a year thereafter.

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

502 (f) The council shall make specific recommendations on matters
503 related to the planning and implementation of the Behavioral Health
504 Partnership which shall include, but not be limited to: (1) Review of
505 any contracts entered into by the Departments of Children and
506 Families, Social Services and Mental Health and Addiction Services
507 with any administrative services organizations, to assure that the
508 administrative services organization's decisions are based solely on
509 clinical management criteria developed by the clinical management
510 committee established in section 17a-22k; (2) review of behavioral
511 health services pursuant to Title XIX and Title XXI of the Social

512 Security Act to assure that federal revenue is being maximized; and (3)
513 [review of behavioral health services under the Charter Oak Health
514 Plan; and (4)] review of periodic reports on the program activities,
515 finances and outcomes, including reports from the director of the
516 Behavioral Health Partnership on achievement of service delivery
517 system goals, pursuant to section 17a-22i. The council may conduct or
518 cause to be conducted an external, independent evaluation of the
519 Behavioral Health Partnership.

520 Sec. 14. Subsection (d) of section 17a-22p of the general statutes is
521 repealed and the following is substituted in lieu thereof (*Effective from*
522 *passage*):

523 (d) An administrative services organization for [Medicaid and
524 HUSKY Plan Part B] the HUSKY Health program shall provide or
525 arrange for on-site assistance to facilitate the appropriate placement, as
526 soon as practicable, of children with behavioral health diagnoses who
527 the administrative services organization knows to have been in an
528 emergency department for over forty-eight hours. The administrative
529 services organization shall provide or arrange for on-site assistance to
530 arrange for the discharge or appropriate placement, as soon as
531 practicable, for children who the administrative services organization
532 knows to have remained in an inpatient hospital unit for more than
533 five days longer than is medically necessary, as agreed by the
534 administrative services organization and the hospital.

535 Sec. 15. Section 17a-22q of the general statutes is repealed and the
536 following is substituted in lieu thereof (*Effective from passage*):

537 The Commissioner of Children and Families shall have the
538 authority to certify providers of behavioral health Medicaid Early and
539 Periodic Screening, Diagnostic and Treatment Services and
540 rehabilitation services for HUSKY [Plan Part] A for the purpose of
541 coverage of Medicaid Early and Periodic Screening, Diagnostic and
542 Treatment Services or optional rehabilitation services. The
543 Commissioner of Children and Families may adopt regulations, in
544 accordance with the provisions of chapter 54, for purposes of

545 certification of such providers. The commissioner may implement
546 policies and procedures for purposes of such certification while in the
547 process of adopting such policies or procedures in regulation form,
548 provided notice of intention to adopt the regulations is [printed in the
549 Connecticut Law Journal] published on the department's Internet web
550 site and the eRegulations System not later than twenty days after
551 implementation and any such policies and procedures shall be valid
552 until the time the regulations are effective.

553 Sec. 16. Section 17b-28 of the general statutes is repealed and the
554 following is substituted in lieu thereof (*Effective from passage*):

555 (a) There is established a Council on Medical Assistance Program
556 Oversight which shall advise the Commissioner of Social Services on
557 the planning and implementation of the health care delivery system
558 for the [following health care programs: The HUSKY Plan, Parts A and
559 B and the Medicaid program, including, but not limited to, the
560 portions of the program serving low income adults, the aged, blind
561 and disabled individuals, individuals who are dually eligible for
562 Medicaid and Medicare and individuals with preexisting medical
563 conditions] HUSKY Health program. The council shall monitor
564 planning and implementation of matters related to Medicaid care
565 management initiatives including, but not limited to, (1) eligibility
566 standards, (2) benefits, (3) access, (4) quality assurance, (5) outcome
567 measures, and (6) the issuance of any request for proposal by the
568 Department of Social Services for utilization of an administrative
569 services organization in connection with such initiatives.

570 (b) On or before June 30, 2011, the council shall be composed of the
571 chairpersons and ranking members of the joint standing committees of
572 the General Assembly having cognizance of matters relating to human
573 services, public health and appropriations and the budgets of state
574 agencies, or their designees; two members of the General Assembly,
575 one to be appointed by the president pro tempore of the Senate and
576 one to be appointed by the speaker of the House of Representatives;
577 the director of the Commission on Aging, or a designee; the director of

578 the Commission on Children, or a designee; a representative of each
579 organization that has been selected by the state to provide managed
580 care and a representative of a primary care case management provider,
581 to be appointed by the president pro tempore of the Senate; two
582 representatives of the insurance industry, to be appointed by the
583 speaker of the House of Representatives; two advocates for persons
584 receiving Medicaid, one to be appointed by the majority leader of the
585 Senate and one to be appointed by the minority leader of the Senate;
586 one advocate for persons with substance use disorders, to be
587 appointed by the majority leader of the House of Representatives; one
588 advocate for persons with psychiatric disabilities, to be appointed by
589 the minority leader of the House of Representatives; two advocates for
590 the Department of Children and Families foster families, one to be
591 appointed by the president pro tempore of the Senate and one to be
592 appointed by the speaker of the House of Representatives; two
593 members of the public who are currently recipients of Medicaid, one to
594 be appointed by the majority leader of the House of Representatives
595 and one to be appointed by the minority leader of the House of
596 Representatives; two representatives of the Department of Social
597 Services, to be appointed by the Commissioner of Social Services; two
598 representatives of the Department of Public Health, to be appointed by
599 the Commissioner of Public Health; two representatives of the
600 Department of Mental Health and Addiction Services, to be appointed
601 by the Commissioner of Mental Health and Addiction Services; two
602 representatives of the Department of Children and Families, to be
603 appointed by the Commissioner of Children and Families; two
604 representatives of the Office of Policy and Management, to be
605 appointed by the Secretary of the Office of Policy and Management;
606 and one representative of the office of the State Comptroller, to be
607 appointed by the State Comptroller.

608 (c) On and after July 1, 2011, the council shall be composed of the
609 following members:

610 (1) The chairpersons and ranking members of the joint standing
611 committees of the General Assembly having cognizance of matters

612 relating to aging, human services, public health and appropriations
613 and the budgets of state agencies, or their designees;

614 (2) Five appointed by the speaker of the House of Representatives,
615 one of whom shall be a member of the General Assembly, one of
616 whom shall be a community provider of adult Medicaid health
617 services, one of whom shall be a recipient of Medicaid benefits for the
618 aged, blind and disabled or an advocate for such a recipient, one of
619 whom shall be a representative of the state's federally qualified health
620 clinics and one of whom shall be a member of the Connecticut Hospital
621 Association;

622 (3) Five appointed by the president pro tempore of the Senate, one
623 of whom shall be a member of the General Assembly, one of whom
624 shall be a representative of the home health care industry, one of
625 whom shall be a primary care medical home provider, one of whom
626 shall be an advocate for Department of Children and Families foster
627 families and one of whom shall be a representative of the business
628 community with experience in cost efficiency management;

629 (4) Three appointed by the majority leader of the House of
630 Representatives, one of whom shall be an advocate for persons with
631 substance abuse disabilities, one of whom shall be a Medicaid dental
632 provider and one of whom shall be a representative of the for-profit
633 nursing home industry;

634 (5) Three appointed by the majority leader of the Senate, one of
635 whom shall be a representative of school-based health centers, one of
636 whom shall be a recipient of benefits under the HUSKY Health
637 program and one of whom shall be a physician who serves Medicaid
638 clients;

639 (6) Three appointed by the minority leader of the House of
640 Representatives, one of whom shall be an advocate for persons with
641 disabilities, one of whom shall be a dually eligible Medicaid-Medicare
642 beneficiary or an advocate for such a beneficiary and one of whom
643 shall be a representative of the not-for-profit nursing home industry;

644 (7) Three appointed by the minority leader of the Senate, one of
645 whom shall be a low-income adult recipient of Medicaid benefits or an
646 advocate for such a recipient, one of whom shall be a representative of
647 hospitals and one of whom shall be a representative of the business
648 community with experience in cost efficiency management;

649 (8) The executive director of the Commission on Aging, or the
650 executive director's designee;

651 (9) The executive director of the Commission on Children, or the
652 executive director's designee;

653 (10) A representative of the Long-Term Care Advisory Council;

654 (11) The Commissioners of Social Services, Children and Families,
655 Public Health, Developmental Services and Mental Health and
656 Addiction Services, and the Commissioner on Aging, or their
657 designees, who shall be ex-officio nonvoting members;

658 (12) The Comptroller, or the Comptroller's designee, who shall be an
659 ex-officio nonvoting member;

660 (13) The Secretary of the Office of Policy and Management, or the
661 secretary's designee, who shall be an ex-officio nonvoting member; and

662 (14) One representative of an administrative services organization
663 which contracts with the Department of Social Services in the
664 administration of the Medicaid program, who shall be a nonvoting
665 member.

666 (d) The council shall choose a chairperson from among its members.
667 The Joint Committee on Legislative Management shall provide
668 administrative support to such chairperson.

669 (e) The council shall monitor and make recommendations
670 concerning: (1) An enrollment process that ensures access for each
671 Department of Social Services administered health care program and
672 effective outreach and client education for such programs; (2) available

673 services comparable to those already in the Medicaid state plan,
674 including those guaranteed under the federal Early and Periodic
675 Screening, Diagnostic and Treatment Services Program under 42 USC
676 1396d; (3) the sufficiency of accessible adult and child primary care
677 providers, specialty providers and hospitals in Medicaid provider
678 networks; (4) the sufficiency of provider rates to maintain the Medicaid
679 network of providers and service access; (5) funding and agency
680 personnel resources to guarantee timely access to services and effective
681 management of the Medicaid program; (6) participation in care
682 management programs including, but not limited to, medical home
683 and health home models by existing community Medicaid providers;
684 (7) the linguistic and cultural competency of providers and other
685 program facilitators and data on the provision of Medicaid linguistic
686 translation services; (8) program quality, including outcome measures
687 and continuous quality improvement initiatives that may include
688 provider quality performance incentives and performance targets for
689 administrative services organizations; (9) timely, accessible and
690 effective client grievance procedures; (10) coordination of the Medicaid
691 care management programs with state and federal health care reforms;
692 (11) eligibility levels for inclusion in the programs; (12) enrollee cost-
693 sharing provisions; (13) a benefit package for each of the health care
694 programs set forth in subsection (a) of this section; (14) coordination of
695 coverage continuity among Medicaid programs and integration of
696 care, including, but not limited to, behavioral health, dental and
697 pharmacy care provided through programs administered by the
698 Department of Social Services; and (15) the need for program quality
699 studies within the areas identified in this section and the department's
700 application for available grant funds for such studies. The chairperson
701 of the council shall ensure that sufficient members of the council
702 participate in the review of any contract entered into by the
703 Department of Social Services and an administrative services
704 organization.

705 (f) The Commissioner of Social Services may, in consultation with
706 an educational institution, apply for any available funding, including
707 federal funding, to support Medicaid care management programs.

708 (g) The Commissioner of Social Services shall provide monthly
709 reports to the council on the matters described in subsection (e) of this
710 section, including, but not limited to, policy changes and proposed
711 regulations that affect Medicaid health services. The commissioner
712 shall also provide the council with quarterly financial reports for each
713 covered Medicaid population which reports shall include a breakdown
714 of sums expended for each covered population.

