



General Assembly

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Bill No. 7062

LCO No. 9377



* 0 9 3 7 7 *

Referred to Committee on No Committee

Introduced by:

REP. SHARKEY, 88th Dist.

REP. ARESIMOWICZ, 30th Dist.

SEN. LOONEY, 11th Dist.

SEN. DUFF, 25th Dist.

***AN ACT IMPLEMENTING THE PROVISIONS OF THE STATE BUDGET
FOR THE BIENNIUM ENDING JUNE 30, 2017, CONCERNING PUBLIC
HEALTH AND HUMAN SERVICES.***

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

1 Section 1. (NEW) (*Effective July 1, 2015*) (a) Not later than September
2 first, annually, the Secretary of the Office of Policy and Management,
3 in consultation with the Commissioner of Public Health, shall (1)
4 determine the amounts appropriated for the needle and syringe
5 exchange program, AIDS services, breast and cervical cancer detection
6 and treatment, x-ray screening and tuberculosis care, and venereal
7 disease control; and (2) inform the Insurance Commissioner of such
8 amounts.

9 (b) (1) As used in this section: (A) "Health insurance" means health
10 insurance of the types specified in subdivisions (1), (2), (4), (11) and
11 (12) of section 38a-469 of the general statutes; and (B) "health care

12 center" has the same meaning as provided in section 38a-175 of the
13 general statutes.

14 (2) Each domestic insurer or health care center doing health
15 insurance business in this state shall annually pay to the Insurance
16 Commissioner, for deposit in the Insurance Fund established under
17 section 38a-52a of the general statutes, a public health fee assessed by
18 the Insurance Commissioner pursuant to this section.

19 (3) Not later than September first, annually, each such insurer or
20 health care center shall report to the Insurance Commissioner, in the
21 form and manner prescribed by said commissioner, the number of
22 insured or enrolled lives in this state as of May first immediately
23 preceding the date for which such insurer or health care center is
24 providing health insurance that provides coverage of the types
25 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of
26 the general statutes. Such number shall not include lives enrolled in
27 Medicare, any medical assistance program administered by the
28 Department of Social Services, workers' compensation insurance or
29 Medicare Part C plans.

30 (c) Not later than November first, annually, the Insurance
31 Commissioner shall determine the fee to be assessed for the current
32 fiscal year against each such insurer and health care center. Such fee
33 shall be calculated by multiplying the number of lives reported to said
34 commissioner pursuant to subdivision (3) of subsection (b) of this
35 section by a factor, determined annually by said commissioner as set
36 forth in this subsection, to fully fund the aggregate amount determined
37 under subsection (a) of this section. The Insurance Commissioner shall
38 determine the factor by dividing the aggregate amount by the total
39 number of lives reported to said commissioner pursuant to subdivision
40 (3) of subsection (b) of this section.

41 (d) Not later than December first, annually, the Insurance
42 Commissioner shall submit a statement to each such insurer and health

43 care center that includes the proposed fee, identified on such statement
44 as the "Public Health fee", for the insurer or health care center,
45 calculated in accordance with this section. Not later than December
46 twentieth, annually, any insurer or health care center may submit an
47 objection to the Insurance Commissioner concerning the proposed
48 public health fee. The Insurance Commissioner, after making any
49 adjustment that said commissioner deems necessary, shall, not later
50 than January first, annually, submit a final statement to each insurer
51 and health care center that includes the final fee for the insurer or
52 health care center. Each such insurer and health care center shall pay
53 such fee to the Insurance Commissioner not later than February first,
54 annually.

55 (e) Any such insurer or health care center aggrieved by an
56 assessment levied under this section may appeal therefrom in the same
57 manner as provided for appeals under section 38a-52 of the general
58 statutes.

59 Sec. 2. Subsection (a) of section 19a-55 of the general statutes is
60 repealed and the following is substituted in lieu thereof (*Effective July*
61 *1, 2015*):

62 (a) The administrative officer or other person in charge of each
63 institution caring for newborn infants shall cause to have administered
64 to every such infant in its care an HIV-related test, as defined in section
65 19a-581, a test for phenylketonuria and other metabolic diseases,
66 hypothyroidism, galactosemia, sickle cell disease, maple syrup urine
67 disease, homocystinuria, biotinidase deficiency, congenital adrenal
68 hyperplasia and such other tests for inborn errors of metabolism as
69 shall be prescribed by the Department of Public Health. The tests shall
70 be administered as soon after birth as is medically appropriate. If the
71 mother has had an HIV-related test pursuant to section 19a-90 or 19a-
72 593, the person responsible for testing under this section may omit an
73 HIV-related test. The Commissioner of Public Health shall (1)
74 administer the newborn screening program, (2) direct persons

75 identified through the screening program to appropriate specialty
76 centers for treatments, consistent with any applicable confidentiality
77 requirements, and (3) set the fees to be charged to institutions to cover
78 all expenses of the comprehensive screening program including
79 testing, tracking and treatment. The fees to be charged pursuant to
80 subdivision (3) of this subsection shall be set at a minimum of [fifty-
81 six] ninety-eight dollars. The Commissioner of Public Health shall
82 publish a list of all the abnormal conditions for which the department
83 screens newborns under the newborn screening program, which shall
84 include screening for amino acid disorders, organic acid disorders and
85 fatty acid oxidation disorders, including, but not limited to, long-chain
86 3-hydroxyacyl CoA dehydrogenase (L-CHAD) and medium-chain
87 acyl-CoA dehydrogenase (MCAD).

88 Sec. 3. Section 38a-1083 of the general statutes is repealed and the
89 following is substituted in lieu thereof (*Effective from passage*):

90 (a) For purposes of sections 38a-1080 to [38a-1091] 38a-1092,
91 inclusive, as amended by this act, and section 4 of this act, "purposes of
92 the exchange" means the purposes of and the pursuit of the goals of
93 the exchange expressed in and pursuant to this section and the
94 performance of the duties and responsibilities of the exchange set forth
95 in sections 38a-1084 to 38a-1092, inclusive, which are hereby
96 determined to be public purposes for which public funds may be
97 expended. The powers enumerated in this section shall be interpreted
98 broadly to effectuate the purposes of the exchange and shall not be
99 construed as a limitation of powers.

100 (b) The goals of the exchange shall be to reduce the number of
101 individuals without health insurance in this state and assist
102 individuals and small employers in the procurement of health
103 insurance by, among other services, offering easily comparable and
104 understandable information about health insurance options.

105 (c) The exchange is authorized and empowered to:

106 (1) Have perpetual [successions] succession as a body politic and
107 corporate and to adopt bylaws for the regulation of its affairs and the
108 conduct of its business;

109 (2) Adopt an official seal and alter the same at pleasure;

110 (3) Maintain an office in the state at such place or places as it may
111 designate;

112 (4) Employ such assistants, agents, managers and other employees
113 as may be necessary or desirable;

114 (5) Acquire, lease, purchase, own, manage, hold and dispose of real
115 and personal property, and lease, convey or deal in or enter into
116 agreements with respect to such property on any terms necessary or
117 incidental to the carrying out of these purposes, provided all such
118 acquisitions of real property for the exchange's own use with amounts
119 appropriated by this state to the exchange or with the proceeds of
120 bonds supported by the full faith and credit of this state shall be
121 subject to the approval of the Secretary of the Office of Policy and
122 Management and the provisions of section 4b-23;

123 (6) Receive and accept, from any source, aid or contributions,
124 including money, property, labor and other things of value;

125 (7) Charge assessments or user fees to health carriers that are
126 capable of offering a qualified health plan through the exchange or
127 otherwise generate funding necessary to support the operations of the
128 exchange and impose interest and penalties on such health carriers for
129 delinquent payments of such assessments or fees;

130 (8) Procure insurance against loss in connection with its property
131 and other assets in such amounts and from such insurers as it deems
132 desirable;

133 (9) Invest any funds not needed for immediate use or disbursement
134 in obligations issued or guaranteed by the United States of America or

135 the state and in obligations that are legal investments for savings banks
136 in the state;

137 (10) Issue bonds, bond anticipation notes and other obligations of
138 the exchange for any of its corporate purposes, and to fund or refund
139 the same and provide for the rights of the holders thereof, and to
140 secure the same by pledge of revenues, notes and mortgages of others;

141 (11) Borrow money for the purpose of obtaining working capital;

142 (12) Account for and audit funds of the exchange and any recipients
143 of funds from the exchange;

144 (13) Make and enter into any contract or agreement necessary or
145 incidental to the performance of its duties and execution of its powers.
146 The contracts entered into by the exchange shall not be subject to the
147 approval of any other state department, office or agency, provided
148 copies of all contracts of the exchange shall be maintained by the
149 exchange as public records, subject to the proprietary rights of any
150 party to the contract;

151 (14) To the extent permitted under its contract with other persons,
152 consent to any termination, modification, forgiveness or other change
153 of any term of any contractual right, payment, royalty, contract or
154 agreement of any kind to which the exchange is a party;

155 (15) Award grants to trained and certified individuals and
156 institutions that will assist individuals, families and small employers
157 and their employees in enrolling in appropriate coverage through the
158 exchange. Applications for grants from the exchange shall be made on
159 a form prescribed by the board;

160 (16) Limit the number of plans offered, and use selective criteria in
161 determining which plans to offer, through the exchange, provided
162 individuals and employers have an adequate number and selection of
163 choices;

164 (17) Evaluate jointly with the Sustinet Health Care Cabinet the
165 feasibility of implementing a basic health program option as set forth
166 in Section 1331 of the Affordable Care Act;

167 (18) Establish one or more subsidiaries, in accordance with section 4
168 of this act, to further the purposes of the exchange;

169 (19) (A) Make loans to each subsidiary established pursuant to
170 section 4 of this act from the assets of the exchange and the proceeds of
171 bonds, bond anticipation notes and other obligations issued by the
172 exchange, provided the source and security for the repayment of such
173 loans are derived from the assets, revenues and resources of the
174 subsidiary, and (B) assign or transfer to such subsidiary any of the
175 rights, moneys or other assets of the exchange, provided such
176 assignment or transfer is not in violation of state or federal law;

177 ~~[(18)]~~ (20) Sue and be sued, plead and be impleaded;

178 ~~[(19)]~~ (21) Adopt regular procedures that are not in conflict with
179 other provisions of the general statutes, for exercising the power of the
180 exchange; and

181 ~~[(20)]~~ (22) Do all acts and things necessary and convenient to carry
182 out the purposes of the exchange, provided such acts or things shall
183 not conflict with the provisions of the Affordable Care Act, regulations
184 adopted thereunder or federal guidance issued pursuant to the
185 Affordable Care Act.

186 (d) (1) The chief executive officer of the exchange shall provide to
187 the commissioner the name of any health carrier that fails to pay any
188 assessment or user fee under subdivision (7) of subsection (c) of this
189 section to the exchange. The commissioner shall see that all laws
190 respecting the authority of the exchange pursuant to said subdivision
191 (7) are faithfully executed. The commissioner has all the powers
192 specifically granted under this title and all further powers that are
193 reasonable and necessary to enable the commissioner to enforce the

194 provisions of said subdivision (7).

195 (2) Any health carrier aggrieved by an administrative action taken
196 by the commissioner under subdivision (1) of this subsection may
197 appeal therefrom in accordance with the provisions of section 4-183,
198 except venue for such appeal shall be in the judicial district of New
199 Britain.

200 Sec. 4. (NEW) (*Effective from passage*) (a) The Connecticut Health
201 Insurance Exchange, established pursuant to section 38a-1081 of the
202 general statutes, may establish one or more subsidiaries for such
203 purposes as prescribed by resolution of the board of directors of the
204 exchange, which purposes shall be consistent with the purposes of the
205 exchange. Each subsidiary shall be deemed a quasi-public agency for
206 the purposes of chapter 12 of the general statutes and shall have all the
207 privileges, immunities, tax exemptions and other exemptions of the
208 exchange. Any such subsidiary may be organized as a stock or
209 nonstock corporation or a limited liability company.

210 (b) Each subsidiary shall have and may exercise the powers of the
211 exchange and such additional powers as are set forth in such
212 resolution, except the powers of the exchange set forth in subdivisions
213 (7), (12), (15), (16), (17) and (21) of subsection (c) of section 38a-1083 of
214 the general statutes, as amended by this act, shall be reserved to the
215 exchange and shall not be exercisable by any subsidiary of the
216 exchange.

217 (c) (1) Each subsidiary shall act through a board of directors, at least
218 one-half of which shall be members of the board of directors of the
219 exchange or their designees or officers or employees of the exchange.

220 (2) The provisions of section 1-125 of the general statutes shall apply
221 to any member of the board of directors, officer or employee of a
222 subsidiary established under this section. Any such member, officer or
223 employee shall not be personally liable for the debts, obligations or
224 liabilities of any such subsidiary as provided in section 1-125 of the

225 general statutes. Any such subsidiary shall, and the exchange may,
226 save harmless and indemnify any such member, officer or employee as
227 provided in section 1-125 of the general statutes.

228 (d) (1) Each subsidiary to which the exchange makes a loan
229 pursuant to subdivision (19) of subsection (c) of section 38a-1083 of the
230 general statutes, as amended by this act, shall repay such loan from the
231 assets, revenues and resources of such subsidiary.

232 (2) Each subsidiary shall be subject to suit, provided its liability shall
233 be limited solely to the assets, revenues and resources of such
234 subsidiary and without recourse to the general funds, revenues or
235 resources or any other assets of the exchange.

236 (3) Each subsidiary may convey or dispose of its assets and pledge
237 its revenues to secure any borrowing, provided any such borrowing
238 shall be a special obligation of the subsidiary and shall be payable
239 solely from the assets, revenues and resources of the subsidiary.

240 (4) Each subsidiary or the exchange may take any action necessary
241 to comply with the provisions of the Internal Revenue Code of 1986, or
242 any subsequent corresponding internal revenue code of the United
243 States, as amended from time to time, to qualify and maintain any
244 subsidiary as a corporation exempt from taxation under said code.

245 Sec. 5. Section 38a-1080 of the general statutes is repealed and the
246 following is substituted in lieu thereof (*Effective from passage*):

247 For purposes of sections 38a-1080 to [38a-1091] 38a-1092, inclusive,
248 and section 4 of this act:

249 (1) "Board" means the board of directors of the Connecticut Health
250 Insurance Exchange;

251 (2) "Commissioner" means the Insurance Commissioner;

252 (3) "Exchange" means the Connecticut Health Insurance Exchange

253 established pursuant to section 38a-1081;

254 (4) "Affordable Care Act" means the Patient Protection and
255 Affordable Care Act, P.L. 111-148, as amended by the Health Care and
256 Education Reconciliation Act, P.L. 111-152, as both may be amended
257 from time to time, and regulations adopted thereunder;

258 (5) (A) "Health benefit plan" means an insurance policy or contract
259 offered, delivered, issued for delivery, renewed, amended or
260 continued in the state by a health carrier to provide, deliver, pay for or
261 reimburse any of the costs of health care services.

262 (B) "Health benefit plan" does not include:

263 (i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9),
264 (14), (15) and (16) of section 38a-469 or any combination thereof;

265 (ii) Coverage issued as a supplement to liability insurance;

266 (iii) Liability insurance, including general liability insurance and
267 automobile liability insurance;

268 (iv) Workers' compensation insurance;

269 (v) Automobile medical payment insurance;

270 (vi) Credit insurance;

271 (vii) Coverage for on-site medical clinics; or

272 (viii) Other similar insurance coverage specified in regulations
273 issued pursuant to the Health Insurance Portability and Accountability
274 Act of 1996, P.L. 104-191, as amended from time to time, under which
275 benefits for health care services are secondary or incidental to other
276 insurance benefits.

277 (C) "Health benefit plan" does not include the following benefits if
278 they are provided under a separate insurance policy, certificate or

279 contract or are otherwise not an integral part of the plan:

280 (i) Limited scope dental or vision benefits;

281 (ii) Benefits for long-term care, nursing home care, home health
282 care, community-based care or any combination thereof; or

283 (iii) Other similar, limited benefits specified in regulations issued
284 pursuant to the Health Insurance Portability and Accountability Act of
285 1996, P.L. 104-191, as amended from time to time;

286 (iv) Other supplemental coverage, similar to coverage of the type
287 specified in subdivisions (9) and (14) of section 38a-469, provided
288 under a group health plan.

289 (D) "Health benefit plan" does not include coverage of the type
290 specified in subdivisions (3) and (13) of section 38a-469 or other fixed
291 indemnity insurance if (i) such coverage is provided under a separate
292 insurance policy, certificate or contract, (ii) there is no coordination
293 between the provision of the benefits and any exclusion of benefits
294 under any group health plan maintained by the same plan sponsor,
295 and (iii) the benefits are paid with respect to an event without regard
296 to whether benefits were also provided under any group health plan
297 maintained by the same plan sponsor;

298 (6) "Health care services" has the same meaning as provided in
299 section 38a-478;

300 (7) "Health carrier" means an insurance company, fraternal benefit
301 society, hospital service corporation, medical service corporation,
302 health care center or other entity subject to the insurance laws and
303 regulations of the state or the jurisdiction of the commissioner that
304 contracts or offers to contract to provide, deliver, pay for or reimburse
305 any of the costs of health care services;

306 (8) "Internal Revenue Code" means the Internal Revenue Code of
307 1986, or any subsequent corresponding internal revenue code of the

308 United States, as amended from time to time;

309 (9) "Person" has the same meaning as provided in section 38a-1;

310 (10) "Qualified dental plan" means a limited scope dental plan that
311 has been certified in accordance with subsection (e) of section 38a-1086;

312 (11) "Qualified employer" has the same meaning as provided in
313 Section 1312 of the Affordable Care Act;

314 (12) "Qualified health plan" means a health benefit plan that has in
315 effect a certification that the plan meets the criteria for certification
316 described in Section 1311(c) of the Affordable Care Act and section
317 38a-1086;

318 (13) "Qualified individual" has the same meaning as provided in
319 Section 1312 of the Affordable Care Act;

320 (14) "Secretary" means the Secretary of the United States
321 Department of Health and Human Services;

322 (15) "Small employer" has the same meaning as provided in section
323 38a-564.

324 Sec. 6. Section 38a-514b of the general statutes is repealed and the
325 following is substituted in lieu thereof (*Effective January 1, 2016*):

326 (a) As used in this section:

327 (1) "Applied behavior analysis" means the design, implementation
328 and evaluation of environmental modifications, using behavioral
329 stimuli and consequences, including the use of direct observation,
330 measurement and functional analysis of the relationship between
331 environment and behavior, to produce socially significant
332 improvement in human behavior.

333 (2) ["Autism services provider"] "Autism spectrum disorder services
334 provider" means any person, entity or group that provides treatment

335 for autism spectrum disorder pursuant to this section.

336 (3) "Autism spectrum disorder" means [a pervasive developmental
337 disorder] "autism spectrum disorder" as set forth in the most recent
338 edition of the American Psychiatric Association's "Diagnostic and
339 Statistical Manual of Mental Disorders". [, including, but not limited to,
340 Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder,
341 Asperger's Disorder and Pervasive Developmental Disorder Not
342 Otherwise Specified.]

343 (4) "Behavioral therapy" means any interactive behavioral therapies
344 derived from evidence-based research and consistent with the services
345 and interventions designated by the Commissioner of Developmental
346 Services pursuant to subsection (l) of section 17a-215c, as amended by
347 this act, including, but not limited to, applied behavior analysis,
348 cognitive behavioral therapy, or other therapies supported by
349 empirical evidence of the effective treatment of individuals diagnosed
350 with [an] autism spectrum disorder, that are: (A) Provided to children
351 less than [fifteen] twenty-one years of age; and (B) provided or
352 supervised by (i) a behavior analyst who is certified by the Behavior
353 Analyst Certification Board, (ii) a licensed physician, or (iii) a licensed
354 psychologist. For the purposes of this subdivision, behavioral therapy
355 is "supervised by" such behavior analyst, licensed physician or licensed
356 psychologist when such supervision entails at least one hour of face-to-
357 face supervision of the autism spectrum disorder services provider by
358 such behavior analyst, licensed physician or licensed psychologist for
359 each ten hours of behavioral therapy provided by the supervised
360 provider.

361 (5) "Diagnosis" means the medically necessary assessment,
362 evaluation or testing performed by a licensed physician, licensed
363 psychologist or licensed clinical social worker to determine if an
364 individual has [an] autism spectrum disorder.

365 (b) Each group health insurance policy providing coverage of the

366 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
367 469 that is delivered, issued for delivery, renewed, amended or
368 continued in this state shall provide coverage for the diagnosis and
369 treatment of autism spectrum disorder. [except that coverage for an
370 insured under such policy who has been diagnosed with autism
371 spectrum disorder prior to the release of the fifth edition of the
372 American Psychiatric Association's "Diagnostic and Statistical Manual
373 of Mental Disorders" shall be provided in accordance with subsection
374 (i) of this section.] For the purposes of this section and section 38a-513c,
375 [an] autism spectrum disorder shall be considered an illness.

376 (c) Such policy shall provide coverage for the following treatments,
377 provided such treatments are (1) medically necessary, and (2)
378 identified and ordered by a licensed physician, licensed psychologist
379 or licensed clinical social worker for an insured who is diagnosed with
380 [an] autism spectrum disorder, in accordance with a treatment plan
381 developed by a behavior analyst who is certified by the Behavior
382 Analyst Certification Board, licensed physician, licensed psychologist
383 or licensed clinical social worker, pursuant to a comprehensive
384 evaluation or reevaluation of the insured:

385 (A) Behavioral therapy;

386 (B) Prescription drugs, to the extent prescription drugs are a
387 covered benefit for other diseases and conditions under such policy,
388 prescribed by a licensed physician, a licensed physician assistant or an
389 advanced practice registered nurse for the treatment of symptoms and
390 comorbidities of autism spectrum disorder;

391 (C) Direct psychiatric or consultative services provided by a
392 licensed psychiatrist;

393 (D) Direct psychological or consultative services provided by a
394 licensed psychologist;

395 (E) Physical therapy provided by a licensed physical therapist;

396 (F) Speech and language pathology services provided by a licensed
397 speech and language pathologist; and

398 (G) Occupational therapy provided by a licensed occupational
399 therapist.

400 [(d) Such policy may limit the coverage for behavioral therapy to a
401 yearly benefit of fifty thousand dollars for a child who is less than nine
402 years of age, thirty-five thousand dollars for a child who is at least nine
403 years of age and less than thirteen years of age and twenty-five
404 thousand dollars for a child who is at least thirteen years of age and
405 less than fifteen years of age.]

406 [(e)] (d) Such policy shall not impose (1) any limits on the number of
407 visits an insured may make to an autism spectrum disorder services
408 provider pursuant to a treatment plan on any basis other than a lack of
409 medical necessity, or (2) a coinsurance, copayment, deductible or other
410 out-of-pocket expense for such coverage that places a greater financial
411 burden on an insured for access to the diagnosis and treatment of [an]
412 autism spectrum disorder than for the diagnosis and treatment of any
413 other medical, surgical or physical health condition under such policy.

414 [(f)] (e) (1) Except for treatments and services received by an insured
415 in an inpatient setting, an insurer, health care center, hospital service
416 corporation, medical service corporation or fraternal benefit society
417 may review a treatment plan developed as set forth in subsection (c) of
418 this section for such insured, in accordance with its utilization review
419 requirements, not more than once every six months unless such
420 insured's licensed physician, licensed psychologist or licensed clinical
421 social worker agrees that a more frequent review is necessary or
422 changes such insured's treatment plan.

423 (2) For the purposes of this section, the results of a diagnosis shall be
424 valid for a period of not less than twelve months, unless such insured's
425 licensed physician, licensed psychologist or licensed clinical social
426 worker determines a shorter period is appropriate or changes the

427 results of such insured's diagnosis.

428 [(g)] (f) Coverage required under this section may be subject to the
429 other general exclusions and limitations of the group health insurance
430 policy, including, but not limited to, coordination of benefits,
431 participating provider requirements, restrictions on services provided
432 by family or household members and case management provisions,
433 except that any utilization review shall be performed in accordance
434 with subsection [(f)] (e) of this section.

435 [(h)] (g) (1) Nothing in this section shall be construed to limit or
436 affect (A) any other covered benefits available to an insured under (i)
437 such group health insurance policy, (ii) section 38a-514, as amended by
438 this act, or (iii) section 38a-516a, as amended by this act, (B) any
439 obligation to provide services to an individual under an individualized
440 education program pursuant to section 10-76d, or (C) any obligation
441 imposed on a public school by the Individual With Disabilities
442 Education Act, 20 USC 1400 et seq., as amended from time to time.

443 (2) Nothing in this section shall be construed to require such group
444 health insurance policy to provide reimbursement for special
445 education and related services provided to an insured pursuant to
446 section 10-76d, unless otherwise required by state or federal law.

447 [(i) Each such group health insurance policy shall maintain, for any
448 insured diagnosed with autism spectrum disorder prior to the release
449 of the fifth edition of the American Psychiatric Association's
450 "Diagnostic and Statistical Manual of Mental Disorders", coverage as
451 set forth in this section for the treatment of said disorder at the benefit
452 levels, at a minimum, provided immediately preceding the release of
453 the fifth edition of the American Psychiatric Association's "Diagnostic
454 and Statistical Manual of Mental Disorders".]

455 Sec. 7. Section 38a-488b of the general statutes is repealed and the
456 following is substituted in lieu thereof (*Effective January 1, 2016*):

457 (a) As used in this section:

458 (1) "Applied behavior analysis" means the design, implementation
459 and evaluation of environmental modifications, using behavioral
460 stimuli and consequences, including the use of direct observation,
461 measurement and functional analysis of the relationship between
462 environment and behavior, to produce socially significant
463 improvement in human behavior.

