



Substitute House Bill No. 6946

Public Act No. 15-69

AN ACT CONCERNING HUSKY PROGRAMS.

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

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 Subsection (d) of section 4-66e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

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

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 Subsection (c) of section 10-223h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

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

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and instructional audit shall be informed by an inventory of the following: (A) Before and after school programs, (B) any school-based health centers, family resource centers or other community services offered at the school, including, but not limited to, social services, mental health services and parenting support programs, (C) whether scientific research-based interventions are being fully implemented at the school, (D) resources for scientific research-based interventions during the school year and summer school programs, (E) resources for gifted and talented students, (F) the length of the school day and the school year, (G) summer school programs, (H) the alternative high school, if any, available to students at the school, (I) the number of teachers employed at the school and the number of teachers who have left the school in each of the previous three school years, (J) student mobility, including the number of students who have been enrolled in and left the school, (K) the number of students whose primary language is not English, (L) the number of students receiving special education services, (M) the number of truants, (N) the number of students who are eligible for free or reduced price lunches, (O) the number of students who are eligible for HUSKY [Plan, Part] A, (P) the curricula used at the school, (Q) the reading curricula and programs for kindergarten to grade three, inclusive, if any, at the school, (R) arts and music programs offered at the school, (S) physical education programs offered and periods for recess or physical activity, (T) the number of school psychologists at the school and the ratio of school psychologists to students at the school, (U) the number of social workers at the school and the ratio of social workers to students at the school, (V) the teacher and administrator performance evaluation program, including the frequency of performance evaluations, how such evaluations are conducted and by whom, the standards for performance ratings and follow-up and remediation plans and the aggregate results of teacher performance evaluation ratings conducted pursuant to section 10-151b and any other available measures of teacher effectiveness, (W) professional development activities and

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

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

(b) (1) In the case of proposals for full-day kindergarten programs, the plan shall include: (A) Information on the number of full-day kindergarten classes that will be offered initially and the number of children to be enrolled in such classes; (B) how the board anticipates expanding the number of full-day kindergarten programs in future school years; (C) the number of additional teachers needed and any additional equipment needed for purposes of such programs; (D) a description of any proposed school building project that is related to the need for additional space for full-day kindergarten programs, including an analysis of the different options available to meet such need, such as relocatable classrooms, the division of existing classrooms, an addition to a building or new construction; (E) information on the curriculum for the full-day kindergarten program pursuant to subdivision (2) of this subsection; (F) information on coordination between the full-day kindergarten program and school readiness programs for the purpose of providing (i) information

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concerning transition from preschool to kindergarten, including the child's preschool records, and (ii) before and after school child care for children attending the full-day kindergarten program; and (G) any additional information the commissioner deems relevant.

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

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

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

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insurance plan.

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

(4) Any new or renewal contract or policy entered into with the state on or after April 1, 1998, to provide health care coverage to eligible beneficiaries under the HUSKY [Plan, Part A, HUSKY Plan, Part B] Health program, or HUSKY Plus [programs] program, each as defined in section 17b-290, as amended by this act;

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

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

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

(b) For the fiscal year ending June 30, 2003, any company that received a payment under subsection (a) of this section shall be entitled to an additional supplemental payment equal to thirty-six dollars and seventy-five cents multiplied by the sum of the number of persons provided health care coverage by the taxpayer under the HUSKY [Plan, Part A, HUSKY Plan, Part B] Health program or the HUSKY Plus [programs] program, each as defined in section 17b-290,

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as amended by this act, on the first day of each month, January to June, inclusive, of 2002, divided by six.

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

(f) Not later than October first of each odd-numbered year, the advisory committee shall submit recommendations concerning the provision of behavioral health services for all children in the state to the Commissioner of Children and Families and the State Advisory Council on Children and Families. The recommendations shall address, but shall not be limited to, the following: (1) The target population for children with behavioral health needs, and assessment and benefit options for children with such needs; (2) the appropriateness and quality of care for children with behavioral health needs; (3) the coordination of behavioral health services provided under the HUSKY [Plan] Health program with services provided by other publicly-funded programs; (4) performance standards for preventive services, family supports and emergency service training programs; (5) assessments of community-based and residential care programs; (6) outcome measurements by reviewing provider practice; and (7) a medication protocol and standards for the monitoring of medication and after-care programs.