715 (h) There is established, within the Council on Medical Assistance
716 Program Oversight, a standing subcommittee to study and make
717 annual recommendations to the council on evidence-based best
718 practices concerning Medicaid cost savings. The subcommittee shall
719 file its first report to the council not later than January 1, 2015. The
720 subcommittee shall consist of the following members, whose work on
721 the council shall consist solely of work on the subcommittee:

722 (1) One appointed by the speaker of the House of Representatives,
723 who shall be a member of the Connecticut Hospital Association;

724 (2) One appointed by the president pro tempore of the Senate, who
725 shall be a representative of the business community with experience in
726 cost efficiency management;

727 (3) One appointed by the majority leader of the House of
728 Representatives, who shall be a representative of the for-profit nursing
729 home industry;

730 (4) One appointed by the majority leader of the Senate, who shall be
731 a physician who serves Medicaid clients;

732 (5) One appointed by the minority leader of the House of
733 Representatives, who shall be a representative of the not-for-profit
734 nursing home industry; and

735 (6) One appointed by the minority leader of the Senate, who shall be
736 a representative of the business community with experience in cost
737 efficiency management.

738 (i) The subcommittee established pursuant to subsection (h) of this
739 section shall choose chairpersons from among its members.

740 (j) The council shall biannually report on its activities and progress
741 to the General Assembly.

742 Sec. 17. Subsection (a) of section 17b-261 of the general statutes is
743 repealed and the following is substituted in lieu thereof (*Effective from*
744 *passage*):

745 (a) Medical assistance shall be provided for any otherwise eligible
746 person whose income, including any available support from legally
747 liable relatives and the income of the person's spouse or dependent
748 child, is not more than one hundred forty-three per cent, pending
749 approval of a federal waiver applied for pursuant to subsection (e) of
750 this section, of the benefit amount paid to a person with no income
751 under the temporary family assistance program in the appropriate
752 region of residence and if such person is an institutionalized
753 individual as defined in Section 1917 of the Social Security Act, 42 USC
754 1396p(h)(3), and has not made an assignment or transfer or other
755 disposition of property for less than fair market value for the purpose
756 of establishing eligibility for benefits or assistance under this section.
757 Any such disposition shall be treated in accordance with Section
758 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
759 property made on behalf of an applicant or recipient or the spouse of
760 an applicant or recipient by a guardian, conservator, person
761 authorized to make such disposition pursuant to a power of attorney
762 or other person so authorized by law shall be attributed to such
763 applicant, recipient or spouse. A disposition of property ordered by a
764 court shall be evaluated in accordance with the standards applied to
765 any other such disposition for the purpose of determining eligibility.
766 The commissioner shall establish the standards for eligibility for
767 medical assistance at one hundred forty-three per cent of the benefit
768 amount paid to a [family unit] household of equal size with no income
769 under the temporary family assistance program in the appropriate
770 region of residence. In determining eligibility, the commissioner shall

771 not consider as income Aid and Attendance pension benefits granted
772 to a veteran, as defined in section 27-103, or the surviving spouse of
773 such veteran. Except as provided in [section] sections 17b-277 and 17b-
774 292, as amended by this act, the medical assistance program shall
775 provide coverage to persons under the age of nineteen with [family]
776 household income up to one hundred [eighty-five] ninety-six per cent
777 of the federal poverty level without an asset limit and to persons under
778 the age of nineteen and their parents and needy caretaker relatives,
779 who qualify for coverage under Section 1931 of the Social Security Act,
780 with [family] household income up to one hundred [eighty-five]
781 ninety-six per cent of the federal poverty level without an asset limit.
782 Such levels shall be based on the regional differences in such benefit
783 amount, if applicable, unless such levels based on regional differences
784 are not in conformance with federal law. Any income in excess of the
785 applicable amounts shall be applied as may be required by said federal
786 law, and assistance shall be granted for the balance of the cost of
787 authorized medical assistance. The Commissioner of Social Services
788 shall provide applicants for assistance under this section, at the time of
789 application, with a written statement advising them of (1) the effect of
790 an assignment or transfer or other disposition of property on eligibility
791 for benefits or assistance, (2) the effect that having income that exceeds
792 the limits prescribed in this subsection will have with respect to
793 program eligibility, and (3) the availability of, and eligibility for,
794 services provided by the Nurturing Families Network established
795 pursuant to section 17b-751b. For coverage dates on or after January 1,
796 2014, the department shall use the modified adjusted gross income
797 financial eligibility rules set forth in section 1902(e)(14) of the Social
798 Security Act and the implementing regulations to determine eligibility
799 for HUSKY A, HUSKY B and HUSKY D applicants, as defined in
800 section 17b-290, as amended by this act. Persons who are determined
801 ineligible for assistance pursuant to this section shall be provided a
802 written statement notifying such persons of their ineligibility and
803 advising such persons of [the availability of HUSKY Plan, Part B health
804 insurance benefits] their potential eligibility for one of the other
805 insurance affordability programs as defined in 42 CFR 435.4.

806 Sec. 18. Section 17b-261e of the general statutes is repealed and the
807 following is substituted in lieu thereof (*Effective from passage*):

808 The Commissioner of Social Services shall provide coverage for
809 isolation care and emergency services provided by the state's mobile
810 field hospital to persons participating in the HUSKY [Plan Part A and
811 Part B and fee for services Medicaid programs] Health program under
812 this chapter.

813 Sec. 19. Section 17b-261h of the general statutes is repealed and the
814 following is substituted in lieu thereof (*Effective from passage*):

815 (a) The Commissioner of Social Services shall, if required, seek a
816 waiver from federal law for the purpose of enhancing the enrollment
817 of HUSKY [Plan, Part] A recipients, as defined in subdivision (13) of
818 section 17b-290, as amended by this act, in available employer-
819 sponsored private health insurance. Such a waiver shall include, but
820 shall not be limited to, provisions that: (1) Require the enrollment of
821 HUSKY [Plan, Part] A parents, needy caretaker relatives and
822 dependents in any available employer-sponsored health insurance to
823 the maximum extent of available coverage as a condition of eligibility
824 when determined to be cost effective by the Department of Social
825 Services; (2) require a subsidy to be paid directly to [the HUSKY Plan,
826 Part] the HUSKY A caretaker [relative] relatives in an amount equal to
827 the premium payment requirements of any available employer-
828 sponsored health insurance paid by way of payroll deduction; and (3)
829 assure HUSKY [Plan, Part] A coverage requirements for medical
830 assistance not covered by any available employer-sponsored health
831 insurance.

832 (b) Notwithstanding any provision of the general statutes or any
833 provision established in a contract between an employer and a health
834 insurance carrier, no HUSKY [Plan, Part] A recipient, required to
835 enroll in available employer-sponsored health insurance under this
836 section, shall be prohibited from enrollment in employer-sponsored
837 health insurance due to limitations on enrollment of employees in
838 employer-sponsored health insurance to open enrollment periods.

839 (c) The Commissioner of Social Services, pursuant to section 17b-10,
840 may implement policies and procedures necessary to administer the
841 provisions of this section while in the process of adopting such policies
842 and procedures as regulation, provided the commissioner [prints]
843 publishes notice of the intent to adopt the regulation [in the
844 Connecticut Law Journal] on the department's Internet web site and
845 the eRegulations System not later than twenty days after the date of
846 implementation. Policies and procedures implemented pursuant to
847 this section shall be valid until the time final regulations are adopted.

848 Sec. 20. Section 17b-290 of the general statutes is repealed and the
849 following is substituted in lieu thereof (*Effective from passage*):

850 As used in [sections 17b-289 to 17b-303, inclusive, and section 16 of
851 public act 97-1 of the October 29 special session] this section and
852 sections 17b-292, as amended by this act, 17b-294a, as amended by this
853 act, 17b-295, as amended by this act, 17b-297a, as amended by this act,
854 17b-297b, as amended by this act, and 17b-300, as amended by this act:

855 (1) "Applicant" means an individual over the age of eighteen years
856 who is a natural or adoptive parent or a legal guardian; a caretaker
857 relative, foster parent or stepparent with whom the child resides [; or a
858 noncustodial parent under order of a court or family support
859 magistrate to provide health insurance, who applies for coverage
860 under the HUSKY Plan, Part B on behalf of a child] and shall include a
861 child who is eighteen years of age or emancipated in accordance with
862 the provisions of sections 46b-150 to 46b-150e, inclusive, and who is
863 applying on his own behalf or on behalf of a minor dependent for
864 coverage under such plan;

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

866 (3) "Coinsurance" means the sharing of health care expenses by the
867 insured and an insurer in a specified ratio;

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

869 (5) "Copayment" means a payment made on behalf of [an enrollee] a

870 member for a specified service under [the HUSKY Plan, Part] HUSKY
871 B;

872 (6) "Cost sharing" means arrangements made on behalf of [an
873 enrollee] a member whereby an applicant pays a portion of the cost of
874 health services, sharing costs with the state and includes copayments,
875 premiums, deductibles and coinsurance;

876 (7) "Deductible" means the amount of out-of-pocket expenses that
877 would be paid for health services on behalf of [an enrollee] a member
878 before becoming payable by the insurer;

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

880 (9) "Durable medical equipment" means [durable medical
881 equipment, as defined in Section 1395x(n) of the Social Security Act;]
882 equipment that meets all of the following requirements:

883 (A) Can withstand repeated use;

884 (B) Is primarily and customarily used to serve a medical purpose;

885 (C) Generally is not useful to a person in the absence of an illness or
886 injury; and

887 (D) Is nondisposable;

888 (10) "Eligible beneficiary" means a child who meets the
889 requirements [specified] in section 17b-292, as amended by this act,
890 [except a child excluded under the provisions of Subtitle J of Public
891 Law 105-33 or a child of any municipal employee eligible for
892 employer-sponsored insurance on or after October 30, 1997, provided a
893 child of such a municipal employee may be eligible for coverage under
894 the HUSKY Plan, Part B if dependent coverage was terminated due to
895 an extreme economic hardship on the part of the employee, as
896 determined by the commissioner] and the requirements specified in
897 Section 2110(b)(2)(B) of the Social Security Act as amended by Section
898 10203(b)(2)(D) of the Affordable Care Act;

899 [(11) "Enrollee" means an eligible beneficiary who receives services
900 under the HUSKY Plan, Part B;

901 (12) "Family" means any combination of the following: (A) An
902 individual; (B) the individual's spouse; (C) any child of the individual
903 or such spouse; or (D) the legal guardian of any such child if the
904 guardian resides with the child;]

905 (11) "Household" has the same meaning as provided in 42 CFR
906 435.603;

907 (12) "Household income" has the same meaning as provided in 42
908 CFR 435.603;

909 (13) ["HUSKY Plan, Part A"] "HUSKY A" means [assistance]
910 Medicaid provided to children, caretaker relatives and pregnant and
911 postpartum women pursuant to section 17b-261, as amended by this
912 act, or 17b-277;

913 (14) ["HUSKY Plan, Part B"] "HUSKY B" means the health [insurance
914 plan] coverage for children established pursuant to the provisions of
915 sections [17b-289 to 17b-303, inclusive, and section 16 of public act 97-1
916 of the October 29 special session;] 17b-290, as amended by this act, 17b-
917 292, as amended by this act, 17b-294a, as amended by this act, 17b-295,
918 as amended by this act, 17b-297a, as amended by this act, 17b-297b, as
919 amended by this act, and 17b-300, as amended by this act;

920 (15) "HUSKY C" means Medicaid provided to individuals who are
921 sixty-five years of age or older or who are blind or have a disability;

922 (16) "HUSKY D" or "Medicaid Coverage for the Lowest Income
923 Populations program" means Medicaid provided to nonpregnant low-
924 income adults who are age eighteen to sixty-four, as authorized
925 pursuant to section 17b-8a;

926 (17) "HUSKY Health" means the combined HUSKY A, HUSKY B,
927 HUSKY C and HUSKY D programs, that provide medical coverage to
928 eligible children, parents, relative caregivers, persons age sixty-five or

929 older, individuals with disabilities, low-income adults, and pregnant
930 women;