464 (2) "Autism spectrum disorder services provider" means any person,
465 entity or group that provides treatment for an autism spectrum
466 disorder pursuant to this section.

467 (3) "Autism spectrum disorder" means "autism spectrum disorder"
468 as set forth in the most recent edition of the American Psychiatric
469 Association's "Diagnostic and Statistical Manual of Mental Disorders".

470 (4) "Behavioral therapy" means any interactive behavioral therapies
471 derived from evidence-based research and consistent with the services
472 and interventions designated by the Commissioner of Developmental
473 Services pursuant to subsection (l) of section 17a-215c, as amended by
474 this act, including, but not limited to, applied behavior analysis,
475 cognitive behavioral therapy, or other therapies supported by
476 empirical evidence of the effective treatment of individuals diagnosed
477 with autism spectrum disorder, that are: (A) Provided to children less
478 than twenty-one years of age; and (B) provided or supervised by (i) a
479 behavior analyst who is certified by the Behavior Analyst Certification
480 Board, (ii) a licensed physician, or (iii) a licensed psychologist. For the
481 purposes of this subdivision, behavioral therapy is "supervised by"
482 such behavior analyst, licensed physician or licensed psychologist
483 when such supervision entails at least one hour of face-to-face
484 supervision of the autism spectrum disorder services provider by such
485 behavior analyst, licensed physician or licensed psychologist for each
486 ten hours of behavioral therapy provided by the supervised provider.

487 (5) "Diagnosis" means the medically necessary assessment,

488 evaluation or testing performed by a licensed physician, licensed
489 psychologist or licensed clinical social worker to determine if an
490 individual has autism spectrum disorder.

491 [(a)] (b) Each individual health insurance policy providing coverage
492 of the type specified in subdivisions (1), (2), (4), (11) and (12) of section
493 38a-469 that is delivered, issued for delivery, renewed, amended or
494 continued in this state shall provide coverage [for physical therapy,
495 speech therapy and occupational therapy services] for the diagnosis
496 and treatment of autism spectrum disorder. [, as set forth in the most
497 recent edition of the American Psychiatric Association's "Diagnostic
498 and Statistical Manual of Mental Disorders", to the extent such services
499 are a covered benefit for other diseases and conditions under such
500 policy, except that coverage for an insured under such policy who has
501 been diagnosed with autism spectrum disorder prior to the release of
502 the fifth edition of the American Psychiatric Association's "Diagnostic
503 and Statistical Manual of Mental Disorders" shall be provided in
504 accordance with subsection (b) of this section.] For the purposes of this
505 section and section 38a-482a, autism spectrum disorder shall be
506 considered an illness.

507 (c) Such policy shall provide coverage for the following treatments,
508 provided such treatments are (1) medically necessary, and (2)
509 identified and ordered by a licensed physician, licensed psychologist
510 or licensed clinical social worker for an insured who is diagnosed with
511 autism spectrum disorder, in accordance with a treatment plan
512 developed by a behavior analyst who is certified by the Behavior
513 Analyst Certification Board, licensed physician, licensed psychologist
514 or licensed clinical social worker, pursuant to a comprehensive
515 evaluation or reevaluation of the insured:

516 (A) Behavioral therapy;

517 (B) Prescription drugs, to the extent prescription drugs are a
518 covered benefit for other diseases and conditions under such policy,

519 prescribed by a licensed physician, a licensed physician assistant or an
520 advanced practice registered nurse for the treatment of symptoms and
521 comorbidities of autism spectrum disorder;

522 (C) Direct psychiatric or consultative services provided by a
523 licensed psychiatrist;

524 (D) Direct psychological or consultative services provided by a
525 licensed psychologist;

526 (E) Physical therapy provided by a licensed physical therapist;

527 (F) Speech and language pathology services provided by a licensed
528 speech and language pathologist; and

529 (G) Occupational therapy provided by a licensed occupational
530 therapist.

531 (d) Such policy shall not impose (1) any limits on the number of
532 visits an insured may make to an autism spectrum disorder services
533 provider pursuant to a treatment plan on any basis other than a lack of
534 medical necessity, or (2) a coinsurance, copayment, deductible or other
535 out-of-pocket expense for such coverage that places a greater financial
536 burden on an insured for access to the diagnosis and treatment of
537 autism spectrum disorder than for the diagnosis and treatment of any
538 other medical, surgical or physical health condition under such policy.

539 (e) (1) Except for treatments and services received by an insured in
540 an inpatient setting, an insurer, health care center, hospital service
541 corporation, medical service corporation or fraternal benefit society
542 may review a treatment plan developed as set forth in subsection (c) of
543 this section for such insured, in accordance with its utilization review
544 requirements, not more than once every six months unless such
545 insured's licensed physician, licensed psychologist or licensed clinical
546 social worker agrees that a more frequent review is necessary or
547 changes such insured's treatment plan.

548 (2) For the purposes of this section, the results of a diagnosis shall be
549 valid for a period of not less than twelve months, unless such insured's
550 licensed physician, licensed psychologist or licensed clinical social
551 worker determines a shorter period is appropriate or changes the
552 results of such insured's diagnosis.

553 (f) Coverage required under this section may be subject to the other
554 general exclusions and limitations of the individual health insurance
555 policy, including, but not limited to, coordination of benefits,
556 participating provider requirements, restrictions on services provided
557 by family or household members and case management provisions,
558 except that any utilization review shall be performed in accordance
559 with subsection (e) of this section.

560 (g) (1) Nothing in this section shall be construed to limit or affect (A)
561 any other covered benefits available to an insured under (i) such
562 individual health insurance policy, (ii) section 38a-488a, as amended
563 by this act, or (iii) section 38a-490a, as amended by this act, (B) any
564 obligation to provide services to an individual under an individualized
565 education program pursuant to section 10-76d, or (C) any obligation
566 imposed on a public school by the Individual With Disabilities
567 Education Act, 20 USC 1400 et seq., as amended from time to time.

568 (2) Nothing in this section shall be construed to require such
569 individual health insurance policy to provide reimbursement for
570 special education and related services provided to an insured pursuant
571 to section 10-76d, unless otherwise required by state or federal law.

572 [(b) Each such policy shall maintain, for any insured diagnosed with
573 autism spectrum disorder prior to the release of the fifth edition of the
574 American Psychiatric Association's "Diagnostic and Statistical Manual
575 of Mental Disorders", coverage for physical therapy, speech therapy
576 and occupational therapy services for the treatment of said disorder at
577 the benefit levels, at a minimum, provided immediately preceding the
578 release of the fifth edition of the American Psychiatric Association's

579 "Diagnostic and Statistical Manual of Mental Disorders".]

580 Sec. 8. Section 38a-516a of the general statutes is repealed and the
581 following is substituted in lieu thereof (*Effective January 1, 2016*):

582 (a) Each group health insurance policy providing coverage of the
583 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
584 469 delivered, issued for delivery, renewed, amended or continued in
585 this state shall provide coverage for medically necessary early
586 intervention services provided as part of an individualized family
587 service plan pursuant to section 17a-248e. Such policy shall [(1)]
588 provide coverage for such services provided by qualified personnel, as
589 defined in section 17a-248, for a child from birth until the child's third
590 birthday; [, and (2) maintain, for any insured diagnosed with autism
591 spectrum disorder prior to the release of the fifth edition of the
592 American Psychiatric Association's "Diagnostic and Statistical Manual
593 of Mental Disorders", coverage for such services for the treatment of
594 said disorder at the benefit levels, at a minimum, provided
595 immediately preceding the release of the fifth edition of the American
596 Psychiatric Association's "Diagnostic and Statistical Manual of Mental
597 Disorders".]

598 (b) No such policy shall impose a coinsurance, copayment,
599 deductible or other out-of-pocket expense for such services, except that
600 a high deductible health plan, as that term is used in subsection (f) of
601 section 38a-520, shall not be subject to the deductible limits set forth in
602 this section.

603 [(c) Such policy shall provide a maximum benefit of six thousand
604 four hundred dollars per child per year and an aggregate benefit of
605 nineteen thousand two hundred dollars per child over the total three-
606 year period, except that for a child with autism spectrum disorder, as
607 defined in section 38a-514b, who is receiving early intervention
608 services as defined in section 17a-248, the maximum benefit available
609 through early intervention providers shall be fifty thousand dollars per

610 child per year and an aggregate benefit of one hundred fifty thousand
611 dollars per child over the total three-year period as provided for in
612 section 38a-514b. Nothing in this section shall be construed to increase
613 the amount of coverage required for autism spectrum disorder for any
614 child beyond the amounts set forth in section 38a-514b. Any coverage
615 provided for autism spectrum disorder through an individualized
616 family service plan pursuant to section 17a-248e shall be credited
617 toward the coverage amounts required under section 38a-514b.]

618 [(d)] (c) No payment made under this section shall (1) [be applied
619 by the insurer, health care center or plan administrator against or
620 result in a loss of benefits due to any maximum lifetime or annual
621 limits specified in the policy, (2)] adversely affect the availability of
622 health insurance to the child, the child's parent or the child's family
623 members insured under any such policy, or [(3)] (2) be a reason for the
624 insurer, health care center or plan administrator to rescind or cancel
625 such policy. Payments made under this section shall not be treated
626 differently than other claim experience for purposes of premium
627 rating.

628 Sec. 9. Section 38a-490a of the general statutes is repealed and the
629 following is substituted in lieu thereof (*Effective January 1, 2016*):

630 (a) Each individual health insurance policy providing coverage of
631 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
632 38a-469 delivered, issued for delivery, renewed, amended or continued
633 in this state shall provide coverage for medically necessary early
634 intervention services provided as part of an individualized family
635 service plan pursuant to section 17a-248e. Such policy shall [(1)]
636 provide coverage for such services provided by qualified personnel, as
637 defined in section 17a-248, for a child from birth until the child's third
638 birthday; [, and (2) maintain, for any insured diagnosed with autism
639 spectrum disorder prior to the release of the fifth edition of the
640 American Psychiatric Association's "Diagnostic and Statistical Manual
641 of Mental Disorders", coverage for such services for the treatment of

642 said disorder at the benefit levels, at a minimum, provided
643 immediately preceding the release of the fifth edition of the American
644 Psychiatric Association's "Diagnostic and Statistical Manual of Mental
645 Disorders".]

646 (b) No such policy shall impose a coinsurance, copayment,
647 deductible or other out-of-pocket expense for such services, except that
648 a high deductible health plan, as that term is used in subsection (f) of
649 section 38a-493, shall not be subject to the deductible limits set forth in
650 this section.

651 [(c) Such policy shall provide a maximum benefit of six thousand
652 four hundred dollars per child per year and an aggregate benefit of
653 nineteen thousand two hundred dollars per child over the total three-
654 year period.]

655 [(d)] (c) No payment made under this section shall (1) [be applied
656 by the insurer, health care center or plan administrator against or
657 result in a loss of benefits due to any maximum lifetime or annual
658 limits specified in the policy, (2)] adversely affect the availability of
659 health insurance to the child, the child's parent or the child's family
660 members insured under any such policy, or [(3)] (2) be a reason for the
661 insurer, health care center or plan administrator to rescind or cancel
662 such policy. Payments made under this section shall not be treated
663 differently than other claim experience for purposes of premium
664 rating.

665 Sec. 10. Section 17a-215c of the general statutes is amended by
666 adding subsection (l) as follows (*Effective from passage*):

667 (NEW) (l) The Commissioner of Developmental Services, in
668 consultation with the Autism Spectrum Disorder Advisory Council,
669 shall designate services and interventions that demonstrate, in
670 accordance with medically established and research-based best
671 practices, empirical effectiveness for the treatment of autism spectrum
672 disorder. The commissioner shall update such designations

673 periodically and whenever the commissioner deems it necessary to
674 conform to changes generally recognized by the relevant medical
675 community in evidence-based practices or research.

676 Sec. 11. Subdivision (3) of subsection (a) of section 38a-591c of the
677 general statutes is repealed and the following is substituted in lieu
678 thereof (*Effective July 1, 2015*):

679 (3) (A) Notwithstanding subdivision (2) of this subsection, for any
680 utilization review for the treatment of a substance use disorder, as
681 described in section 17a-458, the clinical review criteria used shall be:
682 (i) The most recent edition of the American Society of Addiction
683 [Medicine's Patient Placement Criteria] Medicine Treatment Criteria
684 for Addictive, Substance-Related, and Co-Occurring Conditions; or (ii)
685 clinical review criteria that the health carrier demonstrates is consistent
686 with the most recent edition of the American Society of Addiction
687 [Medicine's Patient Placement Criteria] Medicine Treatment Criteria
688 for Addictive, Substance-Related, and Co-Occurring Conditions, in
689 accordance with subparagraph (B) of this subdivision.

690 (B) A health carrier that uses clinical review criteria as set forth in
691 subparagraph (A)(ii) of this subdivision shall create and maintain a
692 document in an easily accessible location on such health carrier's
693 Internet web site that (i) compares each aspect of such clinical review
694 criteria with the American Society of Addiction [Medicine's Patient
695 Placement Criteria] Medicine Treatment Criteria for Addictive,
696 Substance-Related, and Co-Occurring Conditions, and (ii) provides
697 citations to peer-reviewed medical literature generally recognized by
698 the relevant medical community or to professional society guidelines
699 that justify each deviation from the American Society of Addiction
700 [Medicine's Patient Placement Criteria] Medicine Treatment Criteria
701 for Addictive, Substance-Related, and Co-Occurring Conditions.

702 Sec. 12. (*Effective from passage*) (a) Not later than October 1, 2015, the
703 Insurance Commissioner shall convene a working group to develop

704 recommendations for behavioral health utilization and quality
705 measures data that should be collected uniformly from state agencies
706 that pay health care claims, group hospitalization and medical and
707 surgical insurance plans established pursuant to section 5-259 of the
708 general statutes, the state medical assistance program and health
709 insurance companies and health care centers that write health
710 insurance policies and health care contracts in this state. The purposes
711 of such recommendations include, but are not limited to, protecting
712 behavioral health parity for youths and other populations.

713 (b) The working group shall consist of the Insurance Commissioner,
714 the Healthcare Advocate, the Commissioners of Social Services, Public
715 Health, Mental Health and Addiction Services, Children and Families
716 and Developmental Services and the Comptroller, or their designees,
717 and may include representatives from health insurance companies or
718 health care centers or any other members the Insurance Commissioner
719 deems necessary and relevant to carry out the working group's duties
720 under this section.

721 (c) (1) The working group shall determine the data that should be
722 collected to inform analysis on (A) coverage for behavioral health
723 services, (B) the adequacy of coverage for behavioral health conditions,
724 including, but not limited to, autism spectrum disorders and substance
725 use disorders, (C) the alignment of medical necessity criteria and
726 utilization management procedures across such agencies, plans,
727 program, companies and centers, (D) the adequacy of health care
728 provider networks, (E) the overall availability of behavioral health care
729 providers in this state, (F) the percentage of behavioral health care
730 providers in this state that are participating providers under a group
731 hospitalization and medical and surgical insurance plan established
732 pursuant to section 5-259 of the general statutes, the state medical
733 assistance program, or a health insurance policy or health care contract
734 delivered, issued for delivery, renewed, amended or continued in this
735 state, and (G) the adequacy of services available for behavioral health
736 conditions, including, but not limited to, autism spectrum disorders

737 and substance use disorders.

738 (2) The recommendations developed by the working group may
739 include data such as (A) per member, per month claim expenses, (B)
740 the median length of a covered treatment for an entire course of
741 treatment by levels of care, (C) utilization review outcome data
742 grouped by levels of care, age categories and levels of review as set
743 forth in part VII of chapter 700c of the general statutes, (D) the number
744 of in-network and out-of-network health care providers by location
745 and provider type, (E) health care provider network management data
746 by location and provider type, and (F) health care provider network
747 fluctuations, the causes of such fluctuations and the decisions made by
748 health insurance companies, health care centers and state agencies
749 regarding the approval of health care providers to join a health care
750 provider network.

751 (d) Not later than January 1, 2016, the Insurance Commissioner shall
752 submit a report of the recommendations of the working group as set
753 forth in subsection (a) of this section, in accordance with the provisions
754 of section 11-4a of the general statutes, to the Governor and the joint
755 standing committees of the General Assembly having cognizance of
756 matters relating to insurance, human services, public health and
757 children.

758 Sec. 13. Subsection (a) of section 38a-514 of the general statutes is
759 repealed and the following is substituted in lieu thereof (*Effective*
760 *January 1, 2016*):

761 (a) Except as provided in subsection (j) of this section, each group
762 health insurance policy, providing coverage of the type specified in
763 subdivisions (1), (2), (4), (11) and (12) of section 38a-469, delivered,
764 issued for delivery, renewed, amended or continued in this state shall
765 provide benefits for the diagnosis and treatment of mental or nervous
766 conditions. For the purposes of this section, "mental or nervous
767 conditions" means mental disorders, as defined in the most recent

768 edition of the American Psychiatric Association's "Diagnostic and
769 Statistical Manual of Mental Disorders". "Mental or nervous
770 conditions" does not include (1) intellectual disabilities, (2) specific
771 learning disorders, (3) motor disorders, (4) communication disorders,
772 (5) caffeine-related disorders, (6) relational problems, and (7) other
773 conditions that may be a focus of clinical attention, that are not
774 otherwise defined as mental disorders in the most recent edition of the
775 American Psychiatric Association's "Diagnostic and Statistical Manual
776 of Mental Disorders". [, except that coverage for an insured under such
777 policy who has been diagnosed with autism spectrum disorder prior to
778 the release of the fifth edition of the American Psychiatric Association's
779 "Diagnostic and Statistical Manual of Mental Disorders" shall be
780 provided in accordance with subsection (i) of section 38a-514b.]

781 Sec. 14. Subsection (a) of section 38a-488a of the general statutes is
782 repealed and the following is substituted in lieu thereof (*Effective*
783 *January 1, 2016*):

784 (a) Each individual health insurance policy providing coverage of
785 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
786 38a-469 delivered, issued for delivery, renewed, amended or continued
787 in this state shall provide benefits for the diagnosis and treatment of
788 mental or nervous conditions. For the purposes of this section, "mental
789 or nervous conditions" means mental disorders, as defined in the most
790 recent edition of the American Psychiatric Association's "Diagnostic
791 and Statistical Manual of Mental Disorders". "Mental or nervous
792 conditions" does not include (1) intellectual disabilities, (2) specific
793 learning disorders, (3) motor disorders, (4) communication disorders,
794 (5) caffeine-related disorders, (6) relational problems, and (7) other
795 conditions that may be a focus of clinical attention, that are not
796 otherwise defined as mental disorders in the most recent edition of the
797 American Psychiatric Association's "Diagnostic and Statistical Manual
798 of Mental Disorders". [, except that coverage for an insured under such
799 policy who has been diagnosed with autism spectrum disorder prior to
800 the release of the fifth edition of the American Psychiatric Association's

801 "Diagnostic and Statistical Manual of Mental Disorders" shall be
802 provided in accordance with subsection (b) of section 38a-488b.]

803 Sec. 15. Subsection (j) of section 21a-254 of the general statutes, as
804 amended by section 5 of substitute house bill 6856 of the current
805 session, as amended by House Amendment Schedule "A", is repealed
806 and the following is substituted in lieu thereof (*Effective October 1,*
807 *2015*):

808 (j) (1) The commissioner shall, within available appropriations,
809 establish an electronic prescription drug monitoring program to
810 collect, by electronic means, prescription information for schedules II,
811 III, IV and V controlled substances that are dispensed by pharmacies,
812 nonresident pharmacies, as defined in section 20-627, outpatient
813 pharmacies in hospitals or institutions or by any other dispenser. The
814 program shall be designed to provide information regarding the
815 prescription of controlled substances in order to prevent the improper
816 or illegal use of the controlled substances and shall not infringe on the
817 legitimate prescribing of a controlled substance by a prescribing
818 practitioner acting in good faith and in the course of professional
819 practice.

820 (2) The commissioner may identify other products or substances to
821 be included in the electronic prescription drug monitoring program
822 established pursuant to subdivision (1) of this subsection.

823 (3) [Each] Prior to July 1, 2016, each pharmacy, nonresident
824 pharmacy, as defined in section 20-627, outpatient pharmacy in a
825 hospital or institution and dispenser shall report to the commissioner,
826 at least weekly, by electronic means or, if a pharmacy or outpatient
827 pharmacy does not maintain records electronically, in a format
828 approved by the commissioner, the following information for all
829 controlled substance prescriptions dispensed by such pharmacy or
830 outpatient pharmacy: (A) Dispenser identification number; (B) the date
831 the prescription for the controlled substance was filled; (C) the

832 prescription number; (D) whether the prescription for the controlled
833 substance is new or a refill; (E) the national drug code number for the
834 drug dispensed; (F) the amount of the controlled substance dispensed
835 and the number of days' supply of the controlled substance; (G) a
836 patient identification number; (H) the patient's first name, last name
837 and street address, including postal code; (I) the date of birth of the
838 patient; (J) the date the prescription for the controlled substance was
839 issued by the prescribing practitioner and the prescribing practitioner's
840 Drug Enforcement Agency's identification number; and (K) the type of
841 payment.

842 (4) On and after July 1, 2016, each pharmacy, nonresident pharmacy,
843 as defined in section 20-627, outpatient pharmacy in a hospital or
844 institution, and dispenser shall report to the commissioner by
845 electronic means, in a format approved by the commissioner, the
846 following information for all controlled substance prescriptions
847 dispensed by such pharmacy or outpatient pharmacy immediately
848 upon, but in no event more than twenty-four hours after, dispensing
849 such prescriptions: (A) Dispenser identification number; (B) the date
850 the prescription for the controlled substance was filled; (C) the
851 prescription number; (D) whether the prescription for the controlled
852 substance is new or a refill; (E) the national drug code number for the
853 drug dispensed; (F) the amount of the controlled substance dispensed
854 and the number of days' supply of the controlled substance; (G) a
855 patient identification number; (H) the patient's first name, last name
856 and street address, including postal code; (I) the date of birth of the
857 patient; (J) the date the prescription for the controlled substance was
858 issued by the prescribing practitioner and the prescribing practitioner's
859 Drug Enforcement Agency's identification number; and (K) the type of
860 payment.

861 ~~[(4)]~~ (5) The commissioner may contract with a vendor for purposes
862 of electronically collecting such controlled substance prescription
863 information. The commissioner and any such vendor shall maintain
864 the information in accordance with the provisions of chapter 400j.

865 [(5)] (6) The commissioner and any such vendor shall not disclose
866 controlled substance prescription information reported pursuant to
867 [subdivision (3)] subdivisions (3) and (4) of this subsection, except as
868 authorized pursuant to the provisions of sections 21a-240 to 21a-283,
869 inclusive. Any person who knowingly violates any provision of this
870 subdivision or subdivision [(4)] (5) of this subsection shall be guilty of
871 a class D felony.

872 [(6)] (7) The commissioner shall provide, upon request, controlled
873 substance prescription information obtained in accordance with
874 [subdivision (3)] subdivisions (3) and (4) of this subsection to the
875 following: (A) The prescribing practitioner, or such practitioner's
876 authorized agent who is also a licensed health care professional, who is
877 treating or has treated a specific patient, provided the information is
878 obtained for purposes related to the treatment of the patient, including
879 the monitoring of controlled substances obtained by the patient; (B) the
880 prescribing practitioner with whom a patient has made contact for the
881 purpose of seeking medical treatment, provided the request is
882 accompanied by a written consent, signed by the prospective patient,
883 for the release of controlled substance prescription information; or (C)
884 the pharmacist who is dispensing controlled substances for a patient,
885 provided the information is obtained for purposes related to the scope
886 of the pharmacist's practice and management of the patient's drug
887 therapy, including the monitoring of controlled substances obtained by
888 the patient. The prescribing practitioner, such practitioner's authorized
889 agent, or the pharmacist shall submit a written and signed request to
890 the commissioner for controlled substance prescription information.
891 Such prescribing practitioner or pharmacist shall not disclose any such
892 request except as authorized pursuant to sections 20-570 to 20-630,
893 inclusive, or sections 21a-240 to 21a-283, inclusive.

894 [(7)] (8) No person or employer shall prohibit, discourage or impede
895 a prescribing practitioner or pharmacist from requesting controlled
896 substance prescription information pursuant to this subsection.

897 [(8)] (9) Prior to prescribing greater than a seventy-two-hour supply
898 of any controlled substance to any patient, the prescribing practitioner
899 or such practitioner's authorized agent who is also a licensed health
900 care professional shall review the patient's records in the electronic
901 prescription drug monitoring program established pursuant to this
902 subsection. Whenever a prescribing practitioner prescribes controlled
903 substances for the continuous or prolonged treatment of any patient,
904 such prescriber, or such prescriber's authorized agent who is also a
905 licensed health care professional, shall review, not less than once every
906 ninety days, the patient's records in such prescription drug monitoring
907 program. If such electronic prescription drug monitoring program is
908 not operational, such prescriber may prescribe greater than a seventy-
909 two-hour supply of a controlled substance to a patient during the time
910 of such program's inoperability, provided such prescriber or such
911 authorized agent reviews the records of such patient in such program
912 not more than twenty-four hours after regaining access to such
913 program.

914 [(9)] (10) The commissioner shall adopt regulations, in accordance
915 with chapter 54, concerning the reporting, evaluation, management
916 and storage of electronic controlled substance prescription
917 information.

918 [(10)] (11) The provisions of this section shall not apply to (A)
919 samples of controlled substances dispensed by a physician to a patient,
920 or (B) any controlled substances dispensed to hospital inpatients.