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

(a) The Commissioner of Social Services and the Commissioner of Children and Families shall, within available appropriations, develop and administer an integrated behavioral health service delivery system to be known as Connecticut Community KidCare. Said system shall provide services to children and youths with behavioral health needs who are in the custody of the Department of Children and Families,

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who are eligible to receive services from [the HUSKY Plan, Part] HUSKY A or the federally subsidized portion of [Part] HUSKY B, or receive services under the voluntary services program operated by the Department of Children and Families. All necessary changes to the IV-E, Title XIX and Title XXI state plans shall be made to maximize federal financial participation. The Commissioner of Social Services may amend the state Medicaid plan to facilitate the claiming of federal reimbursement for private nonmedical institutions as defined in the Social Security Act. The Commissioner of Social Services may implement policies and procedures necessary to provide reimbursement for the services provided by private nonmedical institutions, as defined in 42 CFR Part 434, while in the process of adopting such policies and procedures in regulation form, provided the commissioner [prints] publishes notice of intention to adopt the regulations [in the Connecticut Law Journal] on the Department of Social Services' Internet web site and the eRegulations System within twenty days of implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

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

(c) Connecticut Community KidCare shall include: (1) A system of care model in which service planning is based on the needs and preferences of the child or youth and his or her family and that places an emphasis on early identification, prevention and treatment; (2) a

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comprehensive behavioral health program with a flexible benefit package that shall include clinically necessary and appropriate home and community-based treatment services and comprehensive support services in the least restrictive setting; (3) community-based care planning and service delivery, including services and supports for children from birth through early childhood that link Connecticut Community KidCare to the early childhood community and promote emotional wellness; (4) comprehensive children and youth behavioral health training for agency and system staff and interested parents and guardians; (5) an efficient balance of local participation and state-wide administration; (6) integration of agency funding to support the benefit package; (7) a performance measurement system for monitoring quality and access; (8) accountability for quality, access and cost; (9) elimination of the major gaps in services and barriers to access services; (10) a system of care that is family-focused with respect for the legal rights of the child or youth and his or her parents and provides training, support and family advocacy services; (11) assurances of timely payment of service claims; (12) assurances that no child or youth shall be disenrolled or inappropriately discharged due to behavioral health care needs; and (13) identification of youths in need of transition services to adult systems.

(d) The Commissioner of Social Services and the Commissioner of Children and Families shall enter into a memorandum of understanding for the purpose of the joint administration of Connecticut Community KidCare. Such memorandum of understanding shall establish mechanisms to administer funding for, establish standards for and monitor implementation of Connecticut Community KidCare and specify that (1) the Department of Social Services, which is the agency designated as the single state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act and is the agency responsible for the administration of [the HUSKY Plan, Part] HUSKY B under Title XXI of

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the Social Security Act, manage all Medicaid and HUSKY [Plan] Health program modifications, waiver amendments, federal reporting and claims processing and provide financial management, and (2) the Department of Children and Families, which is the state agency responsible for administering and evaluating a comprehensive and integrated state-wide program of services for children and youths with behavioral health needs, define the services to be included in the continuum of care and develop state-wide training programs for providers, families and other persons.

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

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

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

(a) The Commissioner of Social Services may, with regard to the provision of behavioral health services provided pursuant to a state plan under Title XIX or Title XXI of the Social Security Act: (1) Contract with one or more administrative services organizations to provide clinical management, provider network development and other administrative services; (2) delegate responsibility to the Department of Children and Families for the clinical management portion of such

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administrative contract or contracts that pertain to HUSKY [Plan Parts] A and B, and other children, adolescents and families served by the Department of Children and Families; and (3) delegate responsibility to the Department of Mental Health and Addiction Services for the clinical management portion of such administrative contract or contracts that pertain to Medicaid recipients who are not enrolled in HUSKY [Plan Part] A.

(b) For purposes of this section, the term "clinical management" describes the process of evaluating and determining the appropriateness of the utilization of behavioral health services and providing assistance to clinicians or beneficiaries to ensure appropriate use of resources and may include, but is not limited to, authorization, concurrent and retrospective review, discharge review, quality management, provider certification and provider performance enhancement. The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall jointly develop clinical management policies and procedures. The Department of Social Services may implement policies and procedures necessary to carry out the purposes of this section, including any necessary changes to existing behavioral health policies and procedures concerning utilization management, while in the process of adopting such policies and procedures in regulation form, provided the Commissioner of Social Services publishes notice of intention to adopt the regulations [in the Connecticut Law Journal] on the department's Internet web site and the eRegulations System within twenty days of implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are adopted.