931 [(15) "HUSKY Plus programs"] (18) "HUSKY Plus" means [two] the
932 supplemental health [insurance programs] program established
933 pursuant to section 17b-294a, as amended by this act, for medically
934 eligible [enrollees of the HUSKY Plan, Part] members of HUSKY B
935 whose medical needs cannot be accommodated within the basic
936 benefit package offered to [enrollees. One program] members. HUSKY
937 Plus shall supplement coverage for those medically eligible [enrollees]
938 members with intensive physical health needs; [and the other program
939 shall supplement coverage for those medically eligible enrollees with
940 intensive behavioral health needs;]

941 [(16) "Income" means income as calculated in the same manner as
942 under the Medicaid program pursuant to section 17b-261;]

943 (19) "Member" means an eligible beneficiary who receives services
944 under HUSKY A, B, C or D;

945 [(17)] (20) "Parent" means a natural parent, stepparent, adoptive
946 parent, guardian or custodian of a child;

947 [(18)] (21) "Premium" means any required payment made by an
948 individual to offset or pay in full the cost under [the HUSKY Plan,
949 Part] HUSKY B;

950 [(19) "Preventive care and services" means: (A) Child preventive
951 care, including periodic and interperiodic well-child visits, routine
952 immunizations, health screenings and routine laboratory tests; (B)
953 prenatal care, including care of all complications of pregnancy; (C) care
954 of newborn infants, including attendance at high-risk deliveries and
955 normal newborn care; (D) WIC evaluations; (E) child abuse assessment
956 required under sections 17a-106a and 46b-129a; (F) preventive dental
957 care for children; and (G) periodicity schedules and reporting based on
958 the standards specified by the American Academy of Pediatrics;

959 (20) "Primary and preventive health care services" means the

960 services of licensed physicians, optometrists, nurses, nurse
961 practitioners, midwives and other related health care professionals
962 which are provided on an outpatient basis, including routine well-
963 child visits, diagnosis and treatment of illness and injury, laboratory
964 tests, diagnostic x-rays, prescription drugs, radiation therapy,
965 chemotherapy, hemodialysis, emergency room services, and outpatient
966 alcohol and substance abuse services, as defined by the commissioner;]

967 [(21)] (22) "Qualified entity" means any entity: (A) Eligible for
968 payments under a state plan approved under Medicaid and which
969 provides medical services under [the HUSKY Plan, Part] HUSKY A, or
970 (B) that is a qualified entity, as defined in 42 USC 1396r-1a, as amended
971 by Section 708 of Public Law 106-554, and that is determined by the
972 commissioner to be capable of making the determination of eligibility.
973 The commissioner shall provide qualified entities with such forms [as
974 are] or information on filing an application electronically as is
975 necessary for an application to be made on behalf of a child under [the
976 HUSKY Plan, Part] HUSKY A and information on how to assist
977 parents, guardians and other persons in completing and filing such
978 forms or electronic application;

979 [(22)] (23) "WIC" means the federal Special Supplemental Food
980 Program for Women, Infants and Children administered by the
981 Department of Public Health pursuant to section 19a-59c.

982 Sec. 21. Section 17b-261j of the general statutes is repealed and the
983 following is substituted in lieu thereof (*Effective from passage*):

984 The Commissioner of Social Services may require utilization of the
985 Easy Breathing model in the HUSKY Health program.

986 Sec. 22. Section 17b-261m of the general statutes is repealed and the
987 following is substituted in lieu thereof (*Effective from passage*):

988 (a) The Commissioner of Social Services may contract with one or
989 more administrative services organizations to provide care
990 coordination, utilization management, disease management, customer

991 service and review of grievances for recipients of assistance under
992 [Medicaid and HUSKY Plan, Parts A and B] the HUSKY Health
993 program. Such organization may also provide network management,
994 credentialing of providers, monitoring of copayments and premiums
995 and other services as required by the commissioner. Subject to
996 approval by applicable federal authority, the Department of Social
997 Services shall utilize the contracted organization's provider network
998 and billing systems in the administration of the program. In order to
999 implement the provisions of this section, the commissioner may
1000 establish rates of payment to providers of medical services under this
1001 section if the establishment of such rates is required to ensure that any
1002 contract entered into with an administrative services organization
1003 pursuant to this section is cost neutral to such providers in the
1004 aggregate and ensures patient access. Utilization may be a factor in
1005 determining cost neutrality.

1006 (b) Any contract entered into with an administrative services
1007 organization, pursuant to subsection (a) of this section, shall include a
1008 provision to reduce inappropriate use of hospital emergency
1009 department services. Such provision may include intensive case
1010 management services and a cost-sharing requirement.

1011 Sec. 23. Section 17b-261m of the general statutes, as amended by
1012 section 1 of public act 14-62, is repealed and the following is
1013 substituted in lieu thereof (*Effective July 1, 2016*):

1014 (a) The Commissioner of Social Services may contract with one or
1015 more administrative services organizations to provide care
1016 coordination, utilization management, disease management, customer
1017 service and review of grievances for recipients of assistance under
1018 [Medicaid and HUSKY Plan, Parts A and B] the HUSKY Health
1019 program. Such organization may also provide network management,
1020 credentialing of providers, monitoring of copayments and premiums
1021 and other services as required by the commissioner. Subject to
1022 approval by applicable federal authority, the Department of Social
1023 Services shall utilize the contracted organization's provider network

1024 and billing systems in the administration of the program. In order to
1025 implement the provisions of this section, the commissioner may
1026 establish rates of payment to providers of medical services under this
1027 section if the establishment of such rates is required to ensure that any
1028 contract entered into with an administrative services organization
1029 pursuant to this section is cost neutral to such providers in the
1030 aggregate and ensures patient access. Utilization may be a factor in
1031 determining cost neutrality.

1032 (b) Any contract entered into with an administrative services
1033 organization, pursuant to subsection (a) of this section, shall include a
1034 provision to reduce inappropriate use of hospital emergency
1035 department services, which may include a cost-sharing requirement.
1036 Such provision shall require intensive case management services,
1037 including, but not limited to: (1) The identification by the
1038 administrative services organization of hospital emergency
1039 departments which may benefit from intensive case management
1040 based on the number of Medicaid clients who are frequent users of
1041 such emergency departments; (2) the creation of regional intensive
1042 case management teams to work with emergency department doctors
1043 to (A) identify Medicaid clients who would benefit from intensive case
1044 management, (B) create care plans for such Medicaid clients, and (C)
1045 monitor progress of such Medicaid clients; and (3) the assignment of at
1046 least one staff member from a regional intensive case management
1047 team to participating hospital emergency departments during hours
1048 when Medicaid clients who are frequent users visit the most and
1049 emergency department use is at its highest. For purposes of this
1050 section and sections 17a-22f, as amended by this act, and 17a-476,
1051 "frequent users" means a Medicaid client with ten or more annual
1052 visits to a hospital emergency department.

1053 (c) The commissioner shall ensure that any contracts entered into
1054 with an administrative services organization include a provision
1055 requiring such administrative services organization to (1) conduct
1056 assessments of primary care doctors and specialists to determine
1057 patient ease of access to services, including, but not limited to, the wait

1058 times for appointments and whether the provider is accepting new
1059 Medicaid clients, and (2) perform outreach to Medicaid clients to (A)
1060 inform them of the advantages of receiving care from a primary care
1061 provider, (B) help to connect such clients with primary care providers
1062 soon after they are enrolled in Medicaid, and (C) for frequent users of
1063 emergency departments, help to arrange visits by Medicaid clients
1064 with primary care providers after such clients are treated at an
1065 emergency department.

1066 (d) The Commissioner of Social Services shall require an
1067 administrative services organization with access to complete client
1068 claim adjudicated history to analyze and annually report, not later
1069 than February first, to the Department of Social Services and the
1070 Council on Medical Assistance Program Oversight, on Medicaid
1071 clients' use of hospital emergency departments. The report shall
1072 include, but not be limited to: (1) A breakdown of the number of
1073 unduplicated clients who visited an emergency department, and (2) for
1074 frequent users of emergency departments, (A) the number of visits
1075 categorized into specific ranges as determined by the Department of
1076 Social Services, (B) the time and day of the visit, (C) the reason for the
1077 visit, (D) whether hospital records indicate such user has a primary
1078 care provider, (E) whether such user had an appointment with a
1079 community provider after the date of the hospital emergency
1080 department visit, and (F) the cost of the visit to the hospital and to the
1081 state Medicaid program. The Department of Social Services shall
1082 monitor its reporting requirements for administrative services
1083 organizations to ensure all contractually obligated reports, including
1084 any emergency department provider analysis reports, are completed
1085 and disseminated as required by contract.

1086 (e) The Commissioner of Social Services shall use the report
1087 required pursuant to subsection (d) of this section to monitor the
1088 performance of an administrative services organization. Performance
1089 measures monitored by the commissioner shall include, but not be
1090 limited to, whether the administrative services organization helps to
1091 arrange visits by frequent users of emergency departments to primary

1092 care providers after treatment at an emergency department.

1093 Sec. 24. Section 17b-278d of the general statutes is repealed and the
1094 following is substituted in lieu thereof (*Effective from passage*):

1095 The Commissioner of Social Services, to the extent permitted by
1096 federal law, shall take such action as may be necessary to amend the
1097 Medicaid state plan and the state children's health insurance plan to
1098 provide coverage without prior authorization for each child diagnosed
1099 with cancer on or after January 1, 2000, who is covered under the
1100 HUSKY [Plan, Part A or Part B] Health program, for
1101 neuropsychological testing ordered by a licensed physician, to assess
1102 the extent of any cognitive or developmental delays in such child due
1103 to chemotherapy or radiation treatment.

1104 Sec. 25. Section 17b-292 of the general statutes is repealed and the
1105 following is substituted in lieu thereof (*Effective from passage*):

1106 (a) A child who resides in a household with [a family] household
1107 income which exceeds one hundred [eighty-five] ninety-six per cent of
1108 the federal poverty level and does not exceed three hundred eighteen
1109 per cent of the federal poverty level may be eligible for subsidized
1110 benefits under [the HUSKY Plan, Part] HUSKY B.

1111 (b) A child who resides in a household with [a family] household
1112 income over three hundred eighteen per cent of the federal poverty
1113 level may be eligible for unsubsidized benefits under [the HUSKY
1114 Plan, Part] HUSKY B.

1115 (c) Whenever a court or family support magistrate orders a
1116 noncustodial parent to provide health insurance for a child, such
1117 parent may provide for coverage under [the HUSKY Plan, Part]
1118 HUSKY B.

1119 (d) To the extent allowed under federal law, the commissioner shall
1120 not pay for services or durable medical equipment under [the HUSKY
1121 Plan, Part B if the enrollee] HUSKY B if the member has other
1122 insurance coverage for [the] such services or [such] equipment. If a

1123 HUSKY B member has limited benefit insurance coverage for services
1124 that are also covered under HUSKY B, the commissioner shall require
1125 such other coverage to pay for the goods or services prior to any
1126 payment under HUSKY B.

1127 (e) A newborn child who otherwise meets the eligibility criteria for
1128 [the HUSKY Plan, Part] HUSKY B shall be eligible for benefits
1129 retroactive to his or her date of birth, provided an application is filed
1130 on behalf of the child not later than thirty days after such date. Any
1131 uninsured child born in a hospital in this state or in a border state
1132 hospital shall be enrolled on an expedited basis in [the HUSKY Plan,
1133 Part] HUSKY B, provided (1) the parent or caretaker relative of such
1134 child resides in this state, and (2) the parent or caretaker relative of
1135 such child authorizes enrollment in the program. The commissioner
1136 shall pay any premium cost such [family] household would otherwise
1137 incur for the first four months of coverage.