921 [(11)] (12) The provisions of this section shall not apply to any
922 institutional pharmacy or pharmacist's drug room operated by a
923 facility, licensed under section 19a-495 and regulations adopted
924 pursuant to said section 19a-495, that dispenses or administers directly
925 to a patient an opioid agonist for treatment of a substance use disorder.

926 Sec. 16. (NEW) (*Effective July 1, 2015*) (a) There is established within
927 the Department of Mental Health and Addiction Services a grant

928 program for the purposes of providing community-based behavioral
929 health services, including (1) care coordination services, and (2) access
930 to information on and referrals to, available health care and social
931 service programs. Such services shall be provided by organizations
932 that provide acute care and emergency behavioral health services. The
933 Commissioner of Mental Health and Addiction Services shall establish
934 eligibility criteria for grants under the program and an application
935 process.

936 (b) Grants shall be issued under the program for the purposes of
937 providing community-based behavioral health services, including (1)
938 care coordination services, and (2) access to information on, and
939 referrals to, available health care and social service programs.

940 Sec. 17. (*Effective July 1, 2015*) (a) The Commissioner of Mental
941 Health and Addiction Services shall, in consultation with the
942 Commissioners of Children and Families and Social Services and
943 providers of behavioral health services, including, but not limited to,
944 hospitals and advocacy agencies, study the current adequacy of
945 psychiatric services. Such study shall include, but need not be limited
946 to: (1) A determination of the number of short-term, intermediate and
947 long-term psychiatric beds needed in each region of the state; (2) the
948 average wait times for each type of psychiatric beds; (3) the impact of
949 wait times on persons in need of inpatient psychiatric services, such
950 persons' families and providers of such inpatient care; (4) identification
951 of public and private funding sources to maintain the number of
952 psychiatric beds needed in the state; (5) access to outpatient services
953 including wait times for initial appointments; (6) available housing
954 options; and (7) access to alternatives to hospitalization including, but
955 not limited to, peer-operated respite programs.

956 (b) Not later than January 1, 2017, the Commissioner of Mental
957 Health and Addiction Services shall report, in accordance with the
958 provisions of section 11-4a of the general statutes, to the joint standing
959 committees of the General Assembly having cognizance of matters

960 relating to appropriations, public health and human services
961 concerning the results of the study described in subsection (a) of this
962 section. Such report shall include, but need not be limited to,
963 recommendations concerning: (1) Expansion of the utilization criteria
964 to increase access to acute, inpatient psychiatric services throughout
965 the state; (2) an increase in the number of long-term, inpatient
966 hospitalization beds available for persons with recurring needs for
967 inpatient behavioral health services; (3) funding to increase the
968 number of psychiatric beds; (4) placement of additional psychiatric
969 beds in health care facilities throughout the state; and (5) funding to
970 increase alternatives to hospitalization, including, but not limited to,
971 access to outpatient services, housing and peer-operated respite
972 programs.

973 Sec. 18. Subdivision (12) of subsection (g) of section 17a-28 of the
974 general statutes is repealed and the following is substituted in lieu
975 thereof (*Effective July 1, 2015*):

976 (12) The Department of Developmental Services, to allow said
977 department to determine eligibility, facilitate enrollment and plan for
978 the provision of services to a child who is a client of said department
979 and who is applying to enroll in or is enrolled in said department's
980 [voluntary] behavioral services program. At the time that a parent or
981 guardian completes an application for enrollment of a child in the
982 Department of Developmental Services' [voluntary] behavioral
983 services program, or at the time that said department updates a child's
984 annual individualized plan of care, said department shall notify such
985 parent or guardian that the Department of Children and Families may
986 provide records to the Department of Developmental Services for the
987 purposes specified in this subdivision without the consent of such
988 parent or guardian;

989 Sec. 19. Subsection (i) of section 17b-261 of the general statutes is
990 repealed and the following is substituted in lieu thereof (*Effective July*
991 *1, 2015*):

992 (i) Medical assistance shall be provided, in accordance with the
993 provisions of subsection (e) of section 17a-6, to any child under the
994 supervision of the Commissioner of Children and Families who is not
995 receiving Medicaid benefits, has not yet qualified for Medicaid benefits
996 or is otherwise ineligible for such benefits. Medical assistance shall also
997 be provided to any child in the [voluntary] behavioral services
998 program operated by the Department of Developmental Services who
999 is not receiving Medicaid benefits, has not yet qualified for Medicaid
1000 benefits or is otherwise ineligible for benefits. To the extent practicable,
1001 the Commissioner of Children and Families and the Commissioner of
1002 Developmental Services shall apply for, or assist such child in
1003 qualifying for, the Medicaid program.

1004 Sec. 20. (*Effective from passage*) (a) The Commissioner of Social
1005 Services and the Commissioner of Public Health shall study the
1006 effectiveness of providing community-based health care services in the
1007 state. Such study shall include, but not be limited to, a review of (1) the
1008 health care needs of persons who access the 9-1-1 system when the
1009 emergency department is not the most appropriate place for such
1010 persons to receive such services, (2) the feasibility of providing short-
1011 term follow-up home visits for persons who have recently been
1012 discharged from a hospital until such time as other health care
1013 providers are able to provide home visits or other follow-up health
1014 care services, (3) the need and feasibility of emergency medical
1015 services personnel to provide home visits to persons who are at a high
1016 risk of being frequent, repeat users of the emergency department to
1017 help such persons manage their chronic diseases and adhere to
1018 medication plans, (4) the need to provide ancillary primary care
1019 services for populations in areas where there is a high utilization of the
1020 9-1-1 system for nonemergency situations, (5) the current best practices
1021 in mobile integrated health care, (6) the scope of practice for
1022 emergency medical services personnel, (7) practice guidelines for
1023 community-based health care services, and (8) Medicaid authority
1024 under which community-based health care services may be covered.

1025 (b) Not later than February 1, 2016, the Commissioners of Social
1026 Services and Public Health shall submit a preliminary report, in
1027 accordance with the provisions of section 11-4a of the general statutes,
1028 on the study performed pursuant to subsection (a) of this section to the
1029 joint standing committees of the General Assembly having cognizance
1030 of matters relating to human services and public health.

1031 (c) Not later than June 1, 2016, the Commissioners of Social Services
1032 and Public Health shall submit a final report, in accordance with the
1033 provisions of section 11-4a of the general statutes, on the results of the
1034 study performed pursuant to subsection (a) of this section to the joint
1035 standing committees of the General Assembly having cognizance of
1036 matters relating to human services and public health.

1037 Sec. 21. (NEW) (*Effective October 1, 2015*) As used in this section,
1038 sections 22 to 26, inclusive, of this act and section 19a-14 of the general
1039 statutes, as amended by this act: (1) "Genetic counselor" means a
1040 person who has been licensed as a genetic counselor under the
1041 provisions of sections 22 to 26, inclusive, of this act; and (2) "genetic
1042 counseling" means the provision of services to individuals, couples,
1043 families and organizations by an appropriately trained individual to
1044 address the physical and psychological issues associated with the
1045 occurrence or risk of occurrence of a genetic disorder, birth defect or
1046 genetically influenced condition or disease in an individual or a family.

1047 Sec. 22. (NEW) (*Effective October 1, 2015*) (a) No person may practice
1048 genetic counseling unless licensed or permitted pursuant to section 23
1049 or 24 of this act.

1050 (b) No person may use the title "genetic counselor", "licensed genetic
1051 counselor", "gene counselor", "genetic consultant", "genetic associate",
1052 or the designation "LGC" or make use of any title, words, letters,
1053 abbreviations or insignia that may reasonably be confused with
1054 licensure as a genetic counselor unless such person is licensed
1055 pursuant to section 23 of this act or has been issued a temporary

1056 permit pursuant to section 24 of this act.

1057 (c) The provisions of this section shall not apply to a person who (1)
1058 is licensed under chapter 370 of the general statutes, (2) is an advanced
1059 practice registered nurse licensed under chapter 378 of the general
1060 statutes, (3) is a nurse-midwife licensed under chapter 377 of the
1061 general statutes, (4) provides genetic counseling while acting within
1062 the scope of practice of the person's license and training, provided the
1063 person does not hold himself or herself out to the public as a genetic
1064 counselor, (5) is employed by the federal government to provide
1065 genetic counseling while in the discharge of the person's official duties,
1066 or (6) is a student enrolled in (A) a genetic counseling educational
1067 program, (B) a medical genetics educational program accredited by the
1068 American Board of Genetic Counseling, or any successor of said board,
1069 or the American Board of Medical Genetics and Genomics, or (C) a
1070 graduate nursing or medical education program in genetics, and
1071 genetic counseling is an integral part of the student's course of study
1072 and such student is performing such counseling under the direct
1073 supervision of a licensed genetic counselor or physician.

1074 Sec. 23. (NEW) (*Effective from passage*) (a) On and after October 1,
1075 2015, the Commissioner of Public Health shall grant a license as a
1076 genetic counselor to any applicant who, except as provided in
1077 subsections (b) and (c) of this section, furnishes evidence satisfactory to
1078 the commissioner that such applicant has earned a certification as a
1079 genetic counselor from the American Board of Genetic Counseling, or
1080 any successor of said board, or the American Board of Medical
1081 Genetics and Genomics. The commissioner shall develop and provide
1082 application forms. The application fee shall be three hundred fifteen
1083 dollars.

1084 (b) An applicant for a license as a genetic counselor may, in lieu of
1085 the requirements set forth in subsection (a) of this section, submit
1086 evidence satisfactory to the commissioner of having, prior to October
1087 1, 2015: (1) Acquired eight years of experience in the practice of genetic

1088 counseling; (2) earned, from an accredited institution of higher
1089 education, a master's or doctoral degree in genetics or a related field;
1090 and (3) attended a continuing education program approved by the
1091 National Society of Genetic Counselors within the five-year period
1092 prior to the date of application.

1093 (c) An applicant for licensure by endorsement shall present
1094 evidence satisfactory to the commissioner that the applicant is licensed
1095 or certified as a genetic counselor, or as a person entitled to perform
1096 similar services under a different designation, in another state or
1097 jurisdiction that has requirements for practicing in such capacity that
1098 are substantially similar to, or higher than, those of this state and that
1099 there are no disciplinary actions or unresolved complaints pending in
1100 this state or any other state.

1101 (d) Licenses issued under this section shall be renewed annually
1102 pursuant to section 19a-88 of the general statutes. The fee for such
1103 renewal shall be one hundred ninety dollars. Each licensed genetic
1104 counselor applying for license renewal shall furnish evidence
1105 satisfactory to the commissioner of having current certification with
1106 the American Board of Genetic Counseling, or any successor of said
1107 board, or the American Board of Medical Genetics and Genomics and
1108 having obtained continuing education units for certification as
1109 required by said boards.

1110 Sec. 24. (NEW) (*Effective October 1, 2015*) The Department of Public
1111 Health may issue a temporary permit to an applicant for licensure as a
1112 genetic counselor who holds a master's degree or higher in genetic
1113 counseling or a related field. Such temporary permit shall authorize
1114 the holder of the temporary permit to practice genetic counseling
1115 under the general supervision of a licensed genetic counselor or a
1116 licensed physician at all times during which the holder of the
1117 temporary permit performs genetic counseling. Such temporary permit
1118 shall be valid for a period not to exceed three hundred sixty-five
1119 calendar days after the date of attaining such master's degree or higher

1120 and shall not be renewable. No temporary permit shall be issued
1121 under this section to any applicant against whom professional
1122 disciplinary action is pending or who is the subject of an unresolved
1123 complaint in this state or any other state. The commissioner may
1124 revoke a temporary permit for good cause, as determined by the
1125 commissioner. The fee for a temporary permit shall be fifty dollars.

1126 Sec. 25. (NEW) (*Effective October 1, 2015*) The Commissioner of
1127 Public Health may take any disciplinary action set forth in section 19a-
1128 17 of the general statutes against a genetic counselor for any of the
1129 following reasons: (1) Failure to conform to the accepted standards of
1130 the profession; (2) conviction of a felony; (3) fraud or deceit in
1131 obtaining or seeking reinstatement of a license to practice genetic
1132 counseling; (4) fraud or deceit in the practice of genetic counseling; (5)
1133 negligent, incompetent or wrongful conduct in professional activities;
1134 (6) physical, mental or emotional illness or disorder resulting in an
1135 inability to conform to the accepted standards of the profession; (7)
1136 alcohol or substance abuse; or (8) wilful falsification of entries in any
1137 hospital, patient or other record pertaining to genetic counseling. The
1138 commissioner may order a license holder to submit to a reasonable
1139 physical or mental examination if his or her physical or mental
1140 capacity to practice safely is the subject of an investigation. The
1141 commissioner may petition the superior court for the judicial district of
1142 Hartford to enforce such order or any action taken pursuant to section
1143 19a-17 of the general statutes. The commissioner shall give notice and
1144 an opportunity to be heard on any contemplated action under section
1145 19a-17 of the general statutes.

1146 Sec. 26. (NEW) (*Effective October 1, 2015*) The Commissioner of
1147 Public Health may adopt regulations, in accordance with the
1148 provisions of chapter 54 of the general statutes, to implement the
1149 provisions of sections 21 to 25, inclusive, of this act.

1150 Sec. 27. Subsection (c) of section 19a-14 of the general statutes is
1151 repealed and the following is substituted in lieu thereof (*Effective*

1152 *October 1, 2015*):

1153 (c) No board shall exist for the following professions that are
1154 licensed or otherwise regulated by the Department of Public Health:

1155 (1) Speech and language pathologist and audiologist;

1156 (2) Hearing instrument specialist;

1157 (3) Nursing home administrator;

1158 (4) Sanitarian;

1159 (5) Subsurface sewage system installer or cleaner;

1160 (6) Marital and family therapist;

1161 (7) Nurse-midwife;

1162 (8) Licensed clinical social worker;

1163 (9) Respiratory care practitioner;

1164 (10) Asbestos contractor and asbestos consultant;

1165 (11) Massage therapist;

1166 (12) Registered nurse's aide;

1167 (13) Radiographer;

1168 (14) Dental hygienist;

1169 (15) Dietitian-Nutritionist;

1170 (16) Asbestos abatement worker;

1171 (17) Asbestos abatement site supervisor;

1172 (18) Licensed or certified alcohol and drug counselor;

- 1173 (19) Professional counselor;
- 1174 (20) Acupuncturist;
- 1175 (21) Occupational therapist and occupational therapist assistant;
- 1176 (22) Lead abatement contractor, lead consultant contractor, lead
1177 consultant, lead abatement supervisor, lead abatement worker,
1178 inspector and planner-project designer;
- 1179 (23) Emergency medical technician, advanced emergency medical
1180 technician, emergency medical responder and emergency medical
1181 services instructor;
- 1182 (24) Paramedic;
- 1183 (25) Athletic trainer;
- 1184 (26) Perfusionist;
- 1185 (27) Master social worker subject to the provisions of section 20-
1186 195v;
- 1187 (28) Radiologist assistant, subject to the provisions of section 20-74tt;
- 1188 (29) Homeopathic physician;
- 1189 (30) Certified water treatment plant operator, certified distribution
1190 system operator, certified small water system operator, certified
1191 backflow prevention device tester and certified cross connection
1192 survey inspector, including certified limited operators, certified
1193 conditional operators and certified operators in training; [and]
- 1194 (31) Tattoo technician; and
- 1195 (32) Genetic counselor.
- 1196 The department shall assume all powers and duties normally vested
1197 with a board in administering regulatory jurisdiction over such

1198 professions. The uniform provisions of this chapter and chapters 368v,
1199 369 to 381a, inclusive, 383 to 388, inclusive, 393a, 395, 398, 399, 400a
1200 and 400c, including, but not limited to, standards for entry and
1201 renewal; grounds for professional discipline; receiving and processing
1202 complaints; and disciplinary sanctions, shall apply, except as otherwise
1203 provided by law, to the professions listed in this subsection.

1204 Sec. 28. Subdivision (14) of subsection (b) of section 17a-408 of the
1205 general statutes is repealed and the following is substituted in lieu
1206 thereof (*Effective July 1, 2015*):

1207 (14) Implement and administer, [on and after July 1, 2014] within
1208 available appropriations, a pilot program that serves home and
1209 community-based care recipients in Hartford County; and

1210 Sec. 29. Subdivision (3) of subsection (b) of section 10-295 of the
1211 general statutes is repealed and the following is substituted in lieu
1212 thereof (*Effective July 1, 2015*):

1213 (3) The Commissioner of Rehabilitation Services may, within
1214 available appropriations, employ certified teachers of the visually
1215 impaired in sufficient numbers to meet the requests for services
1216 received from school districts. In responding to such requests, the
1217 commissioner shall utilize a formula for determining the number of
1218 teachers needed to serve the school districts, crediting six points for
1219 each Braille-learning child and one point for each other child, with one
1220 full-time certified teacher of the visually impaired assigned for every
1221 twenty-five points credited. The commissioner shall exercise due
1222 diligence to employ the needed number of certified teachers of the
1223 visually impaired, but shall not be liable for lack of resources. Funds
1224 appropriated to said account may also be utilized to employ
1225 [rehabilitation teachers, rehabilitation technologists and orientation
1226 and mobility teachers] additional staff in numbers sufficient to provide
1227 compensatory skills evaluations and training to blind and visually
1228 impaired children [. In addition, up to five per cent of such

1229 appropriation may also be utilized to employ] and special assistants to
1230 the blind and other support staff necessary to ensure the efficient
1231 operation of service delivery. Not later than October first of each year,
1232 the Commissioner of Rehabilitation Services shall determine the
1233 number of teachers needed based on the formula provided in this
1234 subdivision. Based on such determination, the Commissioner of
1235 Rehabilitation Services shall estimate the funding needed to pay such
1236 teachers' salaries [, benefits] and related expenses.

1237 Sec. 30. Subsection (a) of section 17b-261 of the general statutes is
1238 repealed and the following is substituted in lieu thereof (*Effective*
1239 *August 1, 2015*):

1240 (a) Medical assistance shall be provided for any otherwise eligible
1241 person whose income, including any available support from legally
1242 liable relatives and the income of the person's spouse or dependent
1243 child, is not more than one hundred forty-three per cent, pending
1244 approval of a federal waiver applied for pursuant to subsection (e) of
1245 this section, of the benefit amount paid to a person with no income
1246 under the temporary family assistance program in the appropriate
1247 region of residence and if such person is an institutionalized
1248 individual as defined in Section 1917 of the Social Security Act, 42 USC
1249 1396p(h)(3), and has not made an assignment or transfer or other
1250 disposition of property for less than fair market value for the purpose
1251 of establishing eligibility for benefits or assistance under this section.
1252 Any such disposition shall be treated in accordance with Section
1253 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
1254 property made on behalf of an applicant or recipient or the spouse of
1255 an applicant or recipient by a guardian, conservator, person
1256 authorized to make such disposition pursuant to a power of attorney
1257 or other person so authorized by law shall be attributed to such
1258 applicant, recipient or spouse. A disposition of property ordered by a
1259 court shall be evaluated in accordance with the standards applied to
1260 any other such disposition for the purpose of determining eligibility.
1261 The commissioner shall establish the standards for eligibility for

1262 medical assistance at one hundred forty-three per cent of the benefit
1263 amount paid to a [family unit] household of equal size with no income
1264 under the temporary family assistance program in the appropriate
1265 region of residence. In determining eligibility, the commissioner shall
1266 not consider as income Aid and Attendance pension benefits granted
1267 to a veteran, as defined in section 27-103, or the surviving spouse of
1268 such veteran. Except as provided in section 17b-277, as amended by
1269 this act, and section 17b-292, as amended by this act, the medical
1270 assistance program shall provide coverage to persons under the age of
1271 nineteen with [family] household income up to one hundred [eighty-
1272 five] ninety-six per cent of the federal poverty level without an asset
1273 limit and to persons under the age of nineteen who qualify for
1274 coverage under Section 1931 of the Social Security Act, with household
1275 income not exceeding one hundred ninety-six per cent of the federal
1276 poverty level without an asset limit, and their parents and needy
1277 caretaker relatives, who qualify for coverage under Section 1931 of the
1278 Social Security Act, with [family] household income [up to] not
1279 exceeding one hundred [eighty-five] fifty per cent of the federal
1280 poverty level without an asset limit. Such levels shall be based on the
1281 regional differences in such benefit amount, if applicable, unless such
1282 levels based on regional differences are not in conformance with
1283 federal law. Any income in excess of the applicable amounts shall be
1284 applied as may be required by said federal law, and assistance shall be
1285 granted for the balance of the cost of authorized medical assistance.
1286 The Commissioner of Social Services shall provide applicants for
1287 assistance under this section, at the time of application, with a written
1288 statement advising them of (1) the effect of an assignment or transfer
1289 or other disposition of property on eligibility for benefits or assistance,
1290 (2) the effect that having income that exceeds the limits prescribed in
1291 this subsection will have with respect to program eligibility, and (3)
1292 the availability of, and eligibility for, services provided by the
1293 Nurturing Families Network established pursuant to section 17b-751b.
1294 For coverage dates on or after January 1, 2014, the department will use
1295 the modified adjusted gross income financial eligibility rules set forth

1296 in Section 1902(e)(14) of the Social Security Act and the implementing
1297 regulations to determine eligibility for HUSKY A, HUSKY B and
1298 HUSKY D applicants, as defined in section 17b-290, as amended by
1299 this act. Persons who are determined ineligible for assistance pursuant
1300 to this section shall be provided a written statement notifying such
1301 persons of their ineligibility and advising such persons of [the
1302 availability of HUSKY Plan, Part B health insurance benefits] their
1303 eligibility for one of the other insurance affordability programs as
1304 defined in 42 CFR 435.4.

1305 Sec. 31. (NEW) (*Effective from passage*) (a) The Commissioner of
1306 Social Services shall review whether a parent or needy caretaker
1307 relative, who qualifies for coverage under Section 1931 of the Social
1308 Security Act and is no longer eligible on and after August 1, 2015, for
1309 Medicaid pursuant to section 17b-261 of the general statutes, as
1310 amended by this act, remains eligible for Medicaid under the same or a
1311 different category of coverage before terminating Medicaid benefits.

1312 (b) The commissioner and the Connecticut Health Insurance
1313 Exchange, established pursuant to section 38a-1081 of the general
1314 statutes, shall ensure that such parent or needy caretaker relative is
1315 given an opportunity to enroll in a qualified health plan without a gap
1316 in coverage. The Connecticut Health Insurance Exchange shall enlist
1317 the assistance of health and social services community-based
1318 organizations to contact and advise such parent or needy caretaker
1319 relative of options for health insurance coverage.

1320 (c) Not later than November 1, 2015, and quarterly thereafter until
1321 December 1, 2017, the commissioner and the Connecticut Health
1322 Insurance Exchange shall report to the Council on Medical Assistance
1323 Program Oversight on the number of such parents and caretaker
1324 relatives who, due to changes in income eligibility effective August 1,
1325 2015, (1) were no longer eligible for Medicaid, (2) remained eligible
1326 after the commissioner's review pursuant to this section, (3) lost
1327 Medicaid coverage and enrolled in a qualified health plan without a

1328 gap in coverage, (4) lost Medicaid coverage and did not enroll in a
1329 qualified health plan immediately after such coverage loss, and (5)
1330 enrolled in a qualified health plan but were disenrolled for failure to
1331 pay premiums.

1332 Sec. 32. Section 17b-277 of the general statutes is repealed and the
1333 following is substituted in lieu thereof (*Effective July 1, 2015*):

1334 (a) The Commissioner of Social Services shall provide, in accordance
1335 with federal law and regulations, medical assistance under the
1336 Medicaid program to needy pregnant women whose families have an
1337 income not exceeding two hundred [fifty] fifty-eight per cent of the
1338 federal poverty level.

1339 (b) The commissioner shall implement presumptive eligibility for
1340 appropriate pregnant women applicants for the Medicaid program in
1341 accordance with Section 1920 of the Social Security Act. The
1342 commissioner shall designate qualified entities to receive and
1343 determine presumptive eligibility under this section consistent with
1344 the provisions of federal law and regulations.

1345 [(c) On or before September 30, 2007, the Commissioner of Social
1346 Services shall submit a state plan amendment or, if required by the
1347 federal government, seek a waiver under federal law to provide health
1348 insurance coverage to pregnant women, who do not otherwise have
1349 creditable coverage, as defined in 42 USC 300gg(c), and who have
1350 income above one hundred eighty-five per cent of the federal poverty
1351 level but not in excess of two hundred fifty per cent of the federal
1352 poverty level. Following approval of such state plan amendment or
1353 approval of such waiver application, the commissioner, on or before
1354 January 1, 2008, shall implement the provisions of subsections (a) and
1355 (b) of this section.]

1356 [(d)] (c) Presumptive eligibility for medical assistance shall be
1357 implemented for any uninsured newborn child born in a hospital in
1358 this state or a border state hospital, provided (1) the parent or

1359 caretaker relative of such child resides in this state, and (2) the parent
1360 or caretaker relative of such child authorizes enrollment in the
1361 program.