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

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

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

(c) The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall require that administrative services organizations managing behavioral health services for Medicaid clients develop intensive case management that includes, but is not limited to: (1) The identification by the administrative services organization of hospital emergency

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departments which may benefit from intensive case management based on the number of Medicaid clients who are frequent users of such emergency departments; (2) the creation of regional intensive case management teams to work with emergency department doctors to (A) identify Medicaid clients who would benefit from intensive case management, (B) create care plans for such Medicaid clients, and (C) monitor progress of such Medicaid clients; and (3) the assignment of at least one staff member from a regional intensive case management team to participating hospital emergency departments during hours when Medicaid clients who are frequent users visit the most and when emergency department use is at its highest.

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

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

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

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

(a) The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall develop and implement an integrated behavioral health service system for [Medicaid and HUSKY Plan Part B] HUSKY Health program members and children enrolled in the voluntary services program operated by the Department of Children and Families and may, at the discretion of the commissioners, include other children, adolescents and families served by the Department of Children and Families or the Court Support Services Division of the Judicial Branch. The integrated behavioral health service system shall be known as the Behavioral Health Partnership. The Behavioral Health Partnership shall seek to increase access to quality behavioral health services by: (1) Expanding individualized, family-centered and community-based services; (2) maximizing federal revenue to fund behavioral health services; (3) reducing unnecessary use of institutional and residential services for children and adults; (4) capturing and investing enhanced federal revenue and savings derived from reduced residential services and

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increased community-based services for HUSKY [Plan Parts] A and B recipients; (5) improving administrative oversight and efficiencies; and (6) monitoring individual outcomes and provider performance, taking into consideration the acuity of the patients served by each provider, and overall program performance.

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

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

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

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

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

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

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

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

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

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

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

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

(10) Eight nonvoting ex-officio members, one each appointed by the Commissioner of Social Services, the Commissioner of Children and

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Families, the Commissioner of Mental Health and Addiction Services, the Commissioner of Developmental Services and the Commissioner of Education to represent his or her department, one appointed by the Chief Court Administrator of the Judicial Branch to represent the Court Support Services Division and one each appointed by the State Comptroller and the Secretary of the Office of Policy and Management to represent said offices; and

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

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

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

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

(f) The council shall make specific recommendations on matters related to the planning and implementation of the Behavioral Health Partnership which shall include, but not be limited to: (1) Review of any contracts entered into by the Departments of Children and Families, Social Services and Mental Health and Addiction Services with any administrative services organizations, to assure that the

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administrative services organization's decisions are based solely on clinical management criteria developed by the clinical management committee established in section 17a-22k; (2) review of behavioral health services pursuant to Title XIX and Title XXI of the Social Security Act to assure that federal revenue is being maximized; and (3) [review of behavioral health services under the Charter Oak Health Plan; and (4)] review of periodic reports on the program activities, finances and outcomes, including reports from the director of the Behavioral Health Partnership on achievement of service delivery system goals, pursuant to section 17a-22i. The council may conduct or cause to be conducted an external, independent evaluation of the Behavioral Health Partnership.

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

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

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

The Commissioner of Children and Families shall have the

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authority to certify providers of behavioral health Medicaid Early and Periodic Screening, Diagnostic and Treatment Services and rehabilitation services for HUSKY [Plan Part] A for the purpose of coverage of Medicaid Early and Periodic Screening, Diagnostic and Treatment Services or optional rehabilitation services. The Commissioner of Children and Families may adopt regulations, in accordance with the provisions of chapter 54, for purposes of certification of such providers. The commissioner may implement policies and procedures for purposes of such certification while in the process of adopting such policies or procedures in regulation form, provided notice of intention to adopt the regulations is [printed in the Connecticut Law Journal] published on the department's Internet web site and the eRegulations System not later than twenty days after implementation and any such policies and procedures shall be valid until the time the regulations are effective.

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

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

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services organization in connection with such initiatives.

(b) On or before June 30, 2011, the council shall be composed of the chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations and the budgets of state agencies, or their designees; two members of the General Assembly, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; the director of the Commission on Aging, or a designee; the director of the Commission on Children, or a designee; a representative of each organization that has been selected by the state to provide managed care and a representative of a primary care case management provider, to be appointed by the president pro tempore of the Senate; two representatives of the insurance industry, to be appointed by the speaker of the House of Representatives; two advocates for persons receiving Medicaid, one to be appointed by the majority leader of the Senate and one to be appointed by the minority leader of the Senate; one advocate for persons with substance use disorders, to be appointed by the majority leader of the House of Representatives; one advocate for persons with psychiatric disabilities, to be appointed by the minority leader of the House of Representatives; two advocates for the Department of Children and Families foster families, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; two members of the public who are currently recipients of Medicaid, one to be appointed by the majority leader of the House of Representatives and one to be appointed by the minority leader of the House of Representatives; two representatives of the Department of Social Services, to be appointed by the Commissioner of Social Services; two representatives of the Department of Public Health, to be appointed by the Commissioner of Public Health; two representatives of the Department of Mental Health and Addiction Services, to be appointed