1138 (f) The commissioner shall implement presumptive eligibility for
1139 children applying for Medicaid and may, if cost effective, implement
1140 presumptive eligibility for children in [families] households with
1141 income under three hundred eighteen per cent of the federal poverty
1142 level applying for [the HUSKY Plan, Part] HUSKY B. Such
1143 presumptive eligibility determinations shall be in accordance with
1144 applicable federal law and regulations. The commissioner shall adopt
1145 regulations, in accordance with chapter 54, to establish standards and
1146 procedures for the designation of [organizations as qualified entities]
1147 an organization as a qualified entity to grant presumptive eligibility.
1148 [Qualified entities shall ensure that] A qualified entity shall, at the time
1149 a presumptive eligibility determination is made, [a completed
1150 application for benefits is submitted to the department] provide
1151 assistance to applicants with the completion and submission of an
1152 application for a full eligibility determination. In establishing such
1153 standards and procedures, the commissioner shall ensure the
1154 representation of state-wide and local organizations that provide
1155 services to children of all ages in each region of the state.

1156 [(g) The commissioner shall provide for a single point of entry
1157 servicer for applicants and enrollees under the HUSKY Plan, Part A
1158 and Part B. The commissioner, in consultation with the servicer, shall
1159 establish a centralized unit to be responsible for processing all
1160 applications for assistance under the HUSKY Plan, Part A and Part B.
1161 The department, through its servicer, shall ensure that a child who is
1162 determined to be eligible for benefits under the HUSKY Plan, Part A,
1163 or the HUSKY Plan, Part B has uninterrupted health insurance
1164 coverage for as long as the parent or guardian elects to enroll or re-
1165 enroll such child in the HUSKY Plan, Part A or Part B. The
1166 commissioner, in consultation with the servicer, and in accordance
1167 with the provisions of section 17b-297, shall jointly market both Part A
1168 and Part B together as the HUSKY Plan and shall develop and
1169 implement public information and outreach activities with community
1170 programs. Such servicer shall electronically transmit data with respect
1171 to enrollment and disenrollment in the HUSKY Plan, Part A and Part B
1172 to the commissioner.

1173 (h) Upon the expiration of any contractual provisions entered into
1174 pursuant to subsection (g) of this section, the commissioner shall
1175 develop a new contract for single point of entry services. The
1176 commissioner may enter into one or more contractual arrangements
1177 for such services for a contract period not to exceed seven years. Such
1178 contracts shall include performance measures, including, but not
1179 limited to, specified time limits for the processing of applications,
1180 parameters setting forth the requirements for a completed and
1181 reviewable application and the percentage of applications forwarded
1182 to the department in a complete and timely fashion. Such contracts
1183 shall also include a process for identifying and correcting
1184 noncompliance with established performance measures, including
1185 sanctions applicable for instances of continued noncompliance with
1186 performance measures.

1187 (i) The single point of entry servicer shall send all applications and
1188 supporting documents to the commissioner for determination of
1189 eligibility. The servicer shall enroll eligible beneficiaries in the

1190 applicant's choice of an administrative services organization. If there is
1191 more than one administrative services organization, upon enrollment
1192 in an administrative services organization, an eligible HUSKY Plan,
1193 Part A or Part B beneficiary shall remain enrolled in such organization
1194 for twelve months from the date of such enrollment unless (1) an
1195 eligible beneficiary demonstrates good cause to the satisfaction of the
1196 commissioner of the need to enroll in a different organization, or (2)
1197 the beneficiary no longer meets program eligibility requirements.

1198 (j) Not later than ten months after the determination of eligibility for
1199 benefits under the HUSKY Plan, Part A and Part B and annually
1200 thereafter, the commissioner or the servicer, as the case may be, shall,
1201 within existing budgetary resources, mail or, upon request of a
1202 participant, electronically transmit an application form to each
1203 participant in the plan for the purposes of obtaining information to
1204 make a determination on continued eligibility beyond the twelve
1205 months of initial eligibility. To the extent permitted by federal law, in
1206 determining eligibility for benefits under the HUSKY Plan, Part A or
1207 Part B with respect to family income, the commissioner or the servicer
1208 shall rely upon information provided in such form by the participant
1209 unless the commissioner or the servicer has reason to believe that such
1210 information is inaccurate or incomplete. The Department of Social
1211 Services shall annually review a random sample of cases to confirm
1212 that, based on the statistical sample, relying on such information is not
1213 resulting in ineligible clients receiving benefits under the HUSKY Plan,
1214 Part A or Part B. The determination of eligibility shall be coordinated
1215 with health plan open enrollment periods.]

1216 (g) In accordance with 42 CFR 435.1110, the commissioner shall
1217 provide Medicaid during a presumptive eligibility period to
1218 individuals who are determined presumptively eligible by a qualified
1219 hospital. A hospital making such a presumptive eligibility
1220 determination shall provide assistance to individuals in completing
1221 and submitting an application for full Medicaid benefits.

1222 [(k)] (h) The commissioner shall implement [the HUSKY Plan, Part]

1223 HUSKY B while in the process of adopting necessary policies and
1224 procedures in regulation form in accordance with the provisions of
1225 section 17b-10.

1226 [(l) The commissioner shall adopt regulations, in accordance with
1227 chapter 54, to establish residency requirements and income eligibility
1228 for participation in the HUSKY Plan, Part B and procedures for a
1229 simplified mail-in application process. Notwithstanding the provisions
1230 of section 17b-257b, such regulations shall provide that any child
1231 adopted from another country by an individual who is a citizen of the
1232 United States and a resident of this state shall be eligible for benefits
1233 under the HUSKY Plan, Part B upon arrival in this state.]

1234 Sec. 26. Section 17b-294a of the general statutes is repealed and the
1235 following is substituted in lieu thereof (*Effective from passage*):

1236 (a) The commissioner shall, within available appropriations,
1237 establish [two] a supplemental health [insurance programs,] program
1238 to be known as HUSKY Plus [programs, for enrollees of the subsidized
1239 portion of the HUSKY Plan, Part B with family incomes which do not
1240 exceed three hundred per cent of the federal poverty level,] for
1241 members of the subsidized portions of HUSKY B whose medical needs
1242 cannot be accommodated within the basic benefit package offered
1243 [enrollees. One program] to members. The HUSKY Plus program shall
1244 supplement coverage for those medically eligible [enrollees] members
1245 with intensive physical health needs. [and one shall supplement
1246 coverage for those medically eligible enrollees with intensive
1247 behavioral health needs.]

1248 (b) Within available appropriations, the commissioner shall contract
1249 with entities to administer and operate the HUSKY Plus program. [for
1250 medically eligible enrollees with intensive physical health needs.] Such
1251 entities shall be the same entities that the Department of Public Health
1252 contracts with to administer and operate the program under Title V of
1253 the Social Security Act. The advisory committee established by the
1254 Department of Public Health for Title V of the Social Security Act shall
1255 be the steering committee for such program, except that such

1256 committee shall include representatives of the Departments of Social
1257 Services and Children and Families.

1258 [(c) Within available appropriations, the commissioner shall
1259 contract with one or more entities to operate the HUSKY Plus program
1260 for medically eligible enrollees with intensive behavioral health needs.
1261 The steering committee for such program shall be established by the
1262 commissioner, in consultation with the Commissioner of Children and
1263 Families. The steering committee shall include representatives of the
1264 Departments of Social Services and Children and Families.]

1265 [(d)] (c) The acuity standards or diagnostic eligibility criteria, or
1266 both, the service benefits package and the provider network for the
1267 HUSKY Plus program [for intensive physical health needs] shall be
1268 consistent with that of Title V of the Social Security Act. Such service
1269 benefit package shall include powered wheelchairs.

1270 [(e) The steering committee for intensive behavioral health needs
1271 shall submit recommendations to the commissioner for acuity
1272 standards or diagnostic eligibility criteria, or both, for admission to the
1273 program for intensive behavioral health needs as well as a service
1274 benefits package. The criteria shall reflect the severity of psychiatric or
1275 substance abuse symptoms, the level of functional impairment
1276 secondary to symptoms and the intensity of service needs. The
1277 network of community-based providers in the program shall include
1278 the services generally provided by child guidance clinics, family
1279 service agencies, youth service bureaus and other community-based
1280 organizations.]

1281 [(f)] (d) The commissioner shall adopt regulations, in accordance
1282 with chapter 54, to establish a procedure for the appeal of a denial of
1283 coverage under [any of] the HUSKY Plus [programs] program. Such
1284 regulations shall provide that (1) an appeal of a denial of coverage for
1285 a medically eligible [enrollee with intensive physical health needs]
1286 member shall be taken to the steering committee, [for intensive
1287 physical health needs, (2) an appeal of a denial of coverage for a
1288 medically eligible enrollee with intensive behavioral health needs shall

1289 be taken to the steering committee for intensive behavioral health
1290 needs, and (3)] and (2) a medically eligible [enrollee with intensive
1291 physical or behavioral health needs] member may appeal the decision
1292 of any such steering committee to the commissioner.

1293 [(g)] (e) The commissioner shall contract for an external quality
1294 review of the HUSKY Plus [programs] program. [Not later than
1295 January 1, 1999, and annually thereafter, the commissioner shall
1296 submit a report to the Governor and the General Assembly on the
1297 HUSKY Plus programs which shall include an evaluation of the health
1298 outcomes and access to care for medically eligible enrollees in the
1299 HUSKY Plus programs.]

1300 [(h)] (f) On and after the date on which any medically eligible
1301 [enrollee] member begins receiving benefits under the HUSKY Plus
1302 [programs] program, such [enrollee] member shall not be eligible for
1303 services under Title V of the Social Security Act.

1304 [(i) Not later than December 1, 1997, or not less than fifteen days
1305 before submission of the state children's health insurance plan to the
1306 joint standing committees of the General Assembly having cognizance
1307 of matters relating to human services, public health, insurance and
1308 appropriations and the budgets of state agencies, whichever is sooner,
1309 the commissioner shall submit to said joint standing committees of the
1310 General Assembly any part of the state children's health insurance plan
1311 that refers to the HUSKY Plus programs. Such submission shall
1312 address acuity standards and diagnostic eligibility criteria, the service
1313 benefit package and coordination between the HUSKY Plan, Part B
1314 and the HUSKY Plus programs and coordination with other state
1315 agencies. Within fifteen days of receipt of such submission, said joint
1316 standing committees of the General Assembly may advise the
1317 commissioner of their approval, denial or modifications, if any, of the
1318 submission. If the joint standing committees do not concur, the
1319 committee chairmen shall appoint a committee on conference which
1320 shall be comprised of three members from each joint standing
1321 committee. At least one member appointed from each committee shall

1322 be a member of the minority party. The report of the committee on
1323 conference shall be made to each committee, which shall vote to accept
1324 or reject the report. The report of the committee on conference may not
1325 be amended. If a joint standing committee rejects the report of the
1326 committee on conference, the submission shall be deemed approved. If
1327 the joint standing committees accept the report, the committee having
1328 cognizance of matters relating to appropriations and the budgets of
1329 state agencies shall advise the commissioner of their approval or
1330 modifications, if any, of the submission, provided if the committees do
1331 not act within fifteen days, the submission shall be deemed approved.]

1332 [(j)] (g) The commissioner shall adopt regulations, in accordance
1333 with the provisions of chapter 54, to establish criteria and specify
1334 services for the HUSKY Plus [programs] program. Such regulations
1335 shall state that the HUSKY Plus [programs] program shall give priority
1336 in such [programs to enrollees with family] program to members with
1337 household incomes at or below two hundred [thirty-five] forty-nine
1338 per cent of the federal poverty level.

1339 [(k)] (h) As used in this section, ["medically eligible enrollee"]
1340 "medically eligible member" means any [enrollee with special needs
1341 related to either physical or behavioral] member with intensive
1342 physical health needs who meets the acuity standards or diagnostic
1343 eligibility criteria adopted by the commissioner regarding the acuity,
1344 diagnosis, functional impairment and intensive service needs of the
1345 [enrollee] member.