1362 Sec. 33. Section 17b-290 of the general statutes is repealed and the
1363 following is substituted in lieu thereof (*Effective August 1, 2015*):

1364 As used in sections [17b-289] 17b-290 to 17b-303, inclusive, as
1365 amended by this act: [and section 16 of public act 97-1 of the October
1366 29 special session:]

1367 (1) "Applicant" means an individual over the age of eighteen years
1368 who is a natural or adoptive parent, [or] a legal guardian, [;] a
1369 caretaker relative, foster parent or stepparent with whom the child
1370 resides [; or a noncustodial parent under order of a court or family
1371 support magistrate to provide health insurance, who applies for
1372 coverage under the HUSKY Plan, Part B on behalf of a child] and shall
1373 include a child who is eighteen years of age or emancipated in
1374 accordance with the provisions of sections 46b-150 to 46b-150e,
1375 inclusive, and who is applying on his own behalf or on behalf of a
1376 minor dependent for coverage under such plan;

1377 (2) "Child" means an individual under nineteen years of age;

1378 (3) "Coinsurance" means the sharing of health care expenses by the
1379 insured and an insurer in a specified ratio;

1380 (4) "Commissioner" means the Commissioner of Social Services;

1381 (5) "Copayment" means a payment made on behalf of [an enrollee] a
1382 member for a specified service under [the HUSKY Plan, Part B]
1383 HUSKY B;

1384 (6) "Cost sharing" means arrangements made on behalf of [an
1385 enrollee] a member whereby an applicant pays a portion of the cost of
1386 health services, sharing costs with the state and includes copayments,
1387 premiums, deductibles and coinsurance;

1388 (7) "Deductible" means the amount of out-of-pocket expenses that
1389 would be paid for health services on behalf of [an enrollee] a member
1390 before becoming payable by the insurer;

1391 (8) "Department" means the Department of Social Services;

1392 (9) "Durable medical equipment" means [durable medical
1393 equipment, as defined in Section 1395x(n) of the Social Security Act]
1394 equipment that meets all of the following requirements:

1395 (A) Can withstand repeated use;

1396 (B) Is primarily and customarily used to serve a medical purpose;

1397 (C) Generally is not useful to a person in the absence of an illness or
1398 injury; and

1399 (D) Is nondisposable;

1400 (10) "Eligible beneficiary" means a child who meets the
1401 requirements [specified] in section 17b-292, as amended by this act,
1402 [except a child excluded under the provisions of Subtitle J of Public
1403 Law 105-33 or a child of any municipal employee eligible for
1404 employer-sponsored insurance on or after October 30, 1997, provided a
1405 child of such a municipal employee may be eligible for coverage under
1406 the HUSKY Plan, Part B if dependent coverage was terminated due to
1407 an extreme economic hardship on the part of the employee, as
1408 determined by the commissioner] and the requirements specified in
1409 section 2110(b)(2)(B) of the Social Security Act as amended by section
1410 10203(b)(2)(D) of the Affordable Care Act;

1411 [(11) "Enrollee" means an eligible beneficiary who receives services
1412 under the HUSKY Plan, Part B;

1413 (12) "Family" means any combination of the following: (A) An
1414 individual; (B) the individual's spouse; (C) any child of the individual
1415 or such spouse; or (D) the legal guardian of any such child if the

1416 guardian resides with the child;]

1417 (11) "Household" has the same meaning as provided in 42 CFR
1418 435.603;

1419 (12) "Household income" has the same meaning as provided in 42
1420 CFR 435.603;

1421 (13) ["HUSKY Plan, Part A"] "HUSKY A" means [assistance]
1422 Medicaid provided to children, caretaker relatives and pregnant and
1423 postpartum women pursuant to section 17b-261, as amended by this
1424 act, or 17b-277, as amended by this act;

1425 (14) ["HUSKY Plan, Part B"] "HUSKY B" means the health [insurance
1426 plan] coverage for children established pursuant to the provisions of
1427 sections [17b-289] 17b-290 to 17b-303, inclusive, as amended by this
1428 act; [and section 16 of public act 97-1 of the October 29 special session;]

1429 (15) "HUSKY C" means Medicaid provided to individuals who are
1430 sixty-five years of age or older or who are blind or have a disability;

1431 (16) "HUSKY D" or "Medicaid Coverage for the Lowest Income
1432 Populations program" means Medicaid provided to nonpregnant low-
1433 income adults who are age eighteen to sixty-four, as authorized
1434 pursuant to section 17b-8a;

1435 (17) "HUSKY Health" means the combined HUSKY A, HUSKY B,
1436 HUSKY C and HUSKY D programs, that provide medical coverage to
1437 eligible children, parents, relative caregivers, persons age sixty-five or
1438 older, individuals with disabilities, low-income adults, and pregnant
1439 women;

1440 [(15) "HUSKY Plus programs"]

1441 (18) "HUSKY Plus" means [two] the supplemental health [insurance
1442 programs] program established pursuant to section 17b-294a for
1443 medically eligible [enrollees of the HUSKY Plan, Part B] members of

1444 HUSKY B whose medical needs cannot be accommodated within the
1445 basic benefit package offered to [enrollees. One program] members.
1446 HUSKY Plus shall supplement coverage for those medically eligible
1447 [enrollees] members with intensive physical health needs; [and the
1448 other program shall supplement coverage for those medically eligible
1449 enrollees with intensive behavioral health needs;]

1450 [(16) "Income" means income as calculated in the same manner as
1451 under the Medicaid program pursuant to section 17b-261;]

1452 (19) "Member" means an eligible beneficiary who receives services
1453 under HUSKY A, B, C or D;

1454 [(17)] (20) "Parent" means a natural parent, stepparent, adoptive
1455 parent, guardian or custodian of a child;

1456 [(18)] (21) "Premium" means any required payment made by an
1457 individual to offset [or pay in full] the cost under [the HUSKY Plan,
1458 Part B] HUSKY B;

1459 [(19)] (22) "Preventive care and services" means: (A) Child
1460 preventive care, including periodic and interperiodic well-child visits,
1461 routine immunizations, health screenings and routine laboratory tests;
1462 (B) prenatal care, including care of all complications of pregnancy; (C)
1463 care of newborn infants, including attendance at high-risk deliveries
1464 and normal newborn care; (D) WIC evaluations; (E) child abuse
1465 assessment required under sections 17a-106a and 46b-129a; (F)
1466 preventive dental care for children; and (G) periodicity schedules and
1467 reporting based on the standards specified by the American Academy
1468 of Pediatrics;

1469 [(20)] (23) "Primary and preventive health care services" means the
1470 services of licensed physicians, optometrists, nurses, nurse
1471 practitioners, midwives and other related health care professionals
1472 which are provided on an outpatient basis, including routine well-
1473 child visits, diagnosis and treatment of illness and injury, laboratory

1474 tests, diagnostic x-rays, prescription drugs, radiation therapy,
1475 chemotherapy, hemodialysis, emergency room services, and outpatient
1476 alcohol and substance abuse services, as defined by the commissioner;

1477 [(21)] (24) "Qualified entity" means any entity: (A) Eligible for
1478 payments under a state plan approved under Medicaid and which
1479 provides medical services under [the HUSKY Plan, Part A] HUSKY A,
1480 or (B) that is a qualified entity, as defined in 42 USC 1396r-1a, as
1481 amended by Section 708 of Public Law 106-554, and that is determined
1482 by the commissioner to be capable of making the determination of
1483 eligibility. The commissioner shall provide qualified entities with such
1484 forms [as are] or information on filing an application electronically as
1485 is necessary for an application to be made on behalf of a child under
1486 [the HUSKY Plan, Part A] HUSKY A and information on how to assist
1487 parents, guardians and other persons in completing and filing such
1488 forms or electronic application;

1489 [(22)] (25) "WIC" means the federal Special Supplemental Food
1490 Program for Women, Infants and Children administered by the
1491 Department of Public Health pursuant to section 19a-59c.

1492 Sec. 34. Section 17b-292 of the general statutes is repealed and the
1493 following is substituted in lieu thereof (*Effective August 1, 2015*):

1494 (a) A child who resides in a household with [a family] household
1495 income which exceeds one hundred [eighty-five] ninety-six per cent of
1496 the federal poverty level and does not exceed three hundred eighteen
1497 per cent of the federal poverty level may be eligible for [subsidized]
1498 benefits under [the HUSKY Plan, Part B] HUSKY B.

1499 [(b)] (b) A child who resides in a household with a family income over
1500 three hundred per cent of the federal poverty level may be eligible for
1501 unsubsidized benefits under the HUSKY Plan, Part B.]

1502 [(c)] (b) Whenever a court or family support magistrate orders a
1503 noncustodial parent to provide health insurance for a child, such

1504 parent may provide for coverage under [the HUSKY Plan, Part B]
1505 HUSKY B.

1506 [(d)] (c) To the extent allowed under federal law, the commissioner
1507 shall not pay for services or durable medical equipment under [the
1508 HUSKY Plan, Part B] HUSKY B if the [enrollee] member has other
1509 insurance coverage for [the] such services or [such] equipment. If a
1510 HUSKY B member has limited benefit insurance coverage for services
1511 that are also covered under HUSKY B, the commissioner shall require
1512 such other coverage to pay for the goods or services prior to any
1513 payment under HUSKY B.

1514 [(e)] (d) A newborn child who otherwise meets the eligibility criteria
1515 for [the HUSKY Plan, Part B] HUSKY B shall be eligible for benefits
1516 retroactive to his or her date of birth, provided an application is filed
1517 on behalf of the child not later than thirty days after such date. Any
1518 uninsured child born in a hospital in this state or in a border state
1519 hospital shall be enrolled on an expedited basis in [the HUSKY Plan,
1520 Part B] HUSKY B, provided (1) the parent or caretaker relative of such
1521 child resides in this state, and (2) the parent or caretaker relative of
1522 such child authorizes enrollment in the program. The commissioner
1523 shall pay any premium cost such [family] household would otherwise
1524 incur for the first four months of coverage.

1525 [(f)] (e) The commissioner shall implement presumptive eligibility
1526 for children applying for Medicaid and may, if cost effective,
1527 implement presumptive eligibility for children in [families] households
1528 with income [under] not exceeding three hundred eighteen per cent of
1529 the federal poverty level applying for [the HUSKY Plan, Part B]
1530 HUSKY B. Such presumptive eligibility determinations shall be in
1531 accordance with applicable federal law and regulations. The
1532 commissioner shall adopt regulations, in accordance with chapter 54,
1533 to establish standards and procedures for the designation of
1534 organizations as qualified entities to grant presumptive eligibility.
1535 Qualified entities shall, [ensure that,] at the time a presumptive

1536 eligibility determination is made, [a completed application for benefits
1537 is submitted to the department] provide assistance to applicants with
1538 the completion and submission of an application for a full eligibility
1539 determination. In establishing such standards and procedures, the
1540 commissioner shall ensure the representation of state-wide and local
1541 organizations that provide services to children of all ages in each
1542 region of the state.

1543 [(g) The commissioner shall provide for a single point of entry
1544 servicer for applicants and enrollees under the HUSKY Plan, Part A
1545 and Part B. The commissioner, in consultation with the servicer, shall
1546 establish a centralized unit to be responsible for processing all
1547 applications for assistance under the HUSKY Plan, Part A and Part B.
1548 The department, through its servicer, shall ensure that a child who is
1549 determined to be eligible for benefits under the HUSKY Plan, Part A,
1550 or the HUSKY Plan, Part B has uninterrupted health insurance
1551 coverage for as long as the parent or guardian elects to enroll or re-
1552 enroll such child in the HUSKY Plan, Part A or Part B. The
1553 commissioner, in consultation with the servicer, and in accordance
1554 with the provisions of section 17b-297, shall jointly market both Part A
1555 and Part B together as the HUSKY Plan and shall develop and
1556 implement public information and outreach activities with community
1557 programs. Such servicer shall electronically transmit data with respect
1558 to enrollment and disenrollment in the HUSKY Plan, Part A and Part B
1559 to the commissioner.

1560 (h) Upon the expiration of any contractual provisions entered into
1561 pursuant to subsection (g) of this section, the commissioner shall
1562 develop a new contract for single point of entry services. The
1563 commissioner may enter into one or more contractual arrangements
1564 for such services for a contract period not to exceed seven years. Such
1565 contracts shall include performance measures, including, but not
1566 limited to, specified time limits for the processing of applications,
1567 parameters setting forth the requirements for a completed and
1568 reviewable application and the percentage of applications forwarded

1569 to the department in a complete and timely fashion. Such contracts
1570 shall also include a process for identifying and correcting
1571 noncompliance with established performance measures, including
1572 sanctions applicable for instances of continued noncompliance with
1573 performance measures.

1574 (i) The single point of entry servicer shall send all applications and
1575 supporting documents to the commissioner for determination of
1576 eligibility. The servicer shall enroll eligible beneficiaries in the
1577 applicant's choice of an administrative services organization. If there is
1578 more than one administrative services organization, upon enrollment
1579 in an administrative services organization, an eligible HUSKY Plan,
1580 Part A or Part B beneficiary shall remain enrolled in such organization
1581 for twelve months from the date of such enrollment unless (1) an
1582 eligible beneficiary demonstrates good cause to the satisfaction of the
1583 commissioner of the need to enroll in a different organization, or (2)
1584 the beneficiary no longer meets program eligibility requirements.

1585 (j) Not later than ten months after the determination of eligibility for
1586 benefits under the HUSKY Plan, Part A and Part B and annually
1587 thereafter, the commissioner or the servicer, as the case may be, shall,
1588 within existing budgetary resources, mail or, upon request of a
1589 participant, electronically transmit an application form to each
1590 participant in the plan for the purposes of obtaining information to
1591 make a determination on continued eligibility beyond the twelve
1592 months of initial eligibility. To the extent permitted by federal law, in
1593 determining eligibility for benefits under the HUSKY Plan, Part A or
1594 Part B with respect to family income, the commissioner or the servicer
1595 shall rely upon information provided in such form by the participant
1596 unless the commissioner or the servicer has reason to believe that such
1597 information is inaccurate or incomplete. The Department of Social
1598 Services shall annually review a random sample of cases to confirm
1599 that, based on the statistical sample, relying on such information is not
1600 resulting in ineligible clients receiving benefits under the HUSKY Plan,
1601 Part A or Part B. The determination of eligibility shall be coordinated

1602 with health plan open enrollment periods.]

1603 (f) In accordance with 42 CFR 435.1110, the commissioner shall
1604 provide Medicaid during a presumptive eligibility period to
1605 individuals who are determined presumptively eligible by a qualified
1606 hospital. A hospital making such a presumptive eligibility
1607 determination shall provide assistance to individuals in completing
1608 and submitting an application for full benefits.

1609 [(k)] (g) The commissioner shall implement [the HUSKY Plan, Part
1610 B] HUSKY B while in the process of adopting necessary policies and
1611 procedures in regulation form in accordance with the provisions of
1612 section 17b-10.

1613 [(l)] The commissioner shall adopt regulations, in accordance with
1614 chapter 54, to establish residency requirements and income eligibility
1615 for participation in the HUSKY Plan, Part B and procedures for a
1616 simplified mail-in application process. Notwithstanding the provisions
1617 of section 17b-257b, such regulations shall provide that any child
1618 adopted from another country by an individual who is a citizen of the
1619 United States and a resident of this state shall be eligible for benefits
1620 under the HUSKY Plan, Part B upon arrival in this state.]

1621 Sec. 35. Subsection (b) of section 17b-104 of the general statutes is
1622 repealed and the following is substituted in lieu thereof (*Effective July*
1623 *1, 2015*):

1624 (b) On July 1, 2007, and annually thereafter, the commissioner shall
1625 increase the payment standards over those of the previous fiscal year
1626 under the temporary family assistance program and the
1627 state-administered general assistance program by the percentage
1628 increase, if any, in the most recent calendar year average in the
1629 consumer price index for urban consumers over the average for the
1630 previous calendar year, provided the annual increase, if any, shall not
1631 exceed five per cent, except that the payment standards for the fiscal
1632 years ending June 30, 2010, June 30, 2011, June 30, 2012, [and] June 30,

1633 2013, June 30, 2016, and June 30, 2017, shall not be increased.

1634 Sec. 36. Subsection (a) of section 17b-106 of the general statutes is
1635 repealed and the following is substituted in lieu thereof (*Effective July*
1636 *1, 2015*):

1637 (a) On January 1, 2006, and on each January first thereafter, the
1638 Commissioner of Social Services shall increase the unearned income
1639 disregard for recipients of the state supplement to the federal
1640 Supplemental Security Income Program by an amount equal to the
1641 federal cost-of-living adjustment, if any, provided to recipients of
1642 federal Supplemental Security Income Program benefits for the
1643 corresponding calendar year. On July 1, 1989, and annually thereafter,
1644 the commissioner shall increase the adult payment standards over
1645 those of the previous fiscal year for the state supplement to the federal
1646 Supplemental Security Income Program by the percentage increase, if
1647 any, in the most recent calendar year average in the consumer price
1648 index for urban consumers over the average for the previous calendar
1649 year, provided the annual increase, if any, shall not exceed five per
1650 cent, except that the adult payment standards for the fiscal years
1651 ending June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June
1652 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June
1653 30, 2002, June 30, 2003, June 30, 2004, June 30, 2005, June 30, 2006, June
1654 30, 2007, June 30, 2008, June 30, 2009, June 30, 2010, June 30, 2011, June
1655 30, 2012, [and] June 30, 2013, June 30, 2016, and June 30, 2017, shall not
1656 be increased. Effective October 1, 1991, the coverage of excess utility
1657 costs for recipients of the state supplement to the federal Supplemental
1658 Security Income Program is eliminated. Notwithstanding the
1659 provisions of this section, the commissioner may increase the personal
1660 needs allowance component of the adult payment standard as
1661 necessary to meet federal maintenance of effort requirements.

1662 Sec. 37. Subdivision (4) of subsection (f) of section 17b-340 of the
1663 general statutes is repealed and the following is substituted in lieu
1664 thereof (*Effective July 1, 2015*):

1665 (4) For the fiscal year ending June 30, 1992, (A) no facility shall
1666 receive a rate that is less than the rate it received for the rate year
1667 ending June 30, 1991; (B) no facility whose rate, if determined pursuant
1668 to this subsection, would exceed one hundred twenty per cent of the
1669 state-wide median rate, as determined pursuant to this subsection,
1670 shall receive a rate which is five and one-half per cent more than the
1671 rate it received for the rate year ending June 30, 1991; and (C) no
1672 facility whose rate, if determined pursuant to this subsection, would be
1673 less than one hundred twenty per cent of the state-wide median rate,
1674 as determined pursuant to this subsection, shall receive a rate which is
1675 six and one-half per cent more than the rate it received for the rate year
1676 ending June 30, 1991. For the fiscal year ending June 30, 1993, no
1677 facility shall receive a rate that is less than the rate it received for the
1678 rate year ending June 30, 1992, or six per cent more than the rate it
1679 received for the rate year ending June 30, 1992. For the fiscal year
1680 ending June 30, 1994, no facility shall receive a rate that is less than the
1681 rate it received for the rate year ending June 30, 1993, or six per cent
1682 more than the rate it received for the rate year ending June 30, 1993.
1683 For the fiscal year ending June 30, 1995, no facility shall receive a rate
1684 that is more than five per cent less than the rate it received for the rate
1685 year ending June 30, 1994, or six per cent more than the rate it received
1686 for the rate year ending June 30, 1994. For the fiscal years ending June
1687 30, 1996, and June 30, 1997, no facility shall receive a rate that is more
1688 than three per cent more than the rate it received for the prior rate
1689 year. For the fiscal year ending June 30, 1998, a facility shall receive a
1690 rate increase that is not more than two per cent more than the rate that
1691 the facility received in the prior year. For the fiscal year ending June
1692 30, 1999, a facility shall receive a rate increase that is not more than
1693 three per cent more than the rate that the facility received in the prior
1694 year and that is not less than one per cent more than the rate that the
1695 facility received in the prior year, exclusive of rate increases associated
1696 with a wage, benefit and staffing enhancement rate adjustment added
1697 for the period from April 1, 1999, to June 30, 1999, inclusive. For the
1698 fiscal year ending June 30, 2000, each facility, except a facility with an

1699 interim rate or replaced interim rate for the fiscal year ending June 30,
1700 1999, and a facility having a certificate of need or other agreement
1701 specifying rate adjustments for the fiscal year ending June 30, 2000,
1702 shall receive a rate increase equal to one per cent applied to the rate the
1703 facility received for the fiscal year ending June 30, 1999, exclusive of
1704 the facility's wage, benefit and staffing enhancement rate adjustment.
1705 For the fiscal year ending June 30, 2000, no facility with an interim rate,
1706 replaced interim rate or scheduled rate adjustment specified in a
1707 certificate of need or other agreement for the fiscal year ending June
1708 30, 2000, shall receive a rate increase that is more than one per cent
1709 more than the rate the facility received in the fiscal year ending June
1710 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a
1711 facility with an interim rate or replaced interim rate for the fiscal year
1712 ending June 30, 2000, and a facility having a certificate of need or other
1713 agreement specifying rate adjustments for the fiscal year ending June
1714 30, 2001, shall receive a rate increase equal to two per cent applied to
1715 the rate the facility received for the fiscal year ending June 30, 2000,
1716 subject to verification of wage enhancement adjustments pursuant to
1717 subdivision (14) of this subsection. For the fiscal year ending June 30,
1718 2001, no facility with an interim rate, replaced interim rate or
1719 scheduled rate adjustment specified in a certificate of need or other
1720 agreement for the fiscal year ending June 30, 2001, shall receive a rate
1721 increase that is more than two per cent more than the rate the facility
1722 received for the fiscal year ending June 30, 2000. For the fiscal year
1723 ending June 30, 2002, each facility shall receive a rate that is two and
1724 one-half per cent more than the rate the facility received in the prior
1725 fiscal year. For the fiscal year ending June 30, 2003, each facility shall
1726 receive a rate that is two per cent more than the rate the facility
1727 received in the prior fiscal year, except that such increase shall be
1728 effective January 1, 2003, and such facility rate in effect for the fiscal
1729 year ending June 30, 2002, shall be paid for services provided until
1730 December 31, 2002, except any facility that would have been issued a
1731 lower rate effective July 1, 2002, than for the fiscal year ending June 30,
1732 2002, due to interim rate status or agreement with the department shall

1733 be issued such lower rate effective July 1, 2002, and have such rate
1734 increased two per cent effective June 1, 2003. For the fiscal year ending
1735 June 30, 2004, rates in effect for the period ending June 30, 2003, shall
1736 remain in effect, except any facility that would have been issued a
1737 lower rate effective July 1, 2003, than for the fiscal year ending June 30,
1738 2003, due to interim rate status or agreement with the department shall
1739 be issued such lower rate effective July 1, 2003. For the fiscal year
1740 ending June 30, 2005, rates in effect for the period ending June 30, 2004,
1741 shall remain in effect until December 31, 2004, except any facility that
1742 would have been issued a lower rate effective July 1, 2004, than for the
1743 fiscal year ending June 30, 2004, due to interim rate status or
1744 agreement with the department shall be issued such lower rate
1745 effective July 1, 2004. Effective January 1, 2005, each facility shall
1746 receive a rate that is one per cent greater than the rate in effect
1747 December 31, 2004. Effective upon receipt of all the necessary federal
1748 approvals to secure federal financial participation matching funds
1749 associated with the rate increase provided in this subdivision, but in
1750 no event earlier than July 1, 2005, and provided the user fee imposed
1751 under section 17b-320 is required to be collected, for the fiscal year
1752 ending June 30, 2006, the department shall compute the rate for each
1753 facility based upon its 2003 cost report filing or a subsequent cost year
1754 filing for facilities having an interim rate for the period ending June 30,
1755 2005, as provided under section 17-311-55 of the regulations of
1756 Connecticut state agencies. For each facility not having an interim rate
1757 for the period ending June 30, 2005, the rate for the period ending June
1758 30, 2006, shall be determined beginning with the higher of the
1759 computed rate based upon its 2003 cost report filing or the rate in
1760 effect for the period ending June 30, 2005. Such rate shall then be
1761 increased by eleven dollars and eighty cents per day except that in no
1762 event shall the rate for the period ending June 30, 2006, be thirty-two
1763 dollars more than the rate in effect for the period ending June 30, 2005,
1764 and for any facility with a rate below one hundred ninety-five dollars
1765 per day for the period ending June 30, 2005, such rate for the period
1766 ending June 30, 2006, shall not be greater than two hundred seventeen

1767 dollars and forty-three cents per day and for any facility with a rate
1768 equal to or greater than one hundred ninety-five dollars per day for
1769 the period ending June 30, 2005, such rate for the period ending June
1770 30, 2006, shall not exceed the rate in effect for the period ending June
1771 30, 2005, increased by eleven and one-half per cent. For each facility
1772 with an interim rate for the period ending June 30, 2005, the interim
1773 replacement rate for the period ending June 30, 2006, shall not exceed
1774 the rate in effect for the period ending June 30, 2005, increased by
1775 eleven dollars and eighty cents per day plus the per day cost of the
1776 user fee payments made pursuant to section 17b-320 divided by
1777 annual resident service days, except for any facility with an interim
1778 rate below one hundred ninety-five dollars per day for the period
1779 ending June 30, 2005, the interim replacement rate for the period
1780 ending June 30, 2006, shall not be greater than two hundred seventeen
1781 dollars and forty-three cents per day and for any facility with an
1782 interim rate equal to or greater than one hundred ninety-five dollars
1783 per day for the period ending June 30, 2005, the interim replacement
1784 rate for the period ending June 30, 2006, shall not exceed the rate in
1785 effect for the period ending June 30, 2005, increased by eleven and one-
1786 half per cent. Such July 1, 2005, rate adjustments shall remain in effect
1787 unless (i) the federal financial participation matching funds associated
1788 with the rate increase are no longer available; or (ii) the user fee
1789 created pursuant to section 17b-320 is not in effect. For the fiscal year
1790 ending June 30, 2007, each facility shall receive a rate that is three per
1791 cent greater than the rate in effect for the period ending June 30, 2006,
1792 except any facility that would have been issued a lower rate effective
1793 July 1, 2006, than for the rate period ending June 30, 2006, due to
1794 interim rate status or agreement with the department, shall be issued
1795 such lower rate effective July 1, 2006. For the fiscal year ending June
1796 30, 2008, each facility shall receive a rate that is two and nine-tenths
1797 per cent greater than the rate in effect for the period ending June 30,
1798 2007, except any facility that would have been issued a lower rate
1799 effective July 1, 2007, than for the rate period ending June 30, 2007, due
1800 to interim rate status or agreement with the department, shall be