1346 Sec. 27. Section 17b-295 of the general statutes is repealed and the
1347 following is substituted in lieu thereof (*Effective from passage*):

1348 (a) The commissioner shall impose cost-sharing requirements,
1349 including the payment of a premium or copayment, in connection with
1350 services provided under [the HUSKY Plan, Part] HUSKY B, to the
1351 extent permitted by federal law. Copayments under [the HUSKY Plan,
1352 Part] HUSKY B [,] shall be the same as those in effect for active state
1353 employees enrolled in a point-of-enrollment health care plan, provided
1354 the [family's] household's annual combined premiums and

1355 copayments do not exceed the maximum annual aggregate cost-
1356 sharing requirement. The cost-sharing requirements imposed by the
1357 commissioner shall be in accordance with the following limitations:

1358 (1) The commissioner may increase the maximum annual aggregate
1359 cost-sharing requirements, provided such cost-sharing requirements
1360 shall not exceed five per cent of the [family's] household's gross annual
1361 income.

1362 (2) In accordance with federal law, the commissioner may impose a
1363 premium requirement on [families] households whose income exceeds
1364 two hundred [thirty-five] forty-nine per cent of the federal poverty
1365 level as a component of the [family's] household's cost-sharing
1366 responsibility and, for the fiscal years ending June 30, 2012, to June 30,
1367 2016, inclusive, may annually increase the premium requirement based
1368 on the percentage increase in the Consumer Price Index for medical
1369 care services; and

1370 (3) The commissioner shall monitor copayments and premiums
1371 under the provisions of subdivision (1) of this subsection.

1372 (b) (1) Except as provided in subdivision (2) of this subsection, the
1373 commissioner may impose limitations on the amount, duration and
1374 scope of benefits under [the HUSKY Plan, Part] HUSKY B.

1375 (2) The limitations adopted by the commissioner pursuant to
1376 subdivision (1) of this subsection shall not preclude coverage of any
1377 item of durable medical equipment or service that is medically
1378 necessary.

1379 Sec. 28. Section 17b-297a of the general statutes is repealed and the
1380 following is substituted in lieu thereof (*Effective from passage*):

1381 The Commissioner of Social Services may seek a waiver, if required,
1382 under Title XXI of the Social Security Act to authorize the use of funds
1383 received under said title to promote the enrollment of children in [the
1384 HUSKY Plan] HUSKY B who are eligible for benefits under other
1385 income-based assistance programs including, but not limited to, free or

1386 reduced school lunch programs.

1387 Sec. 29. Section 17b-297b of the general statutes is repealed and the
1388 following is substituted in lieu thereof (*Effective from passage*):

1389 (a) To the extent permitted by federal law, the Commissioners of
1390 Social Services and Education, in consultation with the board of
1391 directors, shall jointly establish procedures for the sharing of
1392 information contained in applications for free and reduced price meals
1393 under the National School Lunch Program for the purpose of
1394 determining whether children participating in said program are
1395 eligible for coverage under the [SustiNet Plan or the HUSKY Plan, Part
1396 A and Part B] HUSKY Health program. The Commissioner of Social
1397 Services shall take all actions necessary to ensure that children
1398 identified as eligible for the [SustiNet Plan, or the HUSKY Plan, Part A
1399 or Part B] HUSKY Health program, are enrolled in the appropriate
1400 plan.

1401 (b) The Commissioner of Education shall establish procedures
1402 whereby an individual may apply for the [SustiNet Plan or the HUSKY
1403 Plan, Part A or Part B] HUSKY Health program, at the same time such
1404 individual applies for the National School Lunch Program.

1405 Sec. 30. Section 17b-300 of the general statutes is repealed and the
1406 following is substituted in lieu thereof (*Effective from passage*):

1407 The applicant for [an enrollee] a HUSKY B member shall notify the
1408 Department of Social Services of any change in circumstance that could
1409 affect the [enrollee's] member's continued eligibility for coverage
1410 under [the HUSKY Plan, Part] HUSKY B within thirty days of such
1411 change. [An enrollee] A member shall be disenrolled if the
1412 commissioner determines the [enrollee] member is no longer eligible
1413 for participation in such plan for reasons including, but not limited to,
1414 those specified in section 17b-301 and the nonpayment of premiums.

1415 Sec. 31. Section 17b-306 of the general statutes is repealed and the
1416 following is substituted in lieu thereof (*Effective from passage*):

1417 (a) The Commissioner of Social Services, in consultation with the
1418 Commissioner of Public Health, shall develop and within available
1419 appropriations implement a plan for a system of preventive health
1420 services for children under [the HUSKY Plan, Part A and Part B]
1421 HUSKY A and B. The goal of the system shall be to improve health
1422 outcomes for all children enrolled in the HUSKY [Plan] Health
1423 program and to reduce racial and ethnic health disparities among
1424 children. Such system shall ensure that services under the federal Early
1425 and Periodic Screening, [Diagnosis] Diagnostic and Treatment
1426 Program are provided to children enrolled in [the HUSKY Plan, Part]
1427 HUSKY A.

1428 (b) The plan shall:

1429 (1) Establish a coordinated system for preventive health services for
1430 [HUSKY Plan, Part A and Part B] HUSKY A and B beneficiaries
1431 including, but not limited to, services under the federal Early and
1432 Periodic Screening, [Diagnosis] Diagnostic and Treatment Program,
1433 ophthalmologic and optometric services, oral health care, care
1434 coordination, chronic disease management and periodicity schedules
1435 based on standards specified by the American Academy of Pediatrics;

1436 (2) Require the Department of Social Services to track the utilization
1437 of services in the system of preventive health services by [HUSKY
1438 Plan, Part A and Part B] HUSKY A and B beneficiaries to ensure that
1439 such beneficiaries receive all the services available under the system
1440 and to track the health outcomes of children; and

1441 (3) Include payment methodologies to create financial incentives
1442 and rewards for health care providers who participate and provide
1443 services in the system, such as case management fees, pay for
1444 performance, and payment for technical support and data entry
1445 associated with patient registries.

1446 [(c) The Commissioner of Social Services shall develop the plan for a
1447 system of preventive health services not later than January 1, 2008, and
1448 implement the plan not later than July 1, 2008.

1449 (d) Not later than July 1, 2009, the Commissioner of Social Services
1450 shall report, in accordance with the provisions of section 11-4a, to the
1451 joint standing committees of the General Assembly having cognizance
1452 of matters relating to human services, insurance and public health on
1453 the plan for a system of preventive health services. The report shall
1454 include information on health outcomes, quality of care and
1455 methodologies utilized in the plan to improve the quality of care and
1456 health outcomes for children.]

1457 Sec. 32. Section 17b-306a of the general statutes is repealed and the
1458 following is substituted in lieu thereof (*Effective from passage*):

1459 (a) The Commissioner of Social Services, in collaboration with the
1460 Commissioners of Public Health and Children and Families, shall
1461 establish a child health quality improvement program for the purpose
1462 of promoting the implementation of evidence-based strategies by
1463 providers participating in the HUSKY [Plan, Part A and Part B] Health
1464 program to improve the delivery of and access to children's health
1465 services. Such strategies shall focus on physical, dental and mental
1466 health services and shall include, but need not be limited to: (1)
1467 Methods for early identification of children with special health care
1468 needs; (2) integration of care coordination and care planning into
1469 children's health services; (3) implementation of standardized data
1470 collection to measure performance improvement; and (4)
1471 implementation of family-centered services in patient care, including,
1472 but not limited to, the development of parent-provider partnerships.
1473 The Commissioner of Social Services shall seek the participation of
1474 public and private entities that are dedicated to improving the delivery
1475 of health services, including medical, dental and mental health
1476 providers, academic professionals with experience in health services
1477 research and performance measurement and improvement, and any
1478 other entity deemed appropriate by the Commissioner of Social
1479 Services, to promote such strategies. The commissioner shall ensure
1480 that such strategies reflect new developments and best practices in the
1481 field of children's health services. As used in this section, "evidence-
1482 based strategies" means policies, procedures and tools that are

1483 informed by research and supported by empirical evidence, including,
1484 but not limited to, research developed by organizations such as the
1485 American Academy of Pediatrics, the American Academy of Family
1486 Physicians, the National Association of Pediatric Nurse Practitioners
1487 and the Institute of Medicine.

1488 (b) Not later than July 1, 2008, and annually thereafter, the
1489 Commissioner of Social Services shall report, in accordance with
1490 section 11-4a, to the joint standing committees of the General
1491 Assembly having cognizance of matters relating to human services,
1492 public health and appropriations, and to the Council on Medical
1493 Assistance Program Oversight on (1) the implementation of any
1494 strategies developed pursuant to subsection (a) of this section, and (2)
1495 the efficacy of such strategies in improving the delivery of and access
1496 to health services for children enrolled in the HUSKY [Plan] Health
1497 program.

1498 (c) The Commissioner of Social Services, in collaboration with the
1499 Council on Medical Assistance Program Oversight, shall, subject to
1500 available appropriations, prepare, annually, a report concerning health
1501 care choices under [the HUSKY Plan, Part] HUSKY A. Such report
1502 shall include, but not be limited to, a comparison of the performance of
1503 each managed care organization, the primary care case management
1504 program and other member service delivery choices. The
1505 commissioner shall provide a copy of each report to all HUSKY [Plan,
1506 Part] A members.

1507 Sec. 33. Section 17b-304 of the general statutes is repealed and the
1508 following is substituted in lieu thereof (*Effective from passage*):

1509 The [commissioner] Commissioner of Social Services shall
1510 implement the policies and procedures necessary to carry out the
1511 provisions of sections [17b-292 to 17b-303, inclusive, 17b-257b, 17b-261
1512 and section 16 of public act 97-1 of the October 29 special session] 17b-
1513 292, as amended by this act, 17b-294a, as amended by this act, 17b-295,
1514 as amended by this act, 17b-297a, as amended by this act, 17b-297b, as
1515 amended by this act, and 17b-300, as amended by this act, while in the

1516 process of adopting such policies and procedures in regulation form,
1517 provided notice of intent to adopt the regulations is published [in the
1518 Connecticut Law Journal within] on the Department of Social Services'
1519 Internet web site and the eRegulations System not later than twenty
1520 days after implementation. Such policies and procedures shall be valid
1521 until the time final regulations are effective.

1522 Sec. 34. Subsection (a) of section 17b-307 of the general statutes is
1523 repealed and the following is substituted in lieu thereof (*Effective from*
1524 *passage*):

1525 (a) Notwithstanding any provision of the general statutes, the
1526 Department of Social Services shall develop and implement a pilot
1527 program for the delivery of health care services through a system of
1528 primary care case management to not less than one thousand
1529 individuals who are otherwise eligible to receive HUSKY [Plan, Part]
1530 A benefits. Primary care providers participating in the primary care
1531 case management pilot program shall provide program beneficiaries
1532 with primary care medical services and arrange for specialty care as
1533 needed. For purposes of this section, "primary care case management"
1534 means a system of care in which the health care services for program
1535 beneficiaries are coordinated by a primary care provider chosen by or
1536 assigned to the beneficiary. The Commissioner of Social Services shall
1537 begin enrollment for the primary care case management system not
1538 later than April 1, 2008.

1539 Sec. 35. Subparagraph (A) of subdivision (2) of subsection (a) of
1540 section 17b-745 of the general statutes is repealed and the following is
1541 substituted in lieu thereof (*Effective from passage*):

1542 (2) (A) The court or family support magistrate shall include in each
1543 support order in a IV-D support case a provision for the health care
1544 coverage of the child. Such provision may include an order for either
1545 parent or both parents to provide such coverage under any or all of
1546 clauses (i), (ii) or (iii) of this subparagraph.

1547 (i) The provision for health care coverage may include an order for

1548 either parent to name any child as a beneficiary of any medical or
1549 dental insurance or benefit plan carried by such parent or available to
1550 such parent at a reasonable cost, as described in clause (iv) of this
1551 subparagraph. If such order requires the parent to maintain insurance
1552 available through an employer, the order shall be enforced using a
1553 National Medical Support Notice as provided in section 46b-88.

1554 (ii) The provision for health care coverage may include an order for
1555 either parent to: (I) Apply for and maintain coverage on behalf of the
1556 child under [the HUSKY Plan, Part] HUSKY B; or (II) provide cash
1557 medical support, as described in clauses (v) and (vi) of this
1558 subparagraph. An order under this clause shall be made only if the
1559 cost to the parent obligated to maintain coverage under [the HUSKY
1560 Plan, Part] HUSKY B, or provide cash medical support is reasonable as
1561 described in clause (iv) of this subparagraph. An order under
1562 subclause (I) of this clause shall be made only if insurance coverage as
1563 described in clause (i) of this subparagraph is unavailable at
1564 reasonable cost to either parent, or inaccessible to the child.

1565 (iii) An order for payment of the child's medical and dental
1566 expenses, other than those described in subclause (II) of clause (v) of
1567 this subparagraph, that are not covered by insurance or reimbursed in
1568 any other manner shall be entered in accordance with the child
1569 support guidelines established pursuant to section 46b-215a.

1570 (iv) Health care coverage shall be deemed reasonable in cost if: (I)
1571 The parent obligated to maintain such coverage would qualify as a
1572 low-income obligor under the child support guidelines established
1573 pursuant to section 46b-215a, based solely on such parent's income,
1574 and the cost does not exceed five per cent of such parent's net income;
1575 or (II) the parent obligated to maintain such coverage would not
1576 qualify as a low-income obligor under such guidelines and the cost
1577 does not exceed seven and one-half per cent of such parent's net
1578 income. In either case, net income shall be determined in accordance
1579 with the child support guidelines established pursuant to section 46b-
1580 215a. If a parent obligated to maintain insurance must obtain coverage

1581 for himself or herself to comply with the order to provide coverage for
1582 the child, reasonable cost shall be determined based on the combined
1583 cost of coverage for such parent and such child.

1584 (v) Cash medical support means: (I) An amount ordered to be paid
1585 toward the cost of premiums for health insurance coverage provided
1586 by a public entity, including [the HUSKY Plan, Part A or Part B]
1587 HUSKY A or B, except as provided in clause (vi) of this subparagraph,
1588 or by another parent through employment or otherwise, or (II) an
1589 amount ordered to be paid, either directly to a medical provider or to
1590 the person obligated to pay such provider, toward any ongoing
1591 extraordinary medical and dental expenses of the child that are not
1592 covered by insurance or reimbursed in any other manner, provided
1593 such expenses are documented and identified specifically on the
1594 record. Cash medical support, as described in subclauses (I) and (II) of
1595 this clause, may be ordered in lieu of an order under clause (i) of this
1596 subparagraph to be effective until such time as health insurance that is
1597 accessible to the child and reasonable in cost becomes available, or in
1598 addition to an order under clause (i) of this subparagraph, provided
1599 the total cost to the obligated parent of insurance and cash medical
1600 support is reasonable, as described in clause (iv) of this subparagraph.
1601 An order for cash medical support shall be payable to the state or the
1602 custodial party, as their interests may appear, provided an order under
1603 subclause (I) of this clause shall be effective only as long as health
1604 insurance coverage is maintained. Any unreimbursed medical and
1605 dental expenses not covered by an order issued pursuant to subclause
1606 (II) of this clause are subject to an order for unreimbursed medical and
1607 dental expenses pursuant to clause (iii) of this subparagraph.

1608 (vi) Cash medical support to offset the cost of any insurance payable
1609 under [the HUSKY Plan, Part A or Part B] HUSKY A or B, shall not be
1610 ordered against a noncustodial parent who is a low-income obligor, as
1611 defined in the child support guidelines established pursuant to section
1612 46b-215a, or against a custodial parent of children covered under [the
1613 HUSKY Plan, Part A or Part B] HUSKY A or B.

1614 Sec. 36. Section 19a-45a of the general statutes is repealed and the
1615 following is substituted in lieu thereof (*Effective from passage*):

1616 The Commissioners of Social Services and Public Health shall enter
1617 into a memorandum of understanding for the purpose of improving
1618 public health service delivery and public health outcomes for low
1619 income populations through the sharing of available [Medicaid,
1620 HUSKY Plus, HUSKY Plan Part B,] HUSKY Health program and Title
1621 V data, provided the sharing of such data: (1) Is directly related to the
1622 administration of the Medicaid state plan or any other applicable state
1623 plan administered by the Department of Social Services or the
1624 Department of Public Health; (2) is in accordance with federal and
1625 state law and regulations concerning the privacy, security,
1626 confidentiality and safeguarding of individually identifiable
1627 information contained in such data; (3) includes a detailed description
1628 of the intended public health service delivery and public health
1629 outcome goals that are achieved by the sharing of such data; and (4)
1630 the costs of compiling and transmitting any such data can be
1631 accomplished within the available resources of the Departments of
1632 Social Services and Public Health.

1633 Sec. 37. Subdivision (6) of section 19a-659 of the general statutes is
1634 repealed and the following is substituted in lieu thereof (*Effective from*
1635 *passage*):

1636 (6) "Medical assistance" means (A) the programs for medical
1637 assistance provided under the Medicaid program, including [the
1638 HUSKY Plan, Part] HUSKY A, or (B) any other state-funded medical
1639 assistance program, including [the HUSKY Plan, Part] HUSKY B;

1640 Sec. 38. Section 22-380e of the general statutes is repealed and the
1641 following is substituted in lieu thereof (*Effective from passage*):

1642 As used in sections 22-380e to 22-380m, inclusive, as amended by
1643 this act:

1644 (1) "Commissioner" means the Commissioner of Agriculture;

- 1645 (2) "Program" means the animal population control program;
- 1646 (3) "Account" means the animal population control account;
- 1647 (4) "Participating veterinarian" means any veterinarian who has
1648 been certified to participate in the program by the commissioner;
- 1649 (5) "Pound" means any state or municipal facility where
1650 impounded, quarantined or stray dogs and cats are kept or any
1651 veterinary hospital or commercial kennel where such dogs or cats are
1652 kept by order of a municipality;
- 1653 (6) "Eligible owner" means a person who has purchased or adopted
1654 a dog or cat from a pound and who is a resident of this state;
- 1655 (7) "Medically unfit" means (A) unsuitable for a surgical procedure
1656 due to any medical condition that may place a dog or cat at life-
1657 threatening risk if a surgical procedure is performed on such animal,
1658 as determined by a participating veterinarian, or (B) unsuitable for
1659 sterilization due to insufficiency in age, as determined by a
1660 participating veterinarian, of a dog or cat under the age of six months;
- 1661 (8) "Neuter" means the surgical procedure of castration on a male
1662 dog or cat;
- 1663 (9) "Spay" means the surgical procedure of ovariohysterectomy on a
1664 female dog or cat;
- 1665 (10) "Voucher" means a nontransferable document provided by the
1666 commissioner and issued by a pound to an eligible owner authorizing
1667 payment of a predetermined amount from the animal population
1668 control account to a participating veterinarian;
- 1669 (11) "Feral cat" means a cat of the species *Felis catus* that is
1670 unowned, that exists in a wild or untamed state or has returned to an
1671 untamed state from domestication and whose behavior is suggestive of
1672 a wild animal; and
- 1673 (12) "Low-income person" means a recipient of or a person eligible

1674 for one of the following public assistance programs:

1675 (A) The supplemental nutrition assistance program authorized by
1676 Title XIII of the federal Food and Agriculture Act of 1977, 7 USC 2011
1677 et seq.;

1678 (B) The federal Temporary Assistance for Needy Families Act
1679 authorized by 42 USC 601 et seq.;

1680 [(C) The Medicaid program authorized by Title XIX of the federal
1681 Social Security Act;

1682 (D) The HUSKY Plan Part A;]

1683 (C) HUSKY A, C or D;

1684 [(E)] (D) The state-administered general assistance program;

1685 [(F)] (E) The state supplement program; or

1686 [(G)] (F) Any other public assistance program that the commissioner
1687 determines to qualify a person as a low-income person.

1688 Sec. 39. Section 38a-472d of the general statutes is repealed and the
1689 following is substituted in lieu thereof (*Effective from passage*):

1690 (a) Not later than January 1, 2006, the Insurance Commissioner, in
1691 consultation with the Commissioner of Social Services and the
1692 Healthcare Advocate, shall develop a comprehensive public education
1693 outreach program to educate health insurance consumers about the
1694 availability and general eligibility requirements of various health
1695 insurance options in this state. The program shall maximize public
1696 information concerning health insurance options in this state and shall
1697 provide for the dissemination of such information on the Insurance
1698 Department's Internet web site.

1699 (b) The information on the department's Internet web site shall
1700 reference the availability and general eligibility requirements of (1)
1701 programs administered by the Department of Social Services,

1702 including, but not limited to, the Medicaid program and [the HUSKY
1703 Plan, Part A and Part B] HUSKY A and B, (2) health insurance
1704 coverage provided by the Comptroller under subsection (i) of section
1705 5-259, (3) health insurance coverage available under comprehensive
1706 health care plans issued pursuant to part IV of this chapter, and (4)
1707 other health insurance coverage offered through local, state or federal
1708 agencies or through entities licensed in this state. The commissioner
1709 shall update the information on the web site at least quarterly.

1710 Sec. 40. Subsection (b) of section 38a-556a of the general statutes is
1711 repealed and the following is substituted in lieu thereof (*Effective from*
1712 *passage*):

1713 (b) Said association shall, in consultation with the Insurance
1714 Commissioner and the Healthcare Advocate, develop, within available
1715 appropriations, a web site, telephone number or other method to serve
1716 as a clearinghouse for information about individual and small
1717 employer health insurance policies and health care plans that are
1718 available to consumers in this state, including, but not limited to, the
1719 [Medicaid program, the HUSKY Plan] HUSKY Health program, the
1720 Municipal Employee Health Insurance Plan set forth in subsection (i)
1721 of section 5-259, and any individual or small employer health
1722 insurance policies or health care plans an insurer, health care center or
1723 other entity chooses to list with the Connecticut Clearinghouse.

1724 Sec. 41. Subdivision (11) of section 38a-1084 of the general statutes is
1725 repealed and the following is substituted in lieu thereof (*Effective from*
1726 *passage*):

1727 (11) Collaborate with the Department of Social Services, to the
1728 extent possible, to allow an enrollee who loses premium tax credit
1729 eligibility under Section 36B of the Internal Revenue Code and is
1730 eligible for HUSKY [Plan, Part] A or any other state or local public
1731 program, to remain enrolled in a qualified health plan;

1732 Sec. 42. Subsection (f) of section 46b-84 of the general statutes is
1733 repealed and the following is substituted in lieu thereof (*Effective from*

1734 *passage*):

1735 (f) (1) After the granting of a decree annulling or dissolving the
1736 marriage or ordering a legal separation, and upon complaint or motion
1737 with order and summons made to the Superior Court by either parent
1738 or by the Commissioner of Administrative Services in any case arising
1739 under subsection (a) or (b) of this section, the court shall inquire into
1740 the child's need of maintenance and the respective abilities of the
1741 parents to supply maintenance. The court shall make and enforce the
1742 decree for the maintenance of the child as it considers just, and may
1743 direct security to be given therefor, including an order to either party
1744 to contract with a third party for periodic payments or payments
1745 contingent on a life to the other party. The court may order that a party
1746 obtain life insurance as such security unless such party proves, by a
1747 preponderance of the evidence, that such insurance is not available to
1748 such party, such party is unable to pay the cost of such insurance or
1749 such party is uninsurable.

1750 (2) The court shall include in each support order a provision for the
1751 health care coverage of the child who is subject to the provisions of
1752 subsection (a) or (b) of this section. Such provision may include an
1753 order for either parent or both parents to provide such coverage under
1754 any or all of subparagraphs (A), (B) or (C) of this subdivision.