1801 issued such lower rate effective July 1, 2007. For the fiscal year ending
1802 June 30, 2009, rates in effect for the period ending June 30, 2008, shall
1803 remain in effect until June 30, 2009, except any facility that would have
1804 been issued a lower rate for the fiscal year ending June 30, 2009, due to
1805 interim rate status or agreement with the department shall be issued
1806 such lower rate. For the fiscal years ending June 30, 2010, and June 30,
1807 2011, rates in effect for the period ending June 30, 2009, shall remain in
1808 effect until June 30, 2011, except any facility that would have been
1809 issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal
1810 year ending June 30, 2011, due to interim rate status or agreement with
1811 the department, shall be issued such lower rate. For the fiscal years
1812 ending June 30, 2012, and June 30, 2013, rates in effect for the period
1813 ending June 30, 2011, shall remain in effect until June 30, 2013, except
1814 any facility that would have been issued a lower rate for the fiscal year
1815 ending June 30, 2012, or the fiscal year ending June 30, 2013, due to
1816 interim rate status or agreement with the department, shall be issued
1817 such lower rate. For the fiscal year ending June 30, 2014, the
1818 department shall determine facility rates based upon 2011 cost report
1819 filings subject to the provisions of this section and applicable
1820 regulations except: (I) A ninety per cent minimum occupancy standard
1821 shall be applied; (II) no facility shall receive a rate that is higher than
1822 the rate in effect on June 30, 2013; and (III) no facility shall receive a
1823 rate that is more than four per cent lower than the rate in effect on June
1824 30, 2013, except that any facility that would have been issued a lower
1825 rate effective July 1, 2013, than for the rate period ending June 30, 2013,
1826 due to interim rate status or agreement with the department, shall be
1827 issued such lower rate effective July 1, 2013. For the fiscal year ending
1828 June 30, 2015, rates in effect for the period ending June 30, 2014, shall
1829 remain in effect until June 30, 2015, except any facility that would have
1830 been issued a lower rate effective July 1, 2014, than for the rate period
1831 ending June 30, 2014, due to interim rate status or agreement with the
1832 department, shall be issued such lower rate effective July 1, 2014. For
1833 the fiscal years ending June 30, 2016, and June 30, 2017, rates shall not
1834 exceed those in effect for the period ending June 30, 2015, except the

1835 rate paid to a facility may be higher than the rate paid to the facility for
1836 the period ending June 30, 2015, if the commissioner provides, within
1837 available appropriations, pro rata fair rent increases, which may, at the
1838 discretion of the commissioner, include increases for facilities which
1839 have undergone a material change in circumstances related to fair rent
1840 additions or moveable equipment placed in service in cost report years
1841 ending September 30, 2014, and September 30, 2015, and not otherwise
1842 included in rates issued. For the fiscal years ending June 30, 2016, and
1843 June 30, 2017, and each succeeding fiscal year, any facility that would
1844 have been issued a lower rate, due to interim rate status, a change in
1845 allowable fair rent or agreement with the department, shall be issued
1846 such lower rate. The Commissioner of Social Services shall add fair
1847 rent increases to any other rate increases established pursuant to this
1848 subdivision for a facility which has undergone a material change in
1849 circumstances related to fair rent, except for the fiscal years ending
1850 June 30, 2010, June 30, 2011, and June 30, 2012, such fair rent increases
1851 shall only be provided to facilities with an approved certificate of need
1852 pursuant to section 17b-352, 17b-353, 17b-354, as amended by this act,
1853 or 17b-355. For the fiscal year ending June 30, 2013, the commissioner
1854 may, within available appropriations, provide pro rata fair rent
1855 increases for facilities which have undergone a material change in
1856 circumstances related to fair rent additions placed in service in cost
1857 report years ending September 30, 2008, to September 30, 2011,
1858 inclusive, and not otherwise included in rates issued. For the fiscal
1859 years ending June 30, 2014, and June 30, 2015, the commissioner may,
1860 within available appropriations, provide pro rata fair rent increases,
1861 which may include moveable equipment at the discretion of the
1862 commissioner, for facilities which have undergone a material change
1863 in circumstances related to fair rent additions or moveable equipment
1864 placed in service in cost report years ending September 30, 2012, and
1865 September 30, 2013, and not otherwise included in rates issued. The
1866 commissioner shall add fair rent increases associated with an
1867 approved certificate of need pursuant to section 17b-352, 17b-353, 17b-
1868 354, as amended by this act, or 17b-355. Interim rates may take into

1869 account reasonable costs incurred by a facility, including wages and
1870 benefits. Notwithstanding the provisions of this section, the
1871 Commissioner of Social Services may, subject to available
1872 appropriations, increase or decrease rates issued to licensed chronic
1873 and convalescent nursing homes and licensed rest homes with nursing
1874 supervision.

1875 Sec. 38. Subsection (g) of section 17b-340 of the general statutes is
1876 repealed and the following is substituted in lieu thereof (*Effective July*
1877 *1, 2015*):

1878 (g) For the fiscal year ending June 30, 1993, any intermediate care
1879 facility for individuals with intellectual disabilities with an operating
1880 cost component of its rate in excess of one hundred forty per cent of
1881 the median of operating cost components of rates in effect January 1,
1882 1992, shall not receive an operating cost component increase. For the
1883 fiscal year ending June 30, 1993, any intermediate care facility for
1884 individuals with intellectual disabilities with an operating cost
1885 component of its rate that is less than one hundred forty per cent of the
1886 median of operating cost components of rates in effect January 1, 1992,
1887 shall have an allowance for real wage growth equal to thirty per cent
1888 of the increase determined in accordance with subsection (q) of section
1889 17-311-52 of the regulations of Connecticut state agencies, provided
1890 such operating cost component shall not exceed one hundred forty per
1891 cent of the median of operating cost components in effect January 1,
1892 1992. Any facility with real property other than land placed in service
1893 prior to October 1, 1991, shall, for the fiscal year ending June 30, 1995,
1894 receive a rate of return on real property equal to the average of the
1895 rates of return applied to real property other than land placed in
1896 service for the five years preceding October 1, 1993. For the fiscal year
1897 ending June 30, 1996, and any succeeding fiscal year, the rate of return
1898 on real property for property items shall be revised every five years.
1899 The commissioner shall, upon submission of a request, allow actual
1900 debt service, comprised of principal and interest, in excess of property
1901 costs allowed pursuant to section 17-311-52 of the regulations of

1902 Connecticut state agencies, provided such debt service terms and
1903 amounts are reasonable in relation to the useful life and the base value
1904 of the property. For the fiscal year ending June 30, 1995, and any
1905 succeeding fiscal year, the inflation adjustment made in accordance
1906 with subsection (p) of section 17-311-52 of the regulations of
1907 Connecticut state agencies shall not be applied to real property costs.
1908 For the fiscal year ending June 30, 1996, and any succeeding fiscal year,
1909 the allowance for real wage growth, as determined in accordance with
1910 subsection (q) of section 17-311-52 of the regulations of Connecticut
1911 state agencies, shall not be applied. For the fiscal year ending June 30,
1912 1996, and any succeeding fiscal year, no rate shall exceed three
1913 hundred seventy-five dollars per day unless the commissioner, in
1914 consultation with the Commissioner of Developmental Services,
1915 determines after a review of program and management costs, that a
1916 rate in excess of this amount is necessary for care and treatment of
1917 facility residents. For the fiscal year ending June 30, 2002, rate period,
1918 the Commissioner of Social Services shall increase the inflation
1919 adjustment for rates made in accordance with subsection (p) of section
1920 17-311-52 of the regulations of Connecticut state agencies to update
1921 allowable fiscal year 2000 costs to include a three and one-half per cent
1922 inflation factor. For the fiscal year ending June 30, 2003, rate period, the
1923 commissioner shall increase the inflation adjustment for rates made in
1924 accordance with subsection (p) of section 17-311-52 of the regulations
1925 of Connecticut state agencies to update allowable fiscal year 2001 costs
1926 to include a one and one-half per cent inflation factor, except that such
1927 increase shall be effective November 1, 2002, and such facility rate in
1928 effect for the fiscal year ending June 30, 2002, shall be paid for services
1929 provided until October 31, 2002, except any facility that would have
1930 been issued a lower rate effective July 1, 2002, than for the fiscal year
1931 ending June 30, 2002, due to interim rate status or agreement with the
1932 department shall be issued such lower rate effective July 1, 2002, and
1933 have such rate updated effective November 1, 2002, in accordance with
1934 applicable statutes and regulations. For the fiscal year ending June 30,
1935 2004, rates in effect for the period ending June 30, 2003, shall remain in

1936 effect, except any facility that would have been issued a lower rate
1937 effective July 1, 2003, than for the fiscal year ending June 30, 2003, due
1938 to interim rate status or agreement with the department shall be issued
1939 such lower rate effective July 1, 2003. For the fiscal year ending June
1940 30, 2005, rates in effect for the period ending June 30, 2004, shall
1941 remain in effect until September 30, 2004. Effective October 1, 2004,
1942 each facility shall receive a rate that is five per cent greater than the
1943 rate in effect September 30, 2004. Effective upon receipt of all the
1944 necessary federal approvals to secure federal financial participation
1945 matching funds associated with the rate increase provided in
1946 subdivision (4) of subsection (f) of this section, but in no event earlier
1947 than October 1, 2005, and provided the user fee imposed under section
1948 17b-320 is required to be collected, each facility shall receive a rate that
1949 is four per cent more than the rate the facility received in the prior
1950 fiscal year, except any facility that would have been issued a lower rate
1951 effective October 1, 2005, than for the fiscal year ending June 30, 2005,
1952 due to interim rate status or agreement with the department, shall be
1953 issued such lower rate effective October 1, 2005. Such rate increase
1954 shall remain in effect unless: (1) The federal financial participation
1955 matching funds associated with the rate increase are no longer
1956 available; or (2) the user fee created pursuant to section 17b-320 is not
1957 in effect. For the fiscal year ending June 30, 2007, rates in effect for the
1958 period ending June 30, 2006, shall remain in effect until September 30,
1959 2006, except any facility that would have been issued a lower rate
1960 effective July 1, 2006, than for the fiscal year ending June 30, 2006, due
1961 to interim rate status or agreement with the department, shall be
1962 issued such lower rate effective July 1, 2006. Effective October 1, 2006,
1963 no facility shall receive a rate that is more than three per cent greater
1964 than the rate in effect for the facility on September 30, 2006, except any
1965 facility that would have been issued a lower rate effective October 1,
1966 2006, due to interim rate status or agreement with the department,
1967 shall be issued such lower rate effective October 1, 2006. For the fiscal
1968 year ending June 30, 2008, each facility shall receive a rate that is two
1969 and nine-tenths per cent greater than the rate in effect for the period

1970 ending June 30, 2007, except any facility that would have been issued a
1971 lower rate effective July 1, 2007, than for the rate period ending June
1972 30, 2007, due to interim rate status, or agreement with the department,
1973 shall be issued such lower rate effective July 1, 2007. For the fiscal year
1974 ending June 30, 2009, rates in effect for the period ending June 30, 2008,
1975 shall remain in effect until June 30, 2009, except any facility that would
1976 have been issued a lower rate for the fiscal year ending June 30, 2009,
1977 due to interim rate status or agreement with the department, shall be
1978 issued such lower rate. For the fiscal years ending June 30, 2010, and
1979 June 30, 2011, rates in effect for the period ending June 30, 2009, shall
1980 remain in effect until June 30, 2011, except any facility that would have
1981 been issued a lower rate for the fiscal year ending June 30, 2010, or the
1982 fiscal year ending June 30, 2011, due to interim rate status or
1983 agreement with the department, shall be issued such lower rate. For
1984 the fiscal year ending June 30, 2012, rates in effect for the period
1985 ending June 30, 2011, shall remain in effect until June 30, 2012, except
1986 any facility that would have been issued a lower rate for the fiscal year
1987 ending June 30, 2012, due to interim rate status or agreement with the
1988 department, shall be issued such lower rate. For the fiscal years ending
1989 June 30, 2014, and June 30, 2015, rates shall not exceed those in effect
1990 for the period ending June 30, 2013, except the rate paid to a facility
1991 may be higher than the rate paid to the facility for the period ending
1992 June 30, 2013, if a capital improvement approved by the Department of
1993 Developmental Services, in consultation with the Department of Social
1994 Services, for the health or safety of the residents was made to the
1995 facility during the fiscal year ending June 30, 2014, or June 30, 2015,
1996 only to the extent such rate increases are within available
1997 appropriations. Any facility that would have been issued a lower rate
1998 for the fiscal year ending June 30, 2014, or the fiscal year ending June
1999 30, 2015, due to interim rate status or agreement with the department,
2000 shall be issued such lower rate. For the fiscal years ending June 30,
2001 2016, and June 30, 2017, rates shall not exceed those in effect for the
2002 period ending June 30, 2015, except the rate paid to a facility may be
2003 higher than the rate paid to the facility for the period ending June 30,

2004 2015, if a capital improvement approved by the Department of
2005 Developmental Services, in consultation with the Department of Social
2006 Services, for the health or safety of the residents was made to the
2007 facility during the fiscal year ending June 30, 2016, or June 30, 2017,
2008 only to the extent such rate increases are within available
2009 appropriations. For the fiscal years ending June 30, 2016, and June 30,
2010 2017, and each succeeding fiscal year, any facility that would have
2011 been issued a lower rate, due to interim rate status, a change in
2012 allowable fair rent or agreement with the department, shall be issued
2013 such lower rate. Any facility that has a significant decrease in land and
2014 building costs shall receive a reduced rate to reflect such decrease in
2015 land and building costs. For the fiscal years ending June 30, 2012, June
2016 30, 2013, June 30, 2014, [and] June 30, 2015, June 30, 2016, and June 30,
2017 2017, the Commissioner of Social Services may provide fair rent
2018 increases to any facility that has undergone a material change in
2019 circumstances related to fair rent and has an approved certificate of
2020 need pursuant to section 17b-352, 17b-353, 17b-354, as amended by this
2021 act, or 17b-355. Notwithstanding the provisions of this section, the
2022 Commissioner of Social Services may, within available appropriations,
2023 increase or decrease rates issued to intermediate care facilities for
2024 individuals with intellectual disabilities to reflect a reduction in
2025 available appropriations as provided in subsection (a) of this section.
2026 For the fiscal years ending June 30, 2014, and June 30, 2015, the
2027 commissioner shall not consider rebasing in determining rates.

2028 Sec. 39. Subsection (a) of section 17b-244 of the general statutes is
2029 repealed and the following is substituted in lieu thereof (*Effective July*
2030 *1, 2015*):

2031 (a) The room and board component of the rates to be paid by the
2032 state to private facilities and facilities operated by regional education
2033 service centers which are licensed to provide residential care pursuant
2034 to section 17a-227, but not certified to participate in the Title XIX
2035 Medicaid program as intermediate care facilities for individuals with
2036 intellectual disabilities, shall be determined annually by the

2037 Commissioner of Social Services, except that rates effective April 30,
2038 1989, shall remain in effect through October 31, 1989. Any facility with
2039 real property other than land placed in service prior to July 1, 1991,
2040 shall, for the fiscal year ending June 30, 1995, receive a rate of return on
2041 real property equal to the average of the rates of return applied to real
2042 property other than land placed in service for the five years preceding
2043 July 1, 1993. For the fiscal year ending June 30, 1996, and any
2044 succeeding fiscal year, the rate of return on real property for property
2045 items shall be revised every five years. The commissioner shall, upon
2046 submission of a request by such facility, allow actual debt service,
2047 comprised of principal and interest, on the loan or loans in lieu of
2048 property costs allowed pursuant to section 17-313b-5 of the regulations
2049 of Connecticut state agencies, whether actual debt service is higher or
2050 lower than such allowed property costs, provided such debt service
2051 terms and amounts are reasonable in relation to the useful life and the
2052 base value of the property. In the case of facilities financed through the
2053 Connecticut Housing Finance Authority, the commissioner shall allow
2054 actual debt service, comprised of principal, interest and a reasonable
2055 repair and replacement reserve on the loan or loans in lieu of property
2056 costs allowed pursuant to section 17-313b-5 of the regulations of
2057 Connecticut state agencies, whether actual debt service is higher or
2058 lower than such allowed property costs, provided such debt service
2059 terms and amounts are determined by the commissioner at the time
2060 the loan is entered into to be reasonable in relation to the useful life
2061 and base value of the property. The commissioner may allow fees
2062 associated with mortgage refinancing provided such refinancing will
2063 result in state reimbursement savings, after comparing costs over the
2064 terms of the existing proposed loans. For the fiscal year ending June 30,
2065 1992, the inflation factor used to determine rates shall be one-half of
2066 the gross national product percentage increase for the period between
2067 the midpoint of the cost year through the midpoint of the rate year. For
2068 fiscal year ending June 30, 1993, the inflation factor used to determine
2069 rates shall be two-thirds of the gross national product percentage
2070 increase from the midpoint of the cost year to the midpoint of the rate

2071 year. For the fiscal years ending June 30, 1996, and June 30, 1997, no
2072 inflation factor shall be applied in determining rates. The
2073 Commissioner of Social Services shall prescribe uniform forms on
2074 which such facilities shall report their costs. Such rates shall be
2075 determined on the basis of a reasonable payment for necessary
2076 services. Any increase in grants, gifts, fund-raising or endowment
2077 income used for the payment of operating costs by a private facility in
2078 the fiscal year ending June 30, 1992, shall be excluded by the
2079 commissioner from the income of the facility in determining the rates
2080 to be paid to the facility for the fiscal year ending June 30, 1993,
2081 provided any operating costs funded by such increase shall not
2082 obligate the state to increase expenditures in subsequent fiscal years.
2083 Nothing contained in this section shall authorize a payment by the
2084 state to any such facility in excess of the charges made by the facility
2085 for comparable services to the general public. The service component
2086 of the rates to be paid by the state to private facilities and facilities
2087 operated by regional education service centers which are licensed to
2088 provide residential care pursuant to section 17a-227, but not certified
2089 to participate in the Title XIX Medicaid programs as intermediate care
2090 facilities for individuals with intellectual disabilities, shall be
2091 determined annually by the Commissioner of Developmental Services
2092 in accordance with section 17b-244a. For the fiscal year ending June 30,
2093 2008, no facility shall receive a rate that is more than two per cent
2094 greater than the rate in effect for the facility on June 30, 2007, except
2095 any facility that would have been issued a lower rate effective July 1,
2096 2007, due to interim rate status or agreement with the department,
2097 shall be issued such lower rate effective July 1, 2007. For the fiscal year
2098 ending June 30, 2009, no facility shall receive a rate that is more than
2099 two per cent greater than the rate in effect for the facility on June 30,
2100 2008, except any facility that would have been issued a lower rate
2101 effective July 1, 2008, due to interim rate status or agreement with the
2102 department, shall be issued such lower rate effective July 1, 2008. For
2103 the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect
2104 for the period ending June 30, 2009, shall remain in effect until June 30,

2105 2011, except that (1) the rate paid to a facility may be higher than the
2106 rate paid to the facility for the period ending June 30, 2009, if a capital
2107 improvement required by the Commissioner of Developmental
2108 Services for the health or safety of the residents was made to the
2109 facility during the fiscal years ending June 30, 2010, or June 30, 2011,
2110 and (2) any facility that would have been issued a lower rate for the
2111 fiscal [years] year ending June 30, 2010, or June 30, 2011, due to interim
2112 rate status or agreement with the department, shall be issued such
2113 lower rate. For the fiscal year ending June 30, 2012, rates in effect for
2114 the period ending June 30, 2011, shall remain in effect until June 30,
2115 2012, except that (A) the rate paid to a facility may be higher than the
2116 rate paid to the facility for the period ending June 30, 2011, if a capital
2117 improvement required by the Commissioner of Developmental
2118 Services for the health or safety of the residents was made to the
2119 facility during the fiscal year ending June 30, 2012, and (B) any facility
2120 that would have been issued a lower rate for the fiscal year ending
2121 June 30, 2012, due to interim rate status or agreement with the
2122 department, shall be issued such lower rate. Any facility that has a
2123 significant decrease in land and building costs shall receive a reduced
2124 rate to reflect such decrease in land and building costs. The rate paid to
2125 a facility may be increased if a capital improvement approved by the
2126 Department of Developmental Services, in consultation with the
2127 Department of Social Services, for the health or safety of the residents
2128 was made to the facility during the fiscal year ending June 30, 2014, or
2129 June 30, 2015, only to the extent such increases are within available
2130 appropriations. For the fiscal years ending June 30, 2016, and June 30,
2131 2017, rates shall not exceed those in effect for the period ending June
2132 30, 2015, except the rate paid to a facility may be higher than the rate
2133 paid to the facility for the period ending June 30, 2015, if a capital
2134 improvement approved by the Department of Developmental Services,
2135 in consultation with the Department of Social Services, for the health
2136 or safety of the residents was made to the facility during the fiscal year
2137 ending June 30, 2016, or June 30, 2017, only to the extent such rate
2138 increases are within available appropriations. For the fiscal years

2139 ending June 30, 2016, and June 30, 2017, and each succeeding fiscal
2140 year, any facility that would have been issued a lower rate, due to
2141 interim rate status, a change in allowable fair rent or agreement with
2142 the department, shall be issued such lower rate.

2143 Sec. 40. Subdivision (1) of subsection (h) of section 17b-340 of the
2144 general statutes is repealed and the following is substituted in lieu
2145 thereof (*Effective July 1, 2015*):

2146 (h) (1) For the fiscal year ending June 30, 1993, any residential care
2147 home with an operating cost component of its rate in excess of one
2148 hundred thirty per cent of the median of operating cost components of
2149 rates in effect January 1, 1992, shall not receive an operating cost
2150 component increase. For the fiscal year ending June 30, 1993, any
2151 residential care home with an operating cost component of its rate that
2152 is less than one hundred thirty per cent of the median of operating cost
2153 components of rates in effect January 1, 1992, shall have an allowance
2154 for real wage growth equal to sixty-five per cent of the increase
2155 determined in accordance with subsection (q) of section 17-311-52 of
2156 the regulations of Connecticut state agencies, provided such operating
2157 cost component shall not exceed one hundred thirty per cent of the
2158 median of operating cost components in effect January 1, 1992.
2159 Beginning with the fiscal year ending June 30, 1993, for the purpose of
2160 determining allowable fair rent, a residential care home with allowable
2161 fair rent less than the twenty-fifth percentile of the state-wide
2162 allowable fair rent shall be reimbursed as having allowable fair rent
2163 equal to the twenty-fifth percentile of the state-wide allowable fair
2164 rent. Beginning with the fiscal year ending June 30, 1997, a residential
2165 care home with allowable fair rent less than three dollars and ten cents
2166 per day shall be reimbursed as having allowable fair rent equal to
2167 three dollars and ten cents per day. Property additions placed in
2168 service during the cost year ending September 30, 1996, or any
2169 succeeding cost year shall receive a fair rent allowance for such
2170 additions as an addition to three dollars and ten cents per day if the
2171 fair rent for the facility for property placed in service prior to

2172 September 30, 1995, is less than or equal to three dollars and ten cents
2173 per day. Beginning with the fiscal year ending June 30, 2016, a
2174 residential care home shall be reimbursed the greater of the allowable
2175 accumulated fair rent reimbursement associated with real property
2176 additions and land as calculated on a per day basis or three dollars and
2177 ten cents per day if the allowable reimbursement associated with real
2178 property additions and land is less than three dollars and ten cents per
2179 day. For the fiscal year ending June 30, 1996, and any succeeding fiscal
2180 year, the allowance for real wage growth, as determined in accordance
2181 with subsection (q) of section 17-311-52 of the regulations of
2182 Connecticut state agencies, shall not be applied. For the fiscal year
2183 ending June 30, 1996, and any succeeding fiscal year, the inflation
2184 adjustment made in accordance with subsection (p) of section 17-311-
2185 52 of the regulations of Connecticut state agencies shall not be applied
2186 to real property costs. Beginning with the fiscal year ending June 30,
2187 1997, minimum allowable patient days for rate computation purposes
2188 for a residential care home with twenty-five beds or less shall be
2189 eighty-five per cent of licensed capacity. Beginning with the fiscal year
2190 ending June 30, 2002, for the purposes of determining the allowable
2191 salary of an administrator of a residential care home with sixty beds or
2192 less the department shall revise the allowable base salary to thirty-
2193 seven thousand dollars to be annually inflated thereafter in accordance
2194 with section 17-311-52 of the regulations of Connecticut state agencies.
2195 The rates for the fiscal year ending June 30, 2002, shall be based upon
2196 the increased allowable salary of an administrator, regardless of
2197 whether such amount was expended in the 2000 cost report period
2198 upon which the rates are based. Beginning with the fiscal year ending
2199 June 30, 2000, and until the fiscal year ending June 30, 2009, inclusive,
2200 the inflation adjustment for rates made in accordance with subsection
2201 (p) of section 17-311-52 of the regulations of Connecticut state agencies
2202 shall be increased by two per cent, and beginning with the fiscal year
2203 ending June 30, 2002, the inflation adjustment for rates made in
2204 accordance with subsection (c) of said section shall be increased by one
2205 per cent. Beginning with the fiscal year ending June 30, 1999, for the

2206 purpose of determining the allowable salary of a related party, the
2207 department shall revise the maximum salary to twenty-seven
2208 thousand eight hundred fifty-six dollars to be annually inflated
2209 thereafter in accordance with section 17-311-52 of the regulations of
2210 Connecticut state agencies and beginning with the fiscal year ending
2211 June 30, 2001, such allowable salary shall be computed on an hourly
2212 basis and the maximum number of hours allowed for a related party
2213 other than the proprietor shall be increased from forty hours to forty-
2214 eight hours per work week. For the fiscal year ending June 30, 2005,
2215 each facility shall receive a rate that is two and one-quarter per cent
2216 more than the rate the facility received in the prior fiscal year, except
2217 any facility that would have been issued a lower rate effective July 1,
2218 2004, than for the fiscal year ending June 30, 2004, due to interim rate
2219 status or agreement with the department shall be issued such lower
2220 rate effective July 1, 2004. Effective upon receipt of all the necessary
2221 federal approvals to secure federal financial participation matching
2222 funds associated with the rate increase provided in subdivision (4) of
2223 subsection (f) of this section, but in no event earlier than October 1,
2224 2005, and provided the user fee imposed under section 17b-320 is
2225 required to be collected, each facility shall receive a rate that is
2226 determined in accordance with applicable law and subject to
2227 appropriations, except any facility that would have been issued a
2228 lower rate effective October 1, 2005, than for the fiscal year ending June
2229 30, 2005, due to interim rate status or agreement with the department,
2230 shall be issued such lower rate effective October 1, 2005. Such rate
2231 increase shall remain in effect unless: (A) The federal financial
2232 participation matching funds associated with the rate increase are no
2233 longer available; or (B) the user fee created pursuant to section 17b-320
2234 is not in effect. For the fiscal year ending June 30, 2007, rates in effect
2235 for the period ending June 30, 2006, shall remain in effect until
2236 September 30, 2006, except any facility that would have been issued a
2237 lower rate effective July 1, 2006, than for the fiscal year ending June 30,
2238 2006, due to interim rate status or agreement with the department,
2239 shall be issued such lower rate effective July 1, 2006. Effective October

2240 1, 2006, no facility shall receive a rate that is more than four per cent
2241 greater than the rate in effect for the facility on September 30, 2006,
2242 except for any facility that would have been issued a lower rate
2243 effective October 1, 2006, due to interim rate status or agreement with
2244 the department, shall be issued such lower rate effective October 1,
2245 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates
2246 in effect for the period ending June 30, 2009, shall remain in effect until
2247 June 30, 2011, except any facility that would have been issued a lower
2248 rate for the fiscal year ending June 30, 2010, or the fiscal year ending
2249 June 30, 2011, due to interim rate status or agreement with the
2250 department, shall be issued such lower rate, except (i) any facility that
2251 would have been issued a lower rate for the fiscal year ending June 30,
2252 2010, or the fiscal year ending June 30, 2011, due to interim rate status
2253 or agreement with the Commissioner of Social Services shall be issued
2254 such lower rate; and (ii) the commissioner may increase a facility's rate
2255 for reasonable costs associated with such facility's compliance with the
2256 provisions of section 19a-495a concerning the administration of
2257 medication by unlicensed personnel. For the fiscal year ending June 30,
2258 2012, rates in effect for the period ending June 30, 2011, shall remain in
2259 effect until June 30, 2012, except that (I) any facility that would have
2260 been issued a lower rate for the fiscal year ending June 30, 2012, due to
2261 interim rate status or agreement with the Commissioner of Social
2262 Services shall be issued such lower rate; and (II) the commissioner may
2263 increase a facility's rate for reasonable costs associated with such
2264 facility's compliance with the provisions of section 19a-495a
2265 concerning the administration of medication by unlicensed personnel.
2266 For the fiscal year ending June 30, 2013, the Commissioner of Social
2267 Services may, within available appropriations, provide a rate increase
2268 to a residential care home. Any facility that would have been issued a
2269 lower rate for the fiscal year ending June 30, 2013, due to interim rate
2270 status or agreement with the Commissioner of Social Services shall be
2271 issued such lower rate. For the fiscal years ending June 30, 2012, and
2272 June 30, 2013, the Commissioner of Social Services may provide fair
2273 rent increases to any facility that has undergone a material change in

2274 circumstances related to fair rent and has an approved certificate of
2275 need pursuant to section 17b-352, 17b-353, 17b-354, as amended by this
2276 act, or 17b-355. For the fiscal years ending June 30, 2014, and June 30,
2277 2015, for those facilities that have a calculated rate greater than the rate
2278 in effect for the fiscal year ending June 30, 2013, the commissioner may
2279 increase facility rates based upon available appropriations up to a stop
2280 gain as determined by the commissioner. No facility shall be issued a
2281 rate that is lower than the rate in effect on June 30, 2013, except that
2282 any facility that would have been issued a lower rate for the fiscal year
2283 ending June 30, 2014, or the fiscal year ending June 30, 2015, due to
2284 interim rate status or agreement with the commissioner, shall be issued
2285 such lower rate. For the fiscal year ending June 30, 2014, and each fiscal
2286 year thereafter, a residential care home shall receive a rate increase for
2287 any capital improvement made during the fiscal year for the health
2288 and safety of residents and approved by the Department of Social
2289 Services, provided such rate increase is within available
2290 appropriations. For the fiscal year ending June 30, 2015, and each
2291 succeeding fiscal year thereafter, costs of less than ten thousand dollars
2292 that are incurred by a facility and are associated with any land,
2293 building or nonmovable equipment repair or improvement that are
2294 reported in the cost year used to establish the facility's rate shall not be
2295 capitalized for a period of more than five years for rate-setting
2296 purposes. For the fiscal year ending June 30, 2015, subject to available
2297 appropriations, the commissioner may, at the commissioner's
2298 discretion: Increase the inflation cost limitation under subsection (c) of
2299 section 17-311-52 of the regulations of Connecticut state agencies,
2300 provided such inflation allowance factor does not exceed a maximum
2301 of five per cent; establish a minimum rate of return applied to real
2302 property of five per cent inclusive of assets placed in service during
2303 cost year 2013; waive the standard rate of return under subsection (f)
2304 of section 17-311-52 of the regulations of Connecticut state agencies for
2305 ownership changes or health and safety improvements that exceed one
2306 hundred thousand dollars and that are required under a consent order
2307 from the Department of Public Health; and waive the rate of return

2308 adjustment under subsection (f) of section 17-311-52 of the regulations
2309 of Connecticut state agencies to avoid financial hardship. For the fiscal
2310 years ending June 30, 2016, and June 30, 2017, rates shall not exceed
2311 those in effect for the period ending June 30, 2015, except the
2312 commissioner may, in the commissioner's discretion and within
2313 available appropriations, provide pro rata fair rent increases to
2314 facilities which have documented fair rent additions placed in service
2315 in cost report years ending September 30, 2014, and September 30,
2316 2015, that are not otherwise included in rates issued. For the fiscal
2317 years ending June 30, 2016, and June 30, 2017, and each succeeding
2318 fiscal year, any facility that would have been issued a lower rate, due
2319 to interim rate status, a change in allowable fair rent or agreement with
2320 the department, shall be issued such lower rate.

2321 Sec. 41. Subsection (a) of section 17b-280 of the general statutes is
2322 repealed and the following is substituted in lieu thereof (*Effective July*
2323 *1, 2015*):

2324 (a) The state shall reimburse for all legend drugs provided under
2325 medical assistance programs administered by the Department of Social
2326 Services at the lower of (1) the rate established by the Centers for
2327 Medicare and Medicaid Services as the federal acquisition cost, (2) the
2328 average wholesale price minus sixteen and one-half per cent, or (3) an
2329 equivalent percentage as established under the Medicaid state plan.
2330 The state shall pay a professional fee of one dollar and [seventy] forty
2331 cents to licensed pharmacies for each prescription dispensed to a
2332 recipient of benefits under a medical assistance program administered
2333 by the Department of Social Services in accordance with federal
2334 regulations. On and after September 4, 1991, payment for legend and
2335 nonlegend drugs provided to Medicaid recipients shall be based upon
2336 the actual package size dispensed. Effective October 1, 1991,
2337 reimbursement for over-the-counter drugs for such recipients shall be
2338 limited to those over-the-counter drugs and products published in the
2339 Connecticut Formulary, or the cross reference list, issued by the
2340 commissioner. The cost of all over-the-counter drugs and products

2341 provided to residents of nursing facilities, chronic disease hospitals,
2342 and intermediate care facilities for individuals with intellectual
2343 disabilities shall be included in the facilities' per diem rate.
2344 Notwithstanding the provisions of this subsection, no dispensing fee
2345 shall be issued for a prescription drug dispensed to a Medicaid
2346 recipient who is a Medicare Part D beneficiary when the prescription
2347 drug is a Medicare Part D drug, as defined in Public Law 108-173, the
2348 Medicare Prescription Drug, Improvement, and Modernization Act of
2349 2003.

2350 Sec. 42. Subsection (b) of section 17b-239e of the general statutes is
2351 repealed and the following is substituted in lieu thereof (*Effective July*
2352 *1, 2015*):

2353 (b) The commissioner may establish a blended inpatient hospital
2354 case rate that includes services provided to all Medicaid recipients and
2355 may exclude certain diagnoses, as determined by the commissioner, if
2356 the establishment of such rates is needed to ensure that the conversion
2357 to an administrative services organization is cost neutral to hospitals in
2358 the aggregate and ensures patient access. Utilization may be a factor in
2359 determining cost neutrality. The Department of Social Services [shall]
2360 may establish, within available appropriations, a supplemental
2361 inpatient pool for [low-cost] certain hospitals.

2362 Sec. 43. Subsection (i) of section 17b-342 of the general statutes is
2363 repealed and the following is substituted in lieu thereof (*Effective July*
2364 *1, 2015*):

2365 (i) (1) On and after July 1, [1992] 2015, the Commissioner of Social
2366 Services shall, within available appropriations, administer a state-
2367 funded portion of the program for persons (A) who are sixty-five years
2368 of age and older; (B) who are inappropriately institutionalized or at
2369 risk of inappropriate institutionalization; (C) whose income is less than
2370 or equal to the amount allowed under subdivision (3) of subsection (a)
2371 of this section; and (D) whose assets, if single, [do not exceed the

2372 minimum community spouse protected amount pursuant to Section
2373 4022.05 of the department's uniform policy manual or, if married, the
2374 couple's assets do not exceed one hundred fifty per cent of said
2375 community spouse protected amount and on and after April 1, 2007,
2376 whose assets, if single,] do not exceed one hundred fifty per cent of the
2377 federal minimum community spouse protected amount pursuant to
2378 [Section 4022.05 of the department's uniform policy manual] 42 USC
2379 1396r-5(f)(2) or, if married, the couple's assets do not exceed two
2380 hundred per cent of said community spouse protected amount. For
2381 program applications received by the Department of Social Services for
2382 the fiscal years ending June 30, 2016, and June 30, 2017, only persons
2383 who require the level of care provided in a nursing home shall be
2384 eligible for the state-funded portion of the program, except for persons
2385 residing in affordable housing under the assisted living demonstration
2386 project established pursuant to section 17b-347e who are otherwise
2387 eligible in accordance with this section.

2388 (2) Except for persons residing in affordable housing under the
2389 assisted living demonstration project established pursuant to section
2390 17b-347e, as provided in subdivision (3) of this subsection, any person
2391 whose income is at or below two hundred per cent of the federal
2392 poverty level and who is ineligible for Medicaid shall contribute
2393 [seven] nine per cent of the cost of his or her care. Any person whose
2394 income exceeds two hundred per cent of the federal poverty level shall
2395 contribute [seven] nine per cent of the cost of his or her care in
2396 addition to the amount of applied income determined in accordance
2397 with the methodology established by the Department of Social Services
2398 for recipients of medical assistance. Any person who does not
2399 contribute to the cost of care in accordance with this subdivision shall
2400 be ineligible to receive services under this subsection. Notwithstanding
2401 any provision of [the general statutes] sections 17b-60 and 17b-61, the
2402 department shall not be required to provide an administrative hearing
2403 to a person found ineligible for services under this subsection because
2404 of a failure to contribute to the cost of care.

2405 (3) Any person who resides in affordable housing under the assisted
2406 living demonstration project established pursuant to section 17b-347e
2407 and whose income is at or below two hundred per cent of the federal
2408 poverty level, shall not be required to contribute to the cost of care.
2409 Any person who resides in affordable housing under the assisted
2410 living demonstration project established pursuant to section 17b-347e
2411 and whose income exceeds two hundred per cent of the federal
2412 poverty level, shall contribute to the applied income amount
2413 determined in accordance with the methodology established by the
2414 Department of Social Services for recipients of medical assistance. Any
2415 person whose income exceeds two hundred per cent of the federal
2416 poverty level and who does not contribute to the cost of care in
2417 accordance with this subdivision shall be ineligible to receive services
2418 under this subsection. Notwithstanding any provision of [the general
2419 statutes] sections 17b-60 and 17b-61, the department shall not be
2420 required to provide an administrative hearing to a person found
2421 ineligible for services under this subsection because of a failure to
2422 contribute to the cost of care.

2423 (4) The annualized cost of services provided to an individual under
2424 the state-funded portion of the program shall not exceed fifty per cent
2425 of the weighted average cost of care in nursing homes in the state,
2426 except an individual who received services costing in excess of such
2427 amount under the Department of Social Services in the fiscal year
2428 ending June 30, 1992, may continue to receive such services, provided
2429 the annualized cost of such services does not exceed eighty per cent of
2430 the weighted average cost of such nursing home care. The
2431 commissioner may allow the cost of services provided to an individual
2432 to exceed the maximum cost established pursuant to this subdivision
2433 in a case of extreme hardship, as determined by the commissioner,
2434 provided in no case shall such cost exceed that of the weighted cost of
2435 such nursing home care.

2436 Sec. 44. Section 17b-131 of the general statutes is repealed and the
2437 following is substituted in lieu thereof (*Effective July 1, 2015*):

2438 When a person in any town, or sent from such town to any licensed
2439 institution or state humane institution, dies or is found dead therein
2440 and does not leave sufficient estate or has no legally liable relative able
2441 to pay the cost of a proper funeral and burial, or upon the death of any
2442 beneficiary under the state-administered general assistance program,
2443 the Commissioner of Social Services shall give to such person a proper
2444 funeral and burial, and shall pay a sum not exceeding one thousand
2445 [eight] four hundred dollars as an allowance toward the funeral
2446 expenses of such deceased, said sum to be paid, upon submission of a
2447 proper bill, to the funeral director, cemetery or crematory, as the case
2448 may be. Such payment for funeral and burial expenses shall be
2449 reduced by (1) the amount in any revocable or irrevocable funeral
2450 fund, (2) any prepaid funeral contract, (3) the face value of any life
2451 insurance policy owned by the decedent, and (4) contributions in
2452 excess of two thousand eight hundred dollars toward such funeral and
2453 burial expenses from all other sources including friends, relatives and
2454 all other persons, organizations, veterans' and other benefit programs
2455 and other agencies.

2456 Sec. 45. Section 17b-84 of the general statutes is repealed and the
2457 following is substituted in lieu thereof (*Effective July 1, 2015*):

2458 Upon the death of any beneficiary under the state supplement or the
2459 temporary family assistance program, the Commissioner of Social
2460 Services shall order the payment of a sum not to exceed one thousand
2461 [eight] four hundred dollars as an allowance toward the funeral and
2462 burial expenses of such deceased. The payment for funeral and burial
2463 expenses shall be reduced by the amount in any revocable or
2464 irrevocable funeral fund, prepaid funeral contract or the face value of
2465 any life insurance policy owned by the recipient. Contributions may be
2466 made by any person for the cost of the funeral and burial expenses of
2467 the deceased over and above the sum established under this section
2468 without thereby diminishing the state's obligation.

2469 Sec. 46. Subsection (c) of section 17b-265d of the general statutes is

2470 repealed and the following is substituted in lieu thereof (*Effective July*
2471 *1, 2015*):

2472 (c) A full benefit dually eligible Medicare Part D beneficiary shall be
2473 responsible for any Medicare Part D prescription drug copayments
2474 imposed pursuant to Public Law 108-173, the Medicare Prescription
2475 Drug, Improvement, and Modernization Act of 2003. [, in amounts not
2476 to exceed fifteen dollars per month. The department shall be
2477 responsible for payment, on behalf of such beneficiary, of any
2478 Medicare Part D prescription drug copayments in any month in which
2479 such copayment amounts exceed fifteen dollars in the aggregate.]

2480 Sec. 47. Subsection (c) of section 17b-242 of the general statutes is
2481 repealed and the following is substituted in lieu thereof (*Effective July*
2482 *1, 2015*):

2483 (c) The home health services fee schedule shall include a fee for the
2484 administration of medication, which shall apply when the purpose of a
2485 nurse's visit is limited to the administration of medication.
2486 Administration of medication may include, but is not limited to, blood
2487 pressure checks, glucometer readings, pulse rate checks and similar
2488 indicators of health status. The fee for medication administration shall
2489 include administration of medications while the nurse is present, the
2490 pre-pouring of additional doses that the client will self-administer at a
2491 later time and the teaching of self-administration. The department
2492 shall not pay for medication administration in addition to any other
2493 nursing service at the same visit. The department may establish prior
2494 authorization requirements for this service. Before implementing such
2495 change, the Commissioner of Social Services shall consult with the
2496 chairpersons of the joint standing committees of the General Assembly
2497 having cognizance of matters relating to public health and human
2498 services. The commissioner shall monitor Medicaid home health care
2499 savings achieved through the implementation of nurse delegation of
2500 medication administration pursuant to section 19a-492e. If, by January
2501 1, 2016, the commissioner determines that the rate of savings is not

2502 adequate to meet the annualized savings assumed in the budget for the
2503 biennium ending June 30, 2017, the department may reduce rates for
2504 medication administration as necessary to achieve the savings
2505 assumed in the budget. Prior to any rate reduction, the department
2506 shall report to the joint standing committees of the General Assembly
2507 having cognizance of matters relating to appropriations and the
2508 budgets of state agencies and human services provider specific cost
2509 and utilization trend data for those patients receiving medication
2510 administration. Should the department determine it necessary to
2511 reduce medication administration rates under this section, it shall
2512 examine the possibility of establishing a separate Medicaid
2513 supplemental rate or a pay-for-performance program for those
2514 providers, as determined by the commissioner, who have established
2515 successful nurse delegation programs.

2516 Sec. 48. Subsection (d) of section 17b-265 of the general statutes is
2517 repealed and the following is substituted in lieu thereof (*Effective July*
2518 *1, 2015*):

2519 (d) When a recipient of medical assistance has personal health
2520 insurance in force covering care or other benefits provided under such
2521 program, payment or part-payment of the premium for such insurance
2522 may be made when deemed appropriate by the Commissioner of
2523 Social Services. Effective January 1, 1992, the commissioner shall limit
2524 reimbursement to medical assistance providers [, except those
2525 providers whose rates are established by the Commissioner of Public
2526 Health pursuant to chapter 368d,] for coinsurance and deductible
2527 payments under Title XVIII of the Social Security Act to assure that the
2528 combined Medicare and Medicaid payment to the provider shall not
2529 exceed the maximum allowable under the Medicaid program fee
2530 schedules.

2531 Sec. 49. Section 17b-273 of the general statutes is repealed and the
2532 following is substituted in lieu thereof (*Effective July 1, 2015*):

2533 On and after April 1, 1983, the Commissioner of Social Services shall
2534 increase the payment rate for ambulance rides eligible under the state
2535 medical assistance program. Subject to federal approval, beginning
2536 with the fiscal year commencing July 1, 2015, the Commissioner of
2537 Social Services shall, within available appropriations, revise the
2538 payment methodology for ambulance services under the Medicaid
2539 program to apply a relative value unit system similar to the payment
2540 methodology used in the Medicare program. The basic life support
2541 nonemergency transport shall be designated as the base rate with the
2542 relative value unit system applied to basic life support nonemergency
2543 transports, basic life support emergency transports, advanced life
2544 support nonemergency transports, advanced life support emergency
2545 transports and paramedic intercept services. For purposes of this
2546 section, "relative value unit" means a numeric value for ambulance
2547 services relative to the value of a base level ambulance service.

2548 Sec. 50. (NEW) (*Effective from passage*) The Department of Social
2549 Services shall cover orthodontic services for a Medicaid recipient
2550 under twenty-one years of age when the Salzmann Handicapping
2551 Malocclusion Index indicates a correctly scored assessment for the
2552 recipient of twenty-six points or greater, subject to prior authorization
2553 requirements. If a recipient's score on the Salzmann Handicapping
2554 Malocclusion Index is less than twenty-six points, the Department of
2555 Social Services shall consider additional substantive information when
2556 determining the need for orthodontic services, including (1)
2557 documentation of the presence of other severe deviations affecting the
2558 oral facial structures; and (2) the presence of severe mental, emotional
2559 or behavioral problems or disturbances, as defined in the most current
2560 edition of the Diagnostic and Statistical Manual of Mental Disorders,
2561 published by the American Psychiatric Association, that affects the
2562 individual's daily functioning. The commissioner may implement
2563 policies and procedures necessary to administer the provisions of this
2564 section while in the process of adopting such policies and procedures
2565 in regulation form, provided the commissioner publishes notice of

2566 intent to adopt regulations on the eRegulations System not later than
2567 twenty days after the date of implementation.

2568 Sec. 51. Subsection (a) of section 17b-354 of the general statutes is
2569 repealed and the following is substituted in lieu thereof (*Effective July*
2570 *1, 2015*):

2571 (a) [Except for applications deemed complete as of August 9, 1991,
2572 the] The Department of Social Services shall not accept or approve any
2573 requests for additional nursing home beds [or modify the capital cost
2574 of any prior approval for the period from September 4, 1991, through
2575 June 30, 2016,] except (1) beds restricted to use by patients [with
2576 acquired immune deficiency syndrome or traumatic brain injury]
2577 requiring neurological rehabilitation; (2) beds associated with a
2578 continuing care facility which guarantees life care for its residents; (3)
2579 Medicaid certified beds to be relocated from one licensed nursing
2580 facility to another licensed nursing facility [, to a new facility] to meet a
2581 priority need identified in the strategic plan developed pursuant to
2582 subsection (c) of section 17b-369, as amended by this act; [or to a small
2583 house nursing home, as defined in section 17b-372,] and (4) Medicaid
2584 beds to be relocated from a licensed facility or facilities to a new
2585 licensed facility, provided at least one currently licensed facility is
2586 closed in the transaction, and the new facility bed total is not less than
2587 ten per cent lower than the total number of beds relocated. The
2588 facilities included in the bed relocation and closure shall be in
2589 accordance with the strategic plan developed pursuant to subsection
2590 (c) of section 17b-369, as amended by this act, provided (A) the
2591 availability of beds in an area of need will not be adversely affected;
2592 and (B) no such relocation shall result in an increase in state
2593 expenditures. [; and (C) the relocation results in a reduction in the
2594 number of nursing facility beds in the state; (4) a request for no more
2595 than twenty beds submitted by a licensed nursing facility that
2596 participates in neither the Medicaid program nor the Medicare
2597 program, admits residents and provides health care to such residents
2598 without regard to their income or assets and demonstrates its financial

2599 ability to provide lifetime nursing home services to such residents
2600 without participating in the Medicaid program to the satisfaction of
2601 the department, provided the department does not accept or approve
2602 more than one request pursuant to this subdivision; (5) a request for no
2603 more than twenty beds associated with a freestanding facility
2604 dedicated to providing hospice care services for terminally ill persons
2605 operated by an organization previously authorized by the Department
2606 of Public Health to provide hospice services in accordance with section
2607 19a-122b; and (6) new or existing Medicaid certified beds to be
2608 relocated from a licensed nursing facility in a municipality with a 2004
2609 estimated population of one hundred twenty-five thousand to a
2610 location within the same municipality, provided such Medicaid
2611 certified beds do not exceed sixty beds. Notwithstanding the
2612 provisions of this subsection, any provision of the general statutes or
2613 any decision of the Office of Health Care Access, (i) the date by which
2614 construction shall begin for each nursing home certificate of need in
2615 effect August 1, 1991, shall be December 31, 1992, (ii) the date by which
2616 a nursing home shall be licensed under each such certificate of need
2617 shall be October 1, 1995, and (iii) the imposition of such dates shall not
2618 require action by the Commissioner of Social Services. Except as
2619 provided in subsection (c) of this section, a nursing home certificate of
2620 need in effect August 1, 1991, shall expire if construction has not begun
2621 or licensure has not been obtained in compliance with the dates set
2622 forth in subparagraphs (i) and (ii) of this subsection.]