1755 (A) The provision for health care coverage may include an order for
1756 either parent to name any child as a beneficiary of any medical or
1757 dental insurance or benefit plan carried by such parent or available to
1758 such parent at a reasonable cost, as described in subparagraph (D) of
1759 this subdivision. If such order in a IV-D support case requires the
1760 parent to maintain insurance available through an employer, the order
1761 shall be enforced using a National Medical Support Notice as provided
1762 in section 46b-88.

1763 (B) The provision for health care coverage may include an order for
1764 either parent to: (i) Apply for and maintain coverage on behalf of the
1765 child under [the HUSKY Plan, Part] HUSKY B; or (ii) provide cash
1766 medical support, as described in subparagraphs (E) and (F) of this

1767 subdivision. An order under this subparagraph shall be made only if
1768 the cost to the parent obligated to maintain the coverage under [the
1769 HUSKY Plan, Part B,] HUSKY B or provide cash medical support is
1770 reasonable, as described in subparagraph (D) of this subdivision. An
1771 order under clause (i) of this subparagraph shall be made only if
1772 insurance coverage as described in subparagraph (A) of this
1773 subdivision is unavailable at reasonable cost to either parent, or
1774 inaccessible to the child.

1775 (C) An order for payment of the child's medical and dental
1776 expenses, other than those described in clause (ii) of subparagraph (E)
1777 of this subdivision, that are not covered by insurance or reimbursed in
1778 any other manner shall be entered in accordance with the child
1779 support guidelines established pursuant to section 46b-215a.

1780 (D) Health care coverage shall be deemed reasonable in cost if: (i)
1781 The parent obligated to maintain such coverage would qualify as a
1782 low-income obligor under the child support guidelines established
1783 pursuant to section 46b-215a, based solely on such parent's income,
1784 and the cost does not exceed five per cent of such parent's net income;
1785 or (ii) the parent obligated to maintain such coverage would not
1786 qualify as a low-income obligor under such guidelines and the cost
1787 does not exceed seven and one-half per cent of such parent's net
1788 income. In either case, net income shall be determined in accordance
1789 with the child support guidelines established pursuant to section 46b-
1790 215a. If a parent obligated to maintain insurance must obtain coverage
1791 for himself or herself to comply with the order to provide coverage for
1792 the child, reasonable cost shall be determined based on the combined
1793 cost of coverage for such parent and such child.

1794 (E) Cash medical support means: (i) An amount ordered to be paid
1795 toward the cost of premiums for health insurance coverage provided
1796 by a public entity, including [the HUSKY Plan, Part A or Part B]
1797 HUSKY A or B, except as provided in subparagraph (F) of this
1798 subdivision, or by another parent through employment or otherwise,
1799 or (ii) an amount ordered to be paid, either directly to a medical

1800 provider or to the person obligated to pay such provider, toward any
1801 ongoing extraordinary medical and dental expenses of the child that
1802 are not covered by insurance or reimbursed in any other manner,
1803 provided such expenses are documented and identified specifically on
1804 the record. Cash medical support, as described in clauses (i) and (ii) of
1805 this subparagraph may be ordered in lieu of an order under
1806 subparagraph (A) of this subdivision to be effective until such time as
1807 health insurance that is accessible to the child and reasonable in cost
1808 becomes available, or in addition to an order under subparagraph (A)
1809 of this subdivision, provided the combined cost of insurance and cash
1810 medical support is reasonable, as defined in subparagraph (D) of this
1811 subdivision. An order for cash medical support shall be payable to the
1812 state or the custodial party, as their interests may appear, provided an
1813 order under clause (i) of this subparagraph shall be effective only as
1814 long as health insurance coverage is maintained. Any unreimbursed
1815 medical and dental expenses not covered by an order issued pursuant
1816 to clause (ii) of this subparagraph are subject to an order for
1817 unreimbursed medical and dental expenses pursuant to subparagraph
1818 (C) of this subdivision.

1819 (F) Cash medical support to offset the cost of any insurance payable
1820 under [the HUSKY Plan, Part A or Part B] HUSKY A or B, shall not be
1821 ordered against a noncustodial parent who is a low-income obligor, as
1822 defined in the child support guidelines established pursuant to section
1823 46b-215a, or against a custodial parent of children covered under [the
1824 HUSKY Plan, Part A or Part B] HUSKY A or B.

1825 Sec. 43. Subsection (c) of section 46b-86 of the general statutes is
1826 repealed and the following is substituted in lieu thereof (*Effective from*
1827 *passage*):

1828 (c) When one of the parties, or a child of the parties, is receiving or
1829 has received aid or care from the state under its aid to families with
1830 dependent children or temporary family assistance program, HUSKY
1831 [Plan, Part] A, or foster care program as provided in Title IV-E of the
1832 Social Security Act, or when one of the parties has applied for child

1833 support enforcement services under Title IV-D of the Social Security
1834 Act as provided in section 17b-179, such motion to modify shall be
1835 filed with the Family Support Magistrate Division for determination in
1836 accordance with subsection (m) of section 46b-231.

1837 Sec. 44. Section 17b-266 of the general statutes is repealed and the
1838 following is substituted in lieu thereof (*Effective from passage*):

1839 (a) The Commissioner of Social Services may, when the
1840 commissioner finds it to be in the public interest, fund part or all of the
1841 cost of benefits to any recipient under sections 17b-260 to 17b-262,
1842 inclusive, 17b-264 to 17b-285, inclusive, 17b-357 to 17b-361, inclusive,
1843 [17b-289 to 17b-303, inclusive, and section 16 of public act 97-1 of the
1844 October 29 special session] 17b-290, as amended by this act, 17b-292, as
1845 amended by this act, 17b-294a, as amended by this act, 17b-295, as
1846 amended by this act, 17b-297a, as amended by this act, 17b-297b, as
1847 amended by this act, and 17b-300, as amended by this act, through the
1848 purchase of insurance from any organization authorized to do a health
1849 insurance business in this state or from any organization specified in
1850 subsection (b) of this section.

1851 (b) The Commissioner of Social Services may require recipients of
1852 Medicaid or other public assistance to receive medical care on a
1853 prepayment or per capita basis, in accordance with federal law and
1854 regulations, if such prepayment is anticipated to result in lower
1855 medical assistance costs to the state. The commissioner may enter into
1856 contracts for the provision of comprehensive health care on a
1857 prepayment or per capita basis in accordance with federal law and
1858 regulations, with the following: (1) A health care center subject to the
1859 provisions of chapter 698a; (2) a consortium of federally-qualified
1860 community health centers and other community-based providers of
1861 health services which are funded by the state; (3) other consortia of
1862 providers of health care services established for the purposes of this
1863 subsection; or (4) an integrated service network providing care
1864 management and comprehensive health care on a prepayment or per
1865 capita basis to elderly and disabled recipients of Medicaid who may

1866 also be eligible for Medicare.

1867 (c) Providers of comprehensive health care services as described in
1868 subdivisions (2), (3) and (4) of subsection (b) of this section shall not be
1869 subject to the provisions of chapter 698a or, in the case of an integrated
1870 service network, sections 17b-239 to 17b-245, inclusive, 17b-281, 17b-
1871 340, 17b-342 and 17b-343. Any such provider shall be certified by the
1872 Commissioner of Social Services in accordance with criteria established
1873 by the commissioner, including, but not limited to, minimum reserve
1874 fund requirements.

1875 (d) The commissioner shall pay all capitation claims which would
1876 otherwise be reimbursed to the health plans described in subsection (b)
1877 of this section in May, 2010, no later than June 30, 2010. Each
1878 subsequent payment made by the commissioner to such health plans
1879 for capitation claims due shall be made in the second month following
1880 the month to which the capitation applies.

1881 (e) On or after May 1, 2000, the payment to the Commissioner of
1882 Social Services of (1) any monetary sanction imposed by the
1883 commissioner on a managed care organization under the provisions of
1884 a contract between the commissioner and such organization entered
1885 into pursuant to this section or sections [17b-289 to 17b-304, inclusive]
1886 17b-290, as amended by this act, 17b-292, as amended by this act, 17b-
1887 294a, as amended by this act, 17b-295, as amended by this act, 17b-
1888 297a, as amended by this act, 17b-297b, as amended by this act, and
1889 17b-300, as amended by this act, or (2) any sum agreed upon by the
1890 commissioner and such an organization as settlement of a claim
1891 brought by the commissioner or the state against such an organization
1892 for failure to comply with the terms of a contract with the
1893 commissioner or fraud affecting the Department of Social Services
1894 shall be deposited in an account designated for use by the department
1895 for expenditures for children's health programs and services.

1896 Sec. 45. Sections 17b-261i, 17b-289, 17b-291, 17b-292a, 17b-297, 17b-
1897 299 and 17b-303 of the general statutes are repealed. (*Effective from*
1898 *passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	4-66e(d)
Sec. 2	<i>from passage</i>	10-223h(c)
Sec. 3	<i>from passage</i>	10-265f(b)
Sec. 4	<i>from passage</i>	10a-132e(b)
Sec. 5	<i>from passage</i>	12-202a(b)(4)
Sec. 6	<i>from passage</i>	12-202b(b)
Sec. 7	<i>from passage</i>	12-202c(b)
Sec. 8	<i>from passage</i>	17a-4a(f)
Sec. 9	<i>from passage</i>	17a-22a
Sec. 10	<i>from passage</i>	17a-22f
Sec. 11	July 1, 2016	17a-22f
Sec. 12	<i>from passage</i>	17a-22h(a)
Sec. 13	<i>from passage</i>	17a-22j
Sec. 14	<i>from passage</i>	17a-22p(d)
Sec. 15	<i>from passage</i>	17a-22q
Sec. 16	<i>from passage</i>	17b-28
Sec. 17	<i>from passage</i>	17b-261(a)
Sec. 18	<i>from passage</i>	17b-261e
Sec. 19	<i>from passage</i>	17b-261h
Sec. 20	<i>from passage</i>	17b-290
Sec. 21	<i>from passage</i>	17b-261j
Sec. 22	<i>from passage</i>	17b-261m
Sec. 23	July 1, 2016	17b-261m
Sec. 24	<i>from passage</i>	17b-278d
Sec. 25	<i>from passage</i>	17b-292
Sec. 26	<i>from passage</i>	17b-294a
Sec. 27	<i>from passage</i>	17b-295
Sec. 28	<i>from passage</i>	17b-297a
Sec. 29	<i>from passage</i>	17b-297b
Sec. 30	<i>from passage</i>	17b-300
Sec. 31	<i>from passage</i>	17b-306
Sec. 32	<i>from passage</i>	17b-306a
Sec. 33	<i>from passage</i>	17b-304
Sec. 34	<i>from passage</i>	17b-307(a)
Sec. 35	<i>from passage</i>	17b-745(a)(2)(A)
Sec. 36	<i>from passage</i>	19a-45a
Sec. 37	<i>from passage</i>	19a-659(6)
Sec. 38	<i>from passage</i>	22-380e

Sec. 39	<i>from passage</i>	38a-472d
Sec. 40	<i>from passage</i>	38a-556a(b)
Sec. 41	<i>from passage</i>	38a-1084(11)
Sec. 42	<i>from passage</i>	46b-84(f)
Sec. 43	<i>from passage</i>	46b-86(c)
Sec. 44	<i>from passage</i>	17b-266
Sec. 45	<i>from passage</i>	Repealer section

Statement of Legislative Commissioners:

In section 20 (18), "17b-294a" was changed to "17b-294a, as amended by this act," for internal consistency. In section 33, "commissioner" was changed to "[commissioner] Commissioner of Social Services" for clarity and "Internet web site of the Department of Social Services" was changed to "Department of Social Services' Internet web site" for internal consistency.