2623 Sec. 52. Subsection (a) of section 17b-340 of the general statutes is
2624 repealed and the following is substituted in lieu thereof (*Effective July*
2625 *1, 2015*):

2626 (a) For purposes of this subsection, (1) a "related party" includes, but
2627 is not limited to, any company related to a chronic and convalescent
2628 nursing home through family association, common ownership, control
2629 or business association with any of the owners, operators or officials of
2630 such nursing home; (2) "company" means any person, partnership,
2631 association, holding company, limited liability company or

2632 corporation; (3) "family association" means a relationship by birth,
2633 marriage or domestic partnership; and (4) "profit and loss statement"
2634 means the most recent annual statement on profits and losses finalized
2635 by a related party before the annual report mandated under this
2636 subsection. The rates to be paid by or for persons aided or cared for by
2637 the state or any town in this state to licensed chronic and convalescent
2638 nursing homes, to chronic disease hospitals associated with chronic
2639 and convalescent nursing homes, to rest homes with nursing
2640 supervision, to licensed residential care homes, as defined by section
2641 19a-490, and to residential facilities for persons with intellectual
2642 disability that are licensed pursuant to section 17a-227 and certified to
2643 participate in the Title XIX Medicaid program as intermediate care
2644 facilities for individuals with intellectual disabilities, for room, board
2645 and services specified in licensing regulations issued by the licensing
2646 agency shall be determined annually, except as otherwise provided in
2647 this subsection, after a public hearing, by the Commissioner of Social
2648 Services, to be effective July first of each year except as otherwise
2649 provided in this subsection. Such rates shall be determined on a basis
2650 of a reasonable payment for such necessary services, which basis shall
2651 take into account as a factor the costs of such services. Cost of such
2652 services shall include reasonable costs mandated by collective
2653 bargaining agreements with certified collective bargaining agents or
2654 other agreements between the employer and employees, provided
2655 "employees" shall not include persons employed as managers or chief
2656 administrators or required to be licensed as nursing home
2657 administrators, and compensation for services rendered by proprietors
2658 at prevailing wage rates, as determined by application of principles of
2659 accounting as prescribed by said commissioner. Cost of such services
2660 shall not include amounts paid by the facilities to employees as salary,
2661 or to attorneys or consultants as fees, where the responsibility of the
2662 employees, attorneys, or consultants is to persuade or seek to persuade
2663 the other employees of the facility to support or oppose unionization.
2664 Nothing in this subsection shall prohibit inclusion of amounts paid for
2665 legal counsel related to the negotiation of collective bargaining

2666 agreements, the settlement of grievances or normal administration of
2667 labor relations. The commissioner may, in the commissioner's
2668 discretion, allow the inclusion of extraordinary and unanticipated
2669 costs of providing services that were incurred to avoid an immediate
2670 negative impact on the health and safety of patients. The commissioner
2671 may, in the commissioner's discretion, based upon review of a facility's
2672 costs, direct care staff to patient ratio and any other related
2673 information, revise a facility's rate for any increases or decreases to
2674 total licensed capacity of more than ten beds or changes to its number
2675 of licensed rest home with nursing supervision beds and chronic and
2676 convalescent nursing home beds. The commissioner may, in the
2677 commissioner's discretion, revise the rate of a facility that is closing.
2678 An interim rate issued for the period during which a facility is closing
2679 shall be based on a review of facility costs, the expected duration of the
2680 close-down period, the anticipated impact on Medicaid costs, available
2681 appropriations and the relationship of the rate requested by the facility
2682 to the average Medicaid rate for a close-down period. The
2683 commissioner may so revise a facility's rate established for the fiscal
2684 year ending June 30, 1993, and thereafter for any bed increases,
2685 decreases or changes in licensure effective after October 1, 1989.
2686 Effective July 1, 1991, in facilities that have both a chronic and
2687 convalescent nursing home and a rest home with nursing supervision,
2688 the rate for the rest home with nursing supervision shall not exceed
2689 such facility's rate for its chronic and convalescent nursing home. All
2690 such facilities for which rates are determined under this subsection
2691 shall report on a fiscal year basis ending on September thirtieth. Such
2692 report shall be submitted to the commissioner by December thirty-first.
2693 Each for-profit chronic and convalescent nursing home that receives
2694 state funding pursuant to this section shall include in such annual
2695 report a profit and loss statement from each related party that receives
2696 from such chronic and convalescent nursing home fifty thousand
2697 dollars or more per year for goods, fees and services. No cause of
2698 action or liability shall arise against the state, the Department of Social
2699 Services, any state official or agent for failure to take action based on

2700 the information required to be reported under this subsection. The
2701 commissioner may reduce the rate in effect for a facility that fails to
2702 submit a complete and accurate report on or before December thirty-
2703 first by an amount not to exceed ten per cent of such rate. If a licensed
2704 residential care home fails to submit a complete and accurate report,
2705 the department shall notify such home of the failure and the home
2706 shall have thirty days from the date the notice was issued to submit a
2707 complete and accurate report. If a licensed residential care home fails
2708 to submit a complete and accurate report not later than thirty days
2709 after the date of notice, such home may not receive a retroactive rate
2710 increase, in the commissioner's discretion. The commissioner shall,
2711 annually, on or before February fifteenth, report the data contained in
2712 the reports of such facilities to the joint standing committee of the
2713 General Assembly having cognizance of matters relating to
2714 appropriations and the budgets of state agencies. For the cost reporting
2715 year commencing October 1, 1985, and for subsequent cost reporting
2716 years, facilities shall report the cost of using the services of any nursing
2717 pool employee by separating said cost into two categories, the portion
2718 of the cost equal to the salary of the employee for whom the nursing
2719 pool employee is substituting shall be considered a nursing cost and
2720 any cost in excess of such salary shall be further divided so that
2721 seventy-five per cent of the excess cost shall be considered an
2722 administrative or general cost and twenty-five per cent of the excess
2723 cost shall be considered a nursing cost, provided if the total nursing
2724 pool costs of a facility for any cost year are equal to or exceed fifteen
2725 per cent of the total nursing expenditures of the facility for such cost
2726 year, no portion of nursing pool costs in excess of fifteen per cent shall
2727 be classified as administrative or general costs. The commissioner, in
2728 determining such rates, shall also take into account the classification of
2729 patients or boarders according to special care requirements or
2730 classification of the facility according to such factors as facilities and
2731 services and such other factors as the commissioner deems reasonable,
2732 including anticipated fluctuations in the cost of providing such
2733 services. The commissioner may establish a separate rate for a facility

2734 or a portion of a facility for traumatic brain injury patients who require
2735 extensive care but not acute general hospital care. Such separate rate
2736 shall reflect the special care requirements of such patients. If changes
2737 in federal or state laws, regulations or standards adopted subsequent
2738 to June 30, 1985, result in increased costs or expenditures in an amount
2739 exceeding one-half of one per cent of allowable costs for the most
2740 recent cost reporting year, the commissioner shall adjust rates and
2741 provide payment for any such increased reasonable costs or
2742 expenditures within a reasonable period of time retroactive to the date
2743 of enforcement. Nothing in this section shall be construed to require
2744 the Department of Social Services to adjust rates and provide payment
2745 for any increases in costs resulting from an inspection of a facility by
2746 the Department of Public Health. Such assistance as the commissioner
2747 requires from other state agencies or departments in determining rates
2748 shall be made available to the commissioner at the commissioner's
2749 request. Payment of the rates established pursuant to this section shall
2750 be conditioned on the establishment by such facilities of admissions
2751 procedures that conform with this section, section 19a-533 and all other
2752 applicable provisions of the law and the provision of equality of
2753 treatment to all persons in such facilities. The established rates shall be
2754 the maximum amount chargeable by such facilities for care of such
2755 beneficiaries, and the acceptance by or on behalf of any such facility of
2756 any additional compensation for care of any such beneficiary from any
2757 other person or source shall constitute the offense of aiding a
2758 beneficiary to obtain aid to which the beneficiary is not entitled and
2759 shall be punishable in the same manner as is provided in subsection (b)
2760 of section 17b-97. For the fiscal year ending June 30, 1992, rates for
2761 licensed residential care homes and intermediate care facilities for
2762 individuals with intellectual disabilities may receive an increase not to
2763 exceed the most recent annual increase in the Regional Data Resources
2764 Incorporated McGraw-Hill Health Care Costs: Consumer Price Index
2765 (all urban)-All Items. Rates for newly certified intermediate care
2766 facilities for individuals with intellectual disabilities shall not exceed
2767 one hundred fifty per cent of the median rate of rates in effect on

2768 January 31, 1991, for intermediate care facilities for individuals with
2769 intellectual disabilities certified prior to February 1, 1991.
2770 Notwithstanding any provision of this section, the Commissioner of
2771 Social Services may, within available appropriations, provide an
2772 interim rate increase for a licensed chronic and convalescent nursing
2773 home or a rest home with nursing supervision for rate periods no
2774 earlier than April 1, 2004, only if the commissioner determines that the
2775 increase is necessary to avoid the filing of a petition for relief under
2776 Title 11 of the United States Code; imposition of receivership pursuant
2777 to sections 19a-542 and 19a-543; or substantial deterioration of the
2778 facility's financial condition that may be expected to adversely affect
2779 resident care and the continued operation of the facility, and the
2780 commissioner determines that the continued operation of the facility is
2781 in the best interest of the state. The commissioner shall consider any
2782 requests for interim rate increases on file with the department from
2783 March 30, 2004, and those submitted subsequently for rate periods no
2784 earlier than April 1, 2004. When reviewing an interim rate increase
2785 request the commissioner shall, at a minimum, consider: (A) Existing
2786 chronic and convalescent nursing home or rest home with nursing
2787 supervision utilization in the area and projected bed need; (B) physical
2788 plant long-term viability and the ability of the owner or purchaser to
2789 implement any necessary property improvements; (C) licensure and
2790 certification compliance history; (D) reasonableness of actual and
2791 projected expenses; and (E) the ability of the facility to meet wage and
2792 benefit costs. No interim rate shall be increased pursuant to this
2793 subsection in excess of one hundred fifteen per cent of the median rate
2794 for the facility's peer grouping, established pursuant to subdivision (2)
2795 of subsection (f) of this section, unless recommended by the
2796 commissioner and approved by the Secretary of the Office of Policy
2797 and Management after consultation with the commissioner. Such
2798 median rates shall be published by the Department of Social Services
2799 not later than April first of each year. In the event that a facility
2800 granted an interim rate increase pursuant to this section is sold or
2801 otherwise conveyed for value to an unrelated entity less than five years

2802 after the effective date of such rate increase, the rate increase shall be
2803 deemed rescinded and the department shall recover an amount equal
2804 to the difference between payments made for all affected rate periods
2805 and payments that would have been made if the interim rate increase
2806 was not granted. The commissioner may seek recovery of such
2807 payments from any facility with common ownership. With the
2808 approval of the Secretary of the Office of Policy and Management, the
2809 commissioner may waive recovery and rescission of the interim rate
2810 for good cause shown that is not inconsistent with this section,
2811 including, but not limited to, transfers to family members that were
2812 made for no value. The commissioner shall provide written quarterly
2813 reports to the joint standing committees of the General Assembly
2814 having cognizance of matters relating to aging, human services and
2815 appropriations and the budgets of state agencies, that identify each
2816 facility requesting an interim rate increase, the amount of the
2817 requested rate increase for each facility, the action taken by the
2818 commissioner and the secretary pursuant to this subsection, and
2819 estimates of the additional cost to the state for each approved interim
2820 rate increase. Nothing in this subsection shall prohibit the
2821 commissioner from increasing the rate of a licensed chronic and
2822 convalescent nursing home or a rest home with nursing supervision
2823 for allowable costs associated with facility capital improvements or
2824 increasing the rate in case of a sale of a licensed chronic and
2825 convalescent nursing home or a rest home with nursing supervision,
2826 pursuant to subdivision (15) of subsection (f) of this section, if
2827 receivership has been imposed on such home.

2828 Sec. 53. Section 17b-239 of the general statutes is repealed and the
2829 following is substituted in lieu thereof (*Effective July 1, 2015*):

2830 (a) (1) Until the time subdivision (2) of this subsection is effective,
2831 the rate to be paid by the state to hospitals receiving appropriations
2832 granted by the General Assembly and to freestanding chronic disease
2833 hospitals providing services to persons aided or cared for by the state
2834 for routine services furnished to state patients, shall be based upon

2835 reasonable cost to such hospital, or the charge to the general public for
2836 ward services or the lowest charge for semiprivate services if the
2837 hospital has no ward facilities, imposed by such hospital, whichever is
2838 lowest, except to the extent, if any, that the commissioner determines
2839 that a greater amount is appropriate in the case of hospitals serving a
2840 disproportionate share of indigent patients. Such rate shall be
2841 promulgated annually by the Commissioner of Social Services within
2842 available appropriations.

2843 (2) On or after July 1, 2013, Medicaid rates paid to acute care [and]
2844 hospitals, including children's hospitals, shall be based on diagnosis-
2845 related groups established and periodically rebased by the
2846 Commissioner of Social Services, provided the Department of Social
2847 Services completes a fiscal analysis of the impact of such rate payment
2848 system on each hospital. The commissioner shall, in accordance with
2849 the provisions of section 11-4a, file a report on the results of the fiscal
2850 analysis not later than six months after implementing the rate payment
2851 system with the joint standing committees of the General Assembly
2852 having cognizance of matters relating to human services and
2853 appropriations and the budgets of state agencies. [The] Within
2854 available appropriations, the commissioner shall annually determine
2855 in-patient [rates] payments for each hospital by multiplying
2856 [diagnostic-related] diagnosis-related group relative weights by a base
2857 rate. Over a period of up to four years beginning on or after January 1,
2858 2016, within available appropriations and at the discretion of the
2859 commissioner, the Department of Social Services shall transition
2860 hospital-specific, diagnosis-related group base rates to state-wide
2861 diagnosis-related group base rates by peer groups determined by the
2862 commissioner. For the purposes of this subsection, "peer group" means
2863 a group comprised of one of the following categories of acute care
2864 hospitals: Privately operated acute care hospitals, publicly operated
2865 acute care hospitals, or acute care children's hospitals licensed by the
2866 Department of Public Health. At the discretion of the Commissioner of
2867 Social Services, the peer group for privately operated acute care

2868 hospitals may be further subdivided into peer groups for privately
2869 operated acute care hospitals. Within available appropriations, the
2870 commissioner may, in his or her discretion, make additional payments
2871 to hospitals based on criteria to be determined by the commissioner.
2872 Upon the conversion to a hospital payment methodology based on
2873 diagnosis-related groups, the commissioner shall evaluate payments
2874 for all hospital services, including, but not limited to, a review of
2875 pediatric psychiatric inpatient units within hospitals. The
2876 commissioner may, within available appropriations, implement a pay-
2877 for-performance program for pediatric psychiatric inpatient care.
2878 Nothing contained in this section shall authorize Medicaid payment by
2879 the state to any such hospital in excess of the charges made by such
2880 hospital for comparable services to the general public.

2881 (b) Effective October 1, 1991, the rate to be paid by the state for the
2882 cost of special services rendered by such hospitals shall be established
2883 annually by the commissioner for each such hospital based on the
2884 reasonable cost to each hospital of such services furnished to state
2885 patients within available appropriations. Nothing contained in this
2886 subsection shall authorize a payment by the state for such services to
2887 any such hospital in excess of the charges made by such hospital for
2888 comparable services to the general public.

2889 (c) The term "reasonable cost" as used in this section means the cost
2890 of care furnished such patients by an efficient and economically
2891 operated facility, computed in accordance with accepted principles of
2892 hospital cost reimbursement. The commissioner may adjust the rate of
2893 payment established under the provisions of this section for the year
2894 during which services are furnished to reflect fluctuations in hospital
2895 costs within available appropriations. Such adjustment may be made
2896 prospectively to cover anticipated fluctuations or may be made
2897 retroactive to any date subsequent to the date of the initial rate
2898 determination for such year or in such other manner as may be
2899 determined by the commissioner. In determining "reasonable cost" the
2900 commissioner may give due consideration to allowances for fully or

2901 partially unpaid bills, reasonable costs mandated by collective
2902 bargaining agreements with certified collective bargaining agents or
2903 other agreements between the employer and employees, provided
2904 "employees" shall not include persons employed as managers or chief
2905 administrators, requirements for working capital and cost of
2906 development of new services, including additions to and replacement
2907 of facilities and equipment. The commissioner shall not give
2908 consideration to amounts paid by the facilities to employees as salary,
2909 or to attorneys or consultants as fees, where the responsibility of the
2910 employees, attorneys or consultants is to persuade or seek to persuade
2911 the other employees of the facility to support or oppose unionization.
2912 Nothing in this subsection shall prohibit the commissioner from
2913 considering amounts paid for legal counsel related to the negotiation
2914 of collective bargaining agreements, the settlement of grievances or
2915 normal administration of labor relations.

2916 (d) (1) Until such time as subdivision (2) of this subsection is
2917 effective, the state shall also pay to such hospitals for each outpatient
2918 clinic and emergency room visit a reasonable rate to be established
2919 annually by the commissioner for each hospital, such rate to be
2920 determined by the reasonable cost of such services and within
2921 available appropriations.

2922 (2) On or after July 1, 2013, with the exception of publicly operated
2923 psychiatric hospitals, hospitals shall be paid for outpatient and
2924 emergency room episodes of care based on prospective rates
2925 established by the commissioner within available appropriations and
2926 in accordance with the Medicare Ambulatory Payment Classification
2927 system in conjunction with a state conversion factor, provided the
2928 Department of Social Services completes a fiscal analysis of the impact
2929 of such rate payment system on each hospital. The Commissioner of
2930 Social Services shall, in accordance with the provisions of section 11-4a,
2931 file a report on the results of the fiscal analysis not later than six
2932 months after implementing the rate payment system with the joint
2933 standing committees of the General Assembly having cognizance of

2934 matters relating to human services and appropriations and the budgets
2935 of state agencies. The Medicare Ambulatory Payment Classification
2936 system shall be ~~[modified]~~ augmented to provide payment for services
2937 not generally covered ~~[by]~~ under the Medicare Ambulatory Payment
2938 Classification system, including, but not limited to, ~~[pediatric,~~
2939 ~~obstetric, neonatal and perinatal services]~~ mammograms, durable
2940 medical equipment, physical, occupational and speech therapy.
2941 Nothing contained in this subsection shall authorize a payment by the
2942 state for such episodes of care to any hospital in excess of the charges
2943 made by such hospital for comparable services to the general public.
2944 [Those outpatient hospital services that do not have an established
2945 Medicare Ambulatory Payment Classification code shall be paid on the
2946 basis of a ratio of cost to charges, or the fixed fee in effect as of January
2947 1, 2013.] Effective upon implementation of the Ambulatory Payment
2948 Classification system, a covered outpatient hospital service that does
2949 not have an established Medicare Ambulatory Payment Classification
2950 code shall be paid in accordance with a fee schedule or an alternative
2951 payment methodology, as determined by the commissioner. Prior to
2952 the implementation of the Ambulatory Payment Classification system,
2953 each hospital's charges shall be based on the charge master in effect as
2954 of June 1, 2015. After implementation of such system, annual increases
2955 in each hospital's charge master shall not exceed, in the aggregate, the
2956 annual increase in the Medicare economic index. The Commissioner of
2957 Social Services shall establish a fee schedule for outpatient hospital
2958 services to be effective on and after January 1, 1995, and may annually
2959 modify such fee schedule if such modification is needed to ensure that
2960 the conversion to an administrative services organization is cost
2961 neutral to hospitals in the aggregate and ensures patient access.
2962 Utilization may be a factor in determining cost neutrality.

2963 (e) On and after January 1, 2015, and concurrent with the
2964 implementation of the diagnosis-related group methodology of
2965 payment to hospitals, an emergency department physician may enroll
2966 separately as a Medicaid provider and qualify for direct

2967 reimbursement for professional services provided in the emergency
2968 department of a hospital to a Medicaid recipient, including services
2969 provided on the same day the Medicaid recipient is admitted to the
2970 hospital. The commissioner shall pay to any such emergency
2971 department physician the Medicaid rate for physicians in accordance
2972 with the physician fee schedule in effect at that time. If the
2973 commissioner determines that payment to an emergency department
2974 physician pursuant to this subsection results in an additional cost to
2975 the state, the commissioner shall adjust such rate in consultation with
2976 the Connecticut Hospital Association and the Connecticut College of
2977 Emergency Physicians to ensure budget neutrality.

2978 (f) The commissioner shall adopt regulations, in accordance with the
2979 provisions of chapter 54, establishing criteria for defining emergency
2980 and nonemergency visits to hospital emergency rooms. All
2981 nonemergency visits to hospital emergency rooms shall be paid at the
2982 hospital's outpatient clinic services rate. Nothing contained in this
2983 subsection or the regulations adopted under this section shall
2984 authorize a payment by the state for such services to any hospital in
2985 excess of the charges made by such hospital for comparable services to
2986 the general public. To the extent permitted by federal law, the
2987 Commissioner of Social Services shall impose cost-sharing
2988 requirements under the medical assistance program for nonemergency
2989 use of hospital emergency room services.

2990 (g) The commissioner shall establish rates to be paid to freestanding
2991 chronic disease hospitals within available appropriations.

2992 (h) The Commissioner of Social Services may implement policies
2993 and procedures as necessary to carry out the provisions of this section
2994 while in the process of adopting the policies and procedures as
2995 regulations, provided notice of intent to adopt the regulations is
2996 published in accordance with the provisions of section 17b-10 not later
2997 than twenty days after the date of implementation.

2998 (i) In the event the commissioner is unable to implement the
2999 provisions of subsection (e) of this section by January 1, 2015, the
3000 commissioner shall submit written notice, not later than thirty-five
3001 days prior to January 1, 2015, to the joint standing committees of the
3002 General Assembly having cognizance of matters relating to human
3003 services and appropriations and the budgets of state agencies
3004 indicating that the department will not be able to implement such
3005 provisions on or before such date. The commissioner shall include in
3006 such notice (1) the reasons why the department will not be able to
3007 implement such provisions by such date, and (2) the date by which the
3008 department will be able to implement such provisions.

3009 (j) The Department of Social Services is not required to increase
3010 rates paid, or to set any rates to be paid to, any hospital based on
3011 inflation, including, but not limited to, any current payments or
3012 adjustments that are being made based on dates of service in previous
3013 years.

3014 Sec. 54. Section 17b-369 of the general statutes is repealed and the
3015 following is substituted in lieu thereof (*Effective July 1, 2015*):

3016 (a) The Commissioner of Social Services, pursuant to Section 6071 of
3017 the Deficit Reduction Act of 2005, shall submit an application to the
3018 Secretary of Health and Human Services to establish a Money Follows
3019 the Person demonstration project. Such project shall serve not more
3020 than five thousand persons and shall be designed to achieve the
3021 objectives set forth in Section 6071(a) of the Deficit Reduction Act of
3022 2005. Services available under the demonstration project shall include,
3023 but not be limited to, personal care assistance services. The
3024 commissioner may apply for a Medicaid research and demonstration
3025 waiver under Section 1115 of the Social Security Act, if such waiver is
3026 necessary to implement the demonstration project. The commissioner
3027 may, if necessary, modify any existing Medicaid home or community-
3028 based waiver if such modification is required to implement the
3029 demonstration project.

3030 (b) (1) The Commissioner of Social Services shall submit, in
3031 accordance with this subdivision, a copy of any report on the Money
3032 Follows the Person demonstration project that the commissioner is
3033 required to submit to the Secretary of Health and Human Services and
3034 that pertains to (A) the status of the implementation of the Money
3035 Follows the Person demonstration project, (B) the anticipated date that
3036 the first eligible person or persons will be transitioned into the
3037 community, or (C) information concerning when and how the
3038 Department of Social Services will transition additional eligible
3039 persons into the community. The commissioner shall submit such copy
3040 to the joint standing committees of the General Assembly having
3041 cognizance of matters relating to aging and human services, in
3042 accordance with the provisions of section 11-4a. Copies of reports
3043 prepared prior to October 1, 2009, shall be submitted by said date and
3044 copies of reports prepared thereafter shall be submitted semiannually.

3045 (2) After October 1, 2009, if the commissioner has not prepared any
3046 new reports for submission to the Secretary of Health and Human
3047 Services for any six-month submission period under subdivision (1) of
3048 this subsection, the commissioner shall prepare and submit a written
3049 report in accordance with this subdivision to the joint standing
3050 committees of the General Assembly having cognizance of matters
3051 relating to aging and human services, in accordance with the
3052 provisions of section 11-4a. Such report shall include (A) the status of
3053 the implementation of the Money Follows the Person demonstration
3054 project, (B) the anticipated date that the first eligible person or persons
3055 will be transitioned into the community, and (C) information
3056 concerning when and how the Department of Social Services will
3057 transition additional eligible persons into the community.

3058 (c) The Commissioner of Social Services shall develop a strategic
3059 plan, consistent with the long-term care plan established pursuant to
3060 section 17b-337, to rebalance Medicaid long-term care supports and
3061 services, including, but not limited to, those supports and services
3062 provided in home, community-based settings and institutional

3063 settings. The commissioner shall include home, community-based and
3064 institutional providers in the development of the strategic plan. In
3065 developing the strategic plan the commissioner shall consider topics
3066 that include, but are not limited to: (1) Regional trends concerning the
3067 state's aging population; (2) trends in the demand for home,
3068 community-based and institutional services; (3) gaps in the provision
3069 of home and community-based services which prevent community
3070 placements; (4) gaps in the provision of institutional care; (5) the
3071 quality of care provided by home, community-based and institutional
3072 providers; (6) the condition of institutional buildings; (7) the state's
3073 regional supply of institutional beds; (8) the current rate structure
3074 applicable to home, community-based and institutional services; (9)
3075 the methods of implementing adjustments to the bed capacity of
3076 individual nursing facilities; and (10) a review of the provisions of
3077 subsection (a) of section 17b-354, as amended by this act.

3078 (d) The Commissioner of Social Services may contract with nursing
3079 facilities, as defined in section 17b-357, and home and community-
3080 based providers for the purpose of carrying out the strategic plan. In
3081 addition, the commissioner may revise a rate paid to a nursing facility
3082 pursuant to section 17b-340, as amended by this act, in order to
3083 effectuate the strategic plan. The commissioner may fund strategic
3084 plan initiatives with federal grant-in-aid resources available to the state
3085 pursuant to the Money Follows the Person demonstration project
3086 pursuant to Section 6071 of the Deficit Reduction Act, P.L. 109-171, and
3087 the State Balancing Incentive Payments Program under the Patient
3088 Protection and Affordable Care Act, P.L. 111-148.

3089 (e) If a nursing facility has reason to know that a resident is likely to
3090 become financially eligible for Medicaid benefits within one hundred
3091 eighty days, the nursing facility shall notify the resident or the
3092 resident's representative and the department. The department may (1)
3093 assess any such resident to determine if the resident prefers and is able
3094 to live appropriately at home or in some other community-based
3095 setting, and (2) develop a care plan and assist the resident in his or her

3096 transition to the community.

3097 [(e)] (f) The Commissioner of Public Health, or the commissioner's
3098 designee, may waive the requirements of sections 19-13-D8t, 19-13-D6
3099 and 19-13-D105 of the regulations of Connecticut state agencies, if a
3100 provider requires such a waiver for purposes of effectuating the
3101 strategic plan developed pursuant to subsection (c) of this section and
3102 the commissioner, or the commissioner's designee, determines that
3103 such waiver will not endanger the health and safety of the provider's
3104 residents or clients. The commissioner, or the commissioner's designee,
3105 may impose conditions on the granting of any waiver which are
3106 necessary to ensure the health and safety of the provider's residents or
3107 clients. The commissioner, or the commissioner's designee, may revoke
3108 any waiver granted pursuant to this subsection upon a finding that the
3109 health or safety of a resident or client of a provider has been
3110 jeopardized.

3111 Sec. 55. (NEW) (*Effective from passage*) (a) The Commissioner of
3112 Social Services may implement an acuity-based methodology for
3113 Medicaid reimbursement of nursing home services. In the course of
3114 developing such a system, the commissioner shall review the skilled
3115 nursing facility prospective payment system developed by the Centers
3116 for Medicare and Medicaid Services, as well as other methodologies
3117 used nationally, and shall consider recommendations from the nursing
3118 home industry.

3119 (b) The Commissioner of Social Services may implement policies as
3120 necessary to carry out the provisions of this section while in the
3121 process of adopting the policies as regulations, provided that prior to
3122 implementation the policies are posted on the eRegulations System
3123 established pursuant to section 4-173b of the general statutes and the
3124 Department of Social Services' Internet web site.

3125 Sec. 56. Section 17b-112c of the general statutes is repealed and the
3126 following is substituted in lieu thereof (*Effective from passage*):

3127 [(a)] Qualified aliens, as defined in Section 431 of Public Law 104-
3128 193, who do not qualify for federally-funded cash assistance, other
3129 lawfully residing immigrant aliens or aliens who formerly held the
3130 status of permanently residing under color of law shall be eligible for
3131 solely state-funded temporary family assistance or cash assistance
3132 under the state-administered general assistance program, provided
3133 other conditions of eligibility are met. [An individual who is granted
3134 assistance under this section must pursue citizenship to the maximum
3135 extent allowed by law as a condition of eligibility unless incapable of
3136 doing so due to a medical problem, language barrier or other reason as
3137 determined by the Commissioner of Social Services. Notwithstanding
3138 the provisions of this section, any qualified alien or other lawfully
3139 residing immigrant alien or alien who formerly held the status of
3140 permanently residing under color of law who is a victim of domestic
3141 violence or who has intellectual disability shall be eligible for
3142 assistance under this section.

3143 (b) Notwithstanding the provisions of subsection (a) of this section:
3144 (1) A qualified alien admitted into the United States on or after August
3145 22, 1996, or other lawfully residing immigrant alien determined
3146 eligible for temporary family assistance or cash assistance under the
3147 state-administered general assistance program prior to July 1, 1997, or
3148 other lawfully residing immigrant alien or alien who formerly held the
3149 status of permanently residing under color of law, shall remain
3150 eligible, and (2) a qualified alien, other lawfully residing immigrant
3151 alien admitted into the United States on or after August 22, 1996, other
3152 lawfully residing immigrant alien or an alien who formerly held the
3153 status of permanently residing under color of law and not determined
3154 eligible prior to July 1, 1997, shall be eligible for such assistance
3155 subsequent to six months from establishing residency in this state.

3156 (c) Notwithstanding the provisions of this section, a qualified alien
3157 or other lawfully residing immigrant alien or alien who formerly held
3158 the status of permanently residing under color of law who is a victim
3159 of domestic violence or who has intellectual disability shall be eligible

3160 for assistance under this section.]

3161 Sec. 57. Subsection (a) of section 17b-342 of the general statutes is
3162 repealed and the following is substituted in lieu thereof (*Effective from*
3163 *passage*):

3164 (a) The Commissioner of Social Services shall administer the
3165 Connecticut home-care program for the elderly state-wide in order to
3166 prevent the institutionalization of elderly persons (1) who are
3167 recipients of medical assistance, (2) who are eligible for such
3168 assistance, (3) who would be eligible for medical assistance if residing
3169 in a nursing facility, or (4) who meet the criteria for the state-funded
3170 portion of the program under subsection (i) of this section. For
3171 purposes of this section, a long-term care facility is a facility that has
3172 been federally certified as a skilled nursing facility or intermediate care
3173 facility. The commissioner shall make any revisions in the state
3174 Medicaid plan required by Title XIX of the Social Security Act prior to
3175 implementing the program. The program shall be structured so that
3176 the net cost to the state for long-term facility care in combination with
3177 the services under the program shall not exceed the net cost the state
3178 would have incurred without the program. The commissioner shall
3179 investigate the possibility of receiving federal funds for the program
3180 and shall apply for any necessary federal waivers. A recipient of
3181 services under the program, and the estate and legally liable relatives
3182 of the recipient, shall be responsible for reimbursement to the state for
3183 such services to the same extent required of a recipient of assistance
3184 under the state supplement program, medical assistance program,
3185 temporary family assistance program or supplemental nutrition
3186 assistance program. Only a United States citizen or a noncitizen who
3187 meets the citizenship requirements for eligibility under the Medicaid
3188 program shall be eligible for home-care services under this section,
3189 except a qualified alien, as defined in Section 431 of Public Law 104-
3190 193, admitted into the United States on or after August 22, 1996, [or]
3191 other lawfully residing immigrant alien [determined eligible for
3192 services under this section prior to July 1, 1997,] or alien who formerly

3193 held the status of permanently residing under color of law shall remain
3194 eligible for such services provided other conditions of eligibility are
3195 met. [Qualified aliens or other lawfully residing immigrant aliens not
3196 determined eligible prior to July 1, 1997, shall be eligible for services
3197 under this section subsequent to six months from establishing
3198 residency. Notwithstanding the provisions of this subsection, any
3199 qualified alien or other lawfully residing immigrant alien or alien who
3200 formerly held the status of permanently residing under color of law
3201 who is a victim of domestic violence or who has intellectual disability
3202 shall be eligible for assistance pursuant to this section. Qualified aliens,
3203 as defined in Section 431 of Public Law 104-193, or other lawfully
3204 residing immigrant aliens or aliens who formerly held the status of
3205 permanently residing under color of law shall be eligible for services
3206 under this section provided other conditions of eligibility are met.]

3207 Sec. 58. Subsection (a) of section 17b-790a of the general statutes is
3208 repealed and the following is substituted in lieu thereof (*Effective from*
3209 *passage*):

3210 (a) The Commissioner of Social Services, within available
3211 appropriations, shall establish a food assistance program for
3212 individuals [entering the United States prior to April 1, 1998,] whose
3213 immigrant status meets the eligibility requirements of the federal Food
3214 and Nutrition Act of 2008, as amended, but who are [no longer] not
3215 eligible for supplemental nutrition assistance solely due to their
3216 immigrant status under Public Law 104-193. [Individuals who enter
3217 the United States after April 1, 1998, must have resided in the state for
3218 six months prior to becoming eligible for the state program.] The
3219 commissioner may administer such program in accordance with the
3220 provisions of the federal supplemental nutrition assistance program,
3221 except those pertaining to the determination of immigrant status under
3222 Public Law 104-193.

3223 Sec. 59. Section 17a-22f of the general statutes is repealed and the
3224 following is substituted in lieu thereof (*Effective from passage*):

3225 (a) The Commissioner of Social Services may, with regard to the
3226 provision of behavioral health services provided pursuant to a state
3227 plan under Title XIX or Title XXI of the Social Security Act: (1) Contract
3228 with one or more administrative services organizations to provide
3229 clinical management, provider network development and other
3230 administrative services; (2) delegate responsibility to the Department
3231 of Children and Families for the clinical management portion of such
3232 administrative contract or contracts that pertain to HUSKY Plan Parts
3233 A and B, and other children, adolescents and families served by the
3234 Department of Children and Families; and (3) delegate responsibility
3235 to the Department of Mental Health and Addiction Services for the
3236 clinical management portion of such administrative contract or
3237 contracts that pertain to Medicaid recipients who are not enrolled in
3238 HUSKY Plan Part A.

3239 (b) For purposes of this section, the term "clinical management"
3240 describes the process of evaluating and determining the
3241 appropriateness of the utilization of behavioral health services and
3242 providing assistance to clinicians or beneficiaries to ensure appropriate
3243 use of resources and may include, but is not limited to, authorization,
3244 concurrent and retrospective review, discharge review, quality
3245 management, provider certification and provider performance
3246 enhancement. The Commissioners of Social Services, Children and
3247 Families, and Mental Health and Addiction Services shall jointly
3248 develop clinical management policies and procedures. The
3249 Department of Social Services may implement policies and procedures
3250 necessary to carry out the purposes of this section, including any
3251 necessary changes to existing behavioral health policies and
3252 procedures concerning utilization management, while in the process of
3253 adopting such policies and procedures in regulation form, provided
3254 the Commissioner of Social Services publishes notice of intention to
3255 adopt the regulations [in the Connecticut Law Journal] on the
3256 department's Internet web site and the eRegulations system within
3257 twenty days of implementing such policies and procedures. Policies

3258 and procedures implemented pursuant to this subsection shall be valid
3259 until the time such regulations are adopted.

3260 Sec. 60. Section 17a-22f of the general statutes, as amended by
3261 section 4 of public act 14-62, is repealed and the following is
3262 substituted in lieu thereof (*Effective July 1, 2016*):

3263 (a) The Commissioner of Social Services may, with regard to the
3264 provision of behavioral health services provided pursuant to a state
3265 plan under Title XIX or Title XXI of the Social Security Act: (1) Contract
3266 with one or more administrative services organizations to provide
3267 clinical management, intensive [case] care management, provider
3268 network development and other administrative services; (2) delegate
3269 responsibility to the Department of Children and Families for the
3270 clinical management portion of such administrative contract or
3271 contracts that pertain to HUSKY Plan Parts A and B, and other
3272 children, adolescents and families served by the Department of
3273 Children and Families; and (3) delegate responsibility to the
3274 Department of Mental Health and Addiction Services for the clinical
3275 management portion of such administrative contract or contracts that
3276 pertain to Medicaid recipients who are not enrolled in HUSKY Plan
3277 Part A.

3278 (b) For purposes of this section, the term "clinical management"
3279 describes the process of evaluating and determining the
3280 appropriateness of the utilization of behavioral health services and
3281 providing assistance to clinicians or beneficiaries to ensure appropriate
3282 use of resources and may include, but is not limited to, authorization,
3283 concurrent and retrospective review, discharge review, quality
3284 management, provider certification and provider performance
3285 enhancement. The Commissioners of Social Services, Children and
3286 Families, and Mental Health and Addiction Services shall jointly
3287 develop clinical management policies and procedures.

3288 [(c) The Commissioners of Social Services, Children and Families,

3289 and Mental Health and Addiction Services shall require that
3290 administrative services organizations managing behavioral health
3291 services for Medicaid clients develop intensive case management that
3292 includes, but is not limited to: (1) The identification by the
3293 administrative services organization of hospital emergency
3294 departments which may benefit from intensive case management
3295 based on the number of Medicaid clients who are frequent users of
3296 such emergency departments; (2) the creation of regional intensive
3297 case management teams to work with emergency department doctors
3298 to (A) identify Medicaid clients who would benefit from intensive case
3299 management, (B) create care plans for such Medicaid clients, and (C)
3300 monitor progress of such Medicaid clients; and (3) the assignment of at
3301 least one staff member from a regional intensive case management
3302 team to participating hospital emergency departments during hours
3303 when Medicaid clients who are frequent users visit the most and when
3304 emergency department use is at its highest.

3305 (d) The Commissioners of Social Services, Children and Families,
3306 and Mental Health and Addiction Services shall ensure that any
3307 contracts entered into with an administrative services organization
3308 require such organization to (1) conduct assessments of behavioral
3309 health providers and specialists to determine patient ease of access to
3310 services, including, but not limited to, the wait times for appointments
3311 and whether the provider is accepting new Medicaid clients; and (2)
3312 perform outreach to Medicaid clients to (A) inform them of the
3313 advantages of receiving care from a behavioral health provider, (B)
3314 help to connect such clients with behavioral health providers soon
3315 after they are enrolled in Medicaid, and (C) for frequent users of
3316 emergency departments, help to arrange visits by Medicaid clients
3317 with behavioral health providers after such clients are treated at an
3318 emergency department.

3319 (e) The Commissioners of Social Services, Children and Families,
3320 and Mental Health and Addiction Services, in consultation with the
3321 Secretary of the Office of Policy and Management, shall ensure that all

3322 expenditures for intensive case management eligible for Medicaid
3323 reimbursement are submitted to the Centers for Medicare and
3324 Medicaid Services.

3325 (f) The Department of Social Services may implement policies and
3326 procedures necessary to carry out the purposes of this section,
3327 including any necessary changes to procedures relating to the
3328 provision of behavioral health services and utilization management,
3329 while in the process of adopting such policies and procedures in
3330 regulation form, provided the Commissioner of Social Services
3331 publishes notice of intention to adopt the regulations in accordance
3332 with the provisions of section 17b-10 not later than twenty days after
3333 implementing such policies and procedures. Policies and procedures
3334 implemented pursuant to this subsection shall be valid until the time
3335 such regulations are adopted.]

3336 Sec. 61. Section 17a-476 of the general statutes, as amended by
3337 section 3 of public act 14-62, is repealed and the following is
3338 substituted in lieu thereof (*Effective July 1, 2016*):

3339 (a) Any general hospital, municipality or nonprofit organization in
3340 Connecticut may apply to the Department of Mental Health and
3341 Addiction Services for funds to establish, expand or maintain
3342 psychiatric or mental health services. The application for funds shall be
3343 submitted on forms provided by the Department of Mental Health and
3344 Addiction Services, and shall be accompanied by (1) a definition of the
3345 towns and areas to be served; (2) a plan by means of which the
3346 applicant proposes to coordinate its activities with those of other local
3347 agencies presently supplying mental health services or contributing in
3348 any way to the mental health of the area; (3) a description of the
3349 services to be provided, and the methods through which these services
3350 will be provided; and (4) indication of the methods that will be
3351 employed to effect a balance in the use of state and local resources so
3352 as to foster local initiative, responsibility and participation. In
3353 accordance with subdivision (4) of section 17a-480 and subdivisions (1)

3354 and (2) of subsection (a) of section 17a-484, the regional mental health
3355 board shall review each such application with the Department of
3356 Mental Health and Addiction Services and make recommendations to
3357 the department with respect to each such application.

3358 (b) Upon receipt of the application with the recommendations of the
3359 regional mental health board and approval by the Department of
3360 Mental Health and Addiction Services, the department shall grant such
3361 funds by way of a contract or grant-in-aid within the appropriation for
3362 any annual fiscal year. No funds authorized by this section shall be
3363 used for the construction or renovation of buildings.

3364 [(c) The Commissioner of Mental Health and Addiction Services
3365 shall require an administrative services organization with which it
3366 contracts to manage mental and behavioral health services to provide
3367 intensive case management. Such intensive case management shall
3368 include, but not be limited to: (1) The identification by the
3369 administrative services organization of hospital emergency
3370 departments which may benefit from intensive case management
3371 based on the number of Medicaid clients who are frequent users of
3372 such emergency departments; (2) the creation of regional intensive
3373 case management teams to work with emergency department doctors
3374 to (A) identify Medicaid clients who would benefit from intensive case
3375 management, (B) create care plans for such Medicaid clients, and (C)
3376 monitor progress of such Medicaid clients; and (3) the assignment of at
3377 least one staff member from a regional intensive case management
3378 team to participating hospital emergency departments during hours
3379 when Medicaid clients who are frequent users visit the most and when
3380 emergency department use is at its highest.]

3381 [(d)] (c) The Commissioner of Mental Health and Addiction Services
3382 may adopt regulations, in accordance with the provisions of chapter
3383 54, concerning minimum standards for eligibility to receive said state
3384 contracted funds and any grants-in-aid. Any such funds or grants-in-
3385 aid made by the Department of Mental Health and Addiction Services

3386 for psychiatric or mental health services shall be made directly to the
3387 agency submitting the application and providing such service or
3388 services.

3389 Sec. 62. Section 17b-261m of the general statutes, as amended by
3390 section 1 of public act 14-62, is repealed and the following is
3391 substituted in lieu thereof (*Effective July 1, 2016*):

3392 (a) The Commissioner of Social Services may contract with one or
3393 more administrative services organizations to provide care
3394 coordination, utilization management, disease management, customer
3395 service and review of grievances for recipients of assistance under
3396 Medicaid and HUSKY Plan, Parts A and B. Such organization may also
3397 provide network management, credentialing of providers, monitoring
3398 of copayments and premiums and other services as required by the
3399 commissioner. Subject to approval by applicable federal authority, the
3400 Department of Social Services shall utilize the contracted
3401 organization's provider network and billing systems in the
3402 administration of the program. In order to implement the provisions of
3403 this section, the commissioner may establish rates of payment to
3404 providers of medical services under this section if the establishment of
3405 such rates is required to ensure that any contract entered into with an
3406 administrative services organization pursuant to this section is cost
3407 neutral to such providers in the aggregate and ensures patient access.
3408 Utilization may be a factor in determining cost neutrality.

3409 (b) Any contract entered into with an administrative services
3410 organization, pursuant to subsection (a) of this section, shall include a
3411 provision to reduce inappropriate use of hospital emergency
3412 department services, which may include a cost-sharing requirement
3413 and intensive care management services. [Such provision shall require
3414 intensive case management services, including, but not limited to: (1)
3415 The identification by the administrative services organization of
3416 hospital emergency departments which may benefit from intensive
3417 case management based on the number of Medicaid clients who are

3418 frequent users of such emergency departments; (2) the creation of
3419 regional intensive case management teams to work with emergency
3420 department doctors to (A) identify Medicaid clients who would benefit
3421 from intensive case management, (B) create care plans for such
3422 Medicaid clients, and (C) monitor progress of such Medicaid clients;
3423 and (3) the assignment of at least one staff member from a regional
3424 intensive case management team to participating hospital emergency
3425 departments during hours when Medicaid clients who are frequent
3426 users visit the most and emergency department use is at its highest.
3427 For purposes of this section and sections 17a-22f and 17a-476, "frequent
3428 users" means a Medicaid client with ten or more annual visits to a
3429 hospital emergency department.

3430 (c) The commissioner shall ensure that any contracts entered into
3431 with an administrative services organization include a provision
3432 requiring such administrative services organization to (1) conduct
3433 assessments of primary care doctors and specialists to determine
3434 patient ease of access to services, including, but not limited to, the wait
3435 times for appointments and whether the provider is accepting new
3436 Medicaid clients, and (2) perform outreach to Medicaid clients to (A)
3437 inform them of the advantages of receiving care from a primary care
3438 provider, (B) help to connect such clients with primary care providers
3439 soon after they are enrolled in Medicaid, and (C) for frequent users of
3440 emergency departments, help to arrange visits by Medicaid clients
3441 with primary care providers after such clients are treated at an
3442 emergency department.

3443 (d) The Commissioner of Social Services shall require an
3444 administrative services organization with access to complete client
3445 claim adjudicated history to analyze and annually report, not later
3446 than February first, to the Department of Social Services and the
3447 Council on Medical Assistance Program Oversight, on Medicaid
3448 clients' use of hospital emergency departments. The report shall
3449 include, but not be limited to: (1) A breakdown of the number of
3450 unduplicated clients who visited an emergency department, and (2) for

3451 frequent users of emergency departments, (A) the number of visits
3452 categorized into specific ranges as determined by the Department of
3453 Social Services, (B) the time and day of the visit, (C) the reason for the
3454 visit, (D) whether hospital records indicate such user has a primary
3455 care provider, (E) whether such user had an appointment with a
3456 community provider after the date of the hospital emergency
3457 department visit, and (F) the cost of the visit to the hospital and to the
3458 state Medicaid program. The Department of Social Services shall
3459 monitor its reporting requirements for administrative services
3460 organizations to ensure all contractually obligated reports, including
3461 any emergency department provider analysis reports, are completed
3462 and disseminated as required by contract.

3463 (e) The Commissioner of Social Services shall use the report
3464 required pursuant to subsection (d) of this section to monitor the
3465 performance of an administrative services organization. Performance
3466 measures monitored by the commissioner shall include, but not be
3467 limited to, whether the administrative services organization helps to
3468 arrange visits by frequent users of emergency departments to primary
3469 care providers after treatment at an emergency department.]

3470 Sec. 63. Section 17b-241a of the general statutes, as amended by
3471 section 5 of public act 14-62, is repealed and the following is
3472 substituted in lieu thereof (*Effective July 1, 2016*):

3473 Notwithstanding any provision of the general statutes, the
3474 Commissioner of Social Services may reimburse the Department of
3475 Mental Health and Addiction Services for targeted case management
3476 services that it provides to its target population, which, for purposes of
3477 this section, shall include individuals with severe and persistent
3478 psychiatric illness and individuals with persistent substance
3479 dependence. The Commissioners of Social Services and Mental Health
3480 and Addiction Services, in consultation with the Secretary of the Office
3481 of Policy and Management, shall ensure that all expenditures for
3482 intensive [case] care management eligible for Medicaid reimbursement

3483 are submitted to the Centers for Medicare and Medicaid Services.

3484 Sec. 64. Section 3 of senate bill 1085 of the current session, as
 3485 amended by Senate Amendment Schedules "A" and "B", is repealed.
 3486 (*Effective from passage*)

3487 Sec. 65. Sections 17b-261t, 17b-278h and 19a-490t of the general
 3488 statutes are repealed. (*Effective July 1, 2015*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2015</i>	New section
Sec. 2	<i>July 1, 2015</i>	19a-55(a)
Sec. 3	<i>from passage</i>	38a-1083
Sec. 4	<i>from passage</i>	New section
Sec. 5	<i>from passage</i>	38a-1080
Sec. 6	<i>January 1, 2016</i>	38a-514b
Sec. 7	<i>January 1, 2016</i>	38a-488b
Sec. 8	<i>January 1, 2016</i>	38a-516a
Sec. 9	<i>January 1, 2016</i>	38a-490a
Sec. 10	<i>from passage</i>	17a-215c
Sec. 11	<i>July 1, 2015</i>	38a-591c(a)(3)
Sec. 12	<i>from passage</i>	New section
Sec. 13	<i>January 1, 2016</i>	38a-514(a)
Sec. 14	<i>January 1, 2016</i>	38a-488a(a)
Sec. 15	<i>October 1, 2015</i>	21a-254(j)
Sec. 16	<i>July 1, 2015</i>	New section
Sec. 17	<i>July 1, 2015</i>	New section
Sec. 18	<i>July 1, 2015</i>	17a-28(g)(12)
Sec. 19	<i>July 1, 2015</i>	17b-261(i)
Sec. 20	<i>from passage</i>	New section
Sec. 21	<i>October 1, 2015</i>	New section
Sec. 22	<i>October 1, 2015</i>	New section
Sec. 23	<i>from passage</i>	New section
Sec. 24	<i>October 1, 2015</i>	New section
Sec. 25	<i>October 1, 2015</i>	New section
Sec. 26	<i>October 1, 2015</i>	New section
Sec. 27	<i>October 1, 2015</i>	19a-14(c)

Sec. 28	July 1, 2015	17a-408(b)(14)
Sec. 29	July 1, 2015	10-295(b)(3)
Sec. 30	August 1, 2015	17b-261(a)
Sec. 31	from passage	New section
Sec. 32	July 1, 2015	17b-277
Sec. 33	August 1, 2015	17b-290
Sec. 34	August 1, 2015	17b-292
Sec. 35	July 1, 2015	17b-104(b)
Sec. 36	July 1, 2015	17b-106(a)
Sec. 37	July 1, 2015	17b-340(f)(4)
Sec. 38	July 1, 2015	17b-340(g)
Sec. 39	July 1, 2015	17b-244(a)
Sec. 40	July 1, 2015	17b-340(h)(1)
Sec. 41	July 1, 2015	17b-280(a)
Sec. 42	July 1, 2015	17b-239e(b)
Sec. 43	July 1, 2015	17b-342(i)
Sec. 44	July 1, 2015	17b-131
Sec. 45	July 1, 2015	17b-84
Sec. 46	July 1, 2015	17b-265d(c)
Sec. 47	July 1, 2015	17b-242(c)
Sec. 48	July 1, 2015	17b-265(d)
Sec. 49	July 1, 2015	17b-273
Sec. 50	from passage	New section
Sec. 51	July 1, 2015	17b-354(a)
Sec. 52	July 1, 2015	17b-340(a)
Sec. 53	July 1, 2015	17b-239
Sec. 54	July 1, 2015	17b-369
Sec. 55	from passage	New section
Sec. 56	from passage	17b-112c
Sec. 57	from passage	17b-342(a)
Sec. 58	from passage	17b-790a(a)
Sec. 59	from passage	17a-22f
Sec. 60	July 1, 2016	17a-22f
Sec. 61	July 1, 2016	17a-476
Sec. 62	July 1, 2016	17b-261m
Sec. 63	July 1, 2016	17b-241a
Sec. 64	from passage	Repealer section
Sec. 65	July 1, 2015	Repealer section