HS *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:** None**Municipal Impact:** None**Explanation**

The bill is not anticipated to result in a fiscal impact as it makes technical changes and conforms to current practice.

The Out Years**State Impact:** None**Municipal Impact:** None

OLR Bill Analysis**sHB 6946*****AN ACT CONCERNING HUSKY PROGRAMS.*****SUMMARY:**

This bill makes numerous technical, conforming, and substantive changes to statutes related to the Department of Social Services' (DSS) HUSKY programs. By law, DSS must provide medical assistance in accordance with the state Medicaid plan and the state Children's Health Insurance Plan and federal law.

The bill creates "HUSKY Health" as a term to refer to HUSKY A, HUSKY B, HUSKY C, and HUSKY D and makes a number of conforming changes. The bill:

1. expands the definition of HUSKY A, which provides Medicaid to children, caretaker relatives, and pregnant women, to conform to federal law and agency practice by including postpartum women;
2. makes several changes to HUSKY B, the state children's health insurance program or S-CHIP;
3. defines HUSKY C as Medicaid provided to individuals who are 65 years of age or older or who are blind or have a disability, conforming to agency practice; and
4. defines HUSKY D or Medicaid Coverage for the Lowest Income Populations program as Medicaid provided to nonpregnant low-income adults who are age 18 to 64, conforming to agency practice.

The bill makes several changes that conform to current DSS practice regarding federal Affordable Care Act requirements for income

eligibility determinations, household definitions, and presumptive eligibility.

The bill eliminates references to the HUSKY Plus program that provided behavioral health services (in practice, DSS has not offered this program since 2006).

The bill redefines “durable medical equipment” to conform to the definition DSS uses in practice.

The bill eliminates requirements for DSS to publish notice of intent to adopt regulations on various topics in the Connecticut Law Journal, and instead requires DSS to publish such notice on its website and the eRegulations system. This conforms to existing law regarding adopting regulations (CGS § 4-168) and current practice.

Finally, the bill eliminates obsolete references to the single point of entry servicer used when Medicaid programs were offered through a managed care delivery system (§25).

EFFECTIVE DATE: Upon passage, except two technical changes are effective July 1, 2016 (§§ 11, 23).

§§ 17, 25, 26, 27, & 45 — MAGI RULES

The federal Affordable Care Act requires state Medicaid agencies (e.g., DSS) to use a Modified Adjusted Gross Income (MAGI) methodology to determine eligibility for several Medicaid coverage groups. The law permits DSS to implement MAGI eligibility rules and the agency has already done so in practice. For coverage dates beginning January 1, 2014, the bill requires DSS to use MAGI eligibility rules to determine eligibility for HUSKY A, B, and D. The bill codifies DSS practices consistent with federal law regarding MAGI eligibility rules and federal definitions.

The bill alters program income limits in order to convert to the MAGI rules, which do not include as many income disregards. The bill alters the income limits for (1) medical assistance for those age 19 and

under, (2) subsidized HUSKY B coverage for children, (3) unsubsidized HUSKY B coverage for children, (4) the federal poverty level (FPL) below which the HUSKY Plus program gives priority, and (5) the FPL above which DSS may impose a premium requirement for HUSKY B.

To conform to federal law and agency practice, the bill adopts the federal definition of “household” and “household income” in place of “family” for purposes of eligibility determinations (see BACKGROUND).

§ 45 — ELIGIBILITY FOR OTHER PROGRAMS

The bill eliminates a requirement that DSS, when redetermining eligibility for HUSKY A and B, also determine eligibility for supplemental nutrition assistance, a child care subsidy program, and benefits under any other DSS-administered program. Federal regulations require DSS, for those Medicaid groups whose eligibility is determined through MAGI rules, to redetermine eligibility without requiring additional information from the applicant if possible, which may preclude determining eligibility for additional programs (42 CFR § 435.916).

§§ 20 & 25 — PRESUMPTIVE ELIGIBILITY

Hospitals

To conform to federal regulations, the bill allows qualified hospitals to determine presumptive Medicaid eligibility. It requires them, when making such a determination, to assist individuals with completing and submitting their Medicaid application (see BACKGROUND). DSS must provide Medicaid during a presumptive eligibility period to those determined eligible by a qualified hospital.

Qualified Entities

By law, DSS must establish standards and procedures to designate qualified entities that may grant presumptive eligibility for HUSKY A and HUSKY B. Current law requires qualified entities to ensure that a completed application for benefits is submitted to DSS when making a

presumptive eligibility determination. The bill instead requires them to provide assistance to applicants with the completion and submission of the application.

By law, DSS must provide qualified entities with necessary forms for HUSKY A applications and information on how to assist parents, guardians, and others with completing and filing such forms. As an alternative to providing forms, the bill allows DSS to provide them with information on filing an application electronically.

§§ 12, 18, 20, & 45 — HUSKY HEALTH

Under the bill, HUSKY Health is the combined HUSKY A, HUSKY B, HUSKY C, and HUSKY D programs that provide medical coverage to eligible children, parents, relative caregivers, people age 65 or older, individuals with disabilities, and pregnant women. The bill expands HUSKY A, which provides Medicaid to children, caretaker relatives, and pregnant women, to also include postpartum women, conforming to federal law and current agency practice (see BACKGROUND).

The bill codifies the definition of (1) HUSKY C as Medicaid provided to individuals who are 65 years of age or older or who are blind or have a disability and (2) HUSKY D or Medicaid Coverage for the Lowest Income Populations program as Medicaid provided to nonpregnant low-income adults who are age 18 to 64.

The bill replaces references to HUSKY programs in the statutes with HUSKY Health. It removes explicit references to Medicaid funded programs not included in HUSKY Health from (1) the Behavioral Health Partnership and (2) a requirement that DSS provide coverage for isolation care and emergency services provided by the state's mobile field hospital. It appears that this is a conforming change, as in practice, DSS considers other Medicaid programs (including programs administered through waivers) to be included in HUSKY Health. Similarly, it also removes reference to Medicaid in determination of low-income status for a program that provides sterilization and vaccination services to dogs and cats owned by low-income

individuals (though the agriculture commissioner may designate other public assistance programs to be included in this determination).

Current law requires the Department of Education (DOE) to establish procedures to allow applicants for free and reduced price meals under the National School Lunch Program to apply for HUSKY A and HUSKY B. The bill expands this requirement to also include HUSKY C and D.

Outreach

The bill eliminates a requirement for DSS to develop a mechanism to increase outreach and maximize enrollment of eligible children and adults in HUSKY A and HUSKY B, and to report annually on the implementation and results of such outreach programs. The bill also eliminates related provisions including (1) a requirement that DSS contract with severe need schools and community-based organizations to, among other things, distribute applications and information on enrolling in HUSKY A and HUSKY B and (2) a requirement that DSS consult with the Latino and Puerto Rican Affairs Commission, the African-American Affairs Commission, and representatives from minority community-based organizations to develop and implement outreach efforts to increase enrollment of medically underserved children and adults. In practice, outreach activities conducted through the federal Affordable Care Act also target these groups.

§ 20 — DURABLE MEDICAL EQUIPMENT

The bill defines durable medical equipment as equipment that:

1. can withstand repeated use,
2. is primarily and customarily used to serve a medical purpose,
3. generally is not useful to a person in the absence of an illness or injury, and
4. is nondisposable.

This definition replaces an erroneous federal reference, which

presumably referred to a federal definition that defined the equipment as including iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle under certain circumstances) used in the patient's home (including certain institutions) whether furnished on a rental basis or purchased, and includes blood-testing strips and blood glucose monitors for individuals with diabetes (42 USC 1395x(n)).

§ 17, 20, 25, 26, & 45 — HUSKY B

State Plan

DSS provides HUSKY B services through the state Children's Health Insurance Program (S-CHIP), a federal program. Current law requires DSS to submit revisions to the S-CHIP plan to the Appropriations, Human Services, Insurance, and Public Health committees for approval, denial, or modification. The bill eliminates this requirement. By law, and in practice, the Council on Medical Assistance Program Oversight (MAPOC) advises DSS on, among other things, the planning and implementation of the health care delivery system for HUSKY B.

Eligible Beneficiary

In addition to converting income limits for eligibility to conform with MAGI rules, the bill changes eligibility requirements by redefining "eligible beneficiary" for HUSKY B. The bill removes an exclusion for children of municipal employees who are eligible for employer-sponsored insurance beginning October 1, 1997, except in cases of extreme economic hardship. Federal law excludes, with certain exceptions, children of families who are eligible for health benefits coverage under a state health benefits plan based on a family member's employment with a public agency.

The bill eliminates the term enrollee to describe eligible beneficiaries who receive HUSKY B services and instead defines "member" as an eligible beneficiary who receives services under HUSKY A, B, C, or D, although "eligible beneficiaries" under the bill and current law only refers to children receiving HUSKY B benefits.

HUSKY Plus

By law, HUSKY Plus provides supplemental health coverage for HUSKY B members whose needs cannot be accommodated within HUSKY B's basic benefit package. Under current law, HUSKY Plus is two programs: one providing coverage for HUSKY B recipients with intensive physical needs and one providing coverage for such recipients with intensive behavioral health needs. The bill eliminates the HUSKY Plus program for behavioral health, conforming to DSS practice. In practice, DSS has been providing behavioral health services through the Behavioral Health Partnership since 2006.

The bill eliminates a requirement that DSS report annually to the governor and the General Assembly on the HUSKY Plus Program, and include in that report an evaluation of health outcomes and access to care for medically-eligible enrollees.

Other Coverage

The bill eliminates a requirement that DSS review HUSKY B applications to determine whether applicants or their employers have discontinued employer-sponsored dependent coverage in order to qualify for HUSKY B, and disapprove such applications in certain cases. The bill instead requires, in cases where a HUSKY B member has limited benefit insurance coverage for services also covered under HUSKY B, DSS to require the other coverage to pay for the goods or services prior to any HUSKY B payment.

Referrals to the Exchange

Under current law, those who DSS determines are ineligible for coverage under Medicaid-funded programs must be provided with a written statement notifying them of their ineligibility and advising them of the availability of HUSKY B. The bill instead requires that those ineligible for HUSKY Health programs be provided with a written statement notifying them of their potential eligibility for other insurance affordability programs (e.g., federal tax credits and subsidies).

BACKGROUND***Household and Household Income***

Federal law generally requires state Medicaid agencies to make financial eligibility determinations based on a tax-based concept of family size and household income (i.e., MAGI-based definitions).

As of January 1, 2014, states can no longer use traditional income disregards for many Medicaid applicants. (Disregards enable applicants to have higher incomes and still qualify for assistance because states disregard a portion of the income.) Instead, states must determine eligibility based on the applicant's modified adjusted gross income, which is an individual's (or couple's) total income reported to the Internal Revenue Service plus tax-exempt interest and foreign earned income.

Hospital Presumptive Eligibility

Federal law requires state Medicaid agencies (e.g., DSS) to provide Medicaid during a presumptive eligibility period to those determined eligible by a qualified hospital. Under federal law, a qualified hospital is one that:

1. participates as a Medicaid provider;
2. notifies the agency of its election to make presumptive eligibility determinations;
3. agrees to make such determinations consistent with state policies and procedures;
4. at the state's option, assists individuals in completing and submitting the full application and understanding its requirements; and
5. has not been disqualified by the agency.

Qualified hospitals may make such eligibility determinations for various groups including children, pregnant women, parents and caretaker relatives, and individuals age 19 and older. State agencies

may limit such determinations to those based on income (42 CFR § 435.1110).

Medicaid Coverage of Postpartum Women

Federal law requires state Medicaid programs to provide categorical eligibility to any woman receiving Medicaid services during her pregnancy for a period from the last day of pregnancy through the end of the month in which a 60-day period, beginning on the last day of pregnancy, ends (42 CFR § 435.170).

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute

Yea 16 Nay 0 (03/24/2015)