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by the Commissioner of Mental Health and Addiction Services; two representatives of the Department of Children and Families, to be appointed by the Commissioner of Children and Families; two representatives of the Office of Policy and Management, to be appointed by the Secretary of the Office of Policy and Management; and one representative of the office of the State Comptroller, to be appointed by the State Comptroller.

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

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

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

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

(4) Three appointed by the majority leader of the House of

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Representatives, one of whom shall be an advocate for persons with substance abuse disabilities, one of whom shall be a Medicaid dental provider and one of whom shall be a representative of the for-profit nursing home industry;

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

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

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

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

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

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

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

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

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

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

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

(e) The council shall monitor and make recommendations concerning: (1) An enrollment process that ensures access for each Department of Social Services administered health care program and effective outreach and client education for such programs; (2) available services comparable to those already in the Medicaid state plan, including those guaranteed under the federal Early and Periodic Screening, Diagnostic and Treatment Services Program under 42 USC 1396d; (3) the sufficiency of accessible adult and child primary care providers, specialty providers and hospitals in Medicaid provider networks; (4) the sufficiency of provider rates to maintain the Medicaid network of providers and service access; (5) funding and agency personnel resources to guarantee timely access to services and effective management of the Medicaid program; (6) participation in care management programs including, but not limited to, medical home and health home models by existing community Medicaid providers; (7) the linguistic and cultural competency of providers and other program facilitators and data on the provision of Medicaid linguistic translation services; (8) program quality, including outcome measures and continuous quality improvement initiatives that may include

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provider quality performance incentives and performance targets for administrative services organizations; (9) timely, accessible and effective client grievance procedures; (10) coordination of the Medicaid care management programs with state and federal health care reforms; (11) eligibility levels for inclusion in the programs; (12) enrollee cost-sharing provisions; (13) a benefit package for each of the health care programs set forth in subsection (a) of this section; (14) coordination of coverage continuity among Medicaid programs and integration of care, including, but not limited to, behavioral health, dental and pharmacy care provided through programs administered by the Department of Social Services; and (15) the need for program quality studies within the areas identified in this section and the department's application for available grant funds for such studies. The chairperson of the council shall ensure that sufficient members of the council participate in the review of any contract entered into by the Department of Social Services and an administrative services organization.

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

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

(h) There is established, within the Council on Medical Assistance Program Oversight, a standing subcommittee to study and make annual recommendations to the council on evidence-based best practices concerning Medicaid cost savings. The subcommittee shall

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file its first report to the council not later than January 1, 2015. The subcommittee shall consist of the following members, whose work on the council shall consist solely of work on the subcommittee:

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

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

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

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

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

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

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

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

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

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(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (e) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate region of residence and if such person is an institutionalized individual as defined in Section 1917 of the Social Security Act, 42 USC 1396p(h)(3), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such disposition shall be treated in accordance with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of property made on behalf of an applicant or recipient or the spouse of an applicant or recipient by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility. The commissioner shall establish the standards for eligibility for medical assistance at one hundred forty-three per cent of the benefit amount paid to a [family unit] household of equal size with no income under the temporary family assistance program in the appropriate region of residence. In determining eligibility, the commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran. Except as provided in [section] sections 17b-277 and 17b-292, as amended by this act, the medical assistance program shall provide coverage to persons under the age of nineteen with [family] household income up to one hundred [eighty-five] ninety-six per cent of the federal poverty level without an asset limit and to persons under

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the age of nineteen and their parents and needy caretaker relatives, who qualify for coverage under Section 1931 of the Social Security Act, with [family] household income up to one hundred [eighty-five] ninety-six per cent of the federal poverty level without an asset limit. Such levels shall be based on the regional differences in such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall be applied as may be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of (1) the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance, (2) the effect that having income that exceeds the limits prescribed in this subsection will have with respect to program eligibility, and (3) the availability of, and eligibility for, services provided by the Nurturing Families Network established pursuant to section 17b-751b. For coverage dates on or after January 1, 2014, the department shall use the modified adjusted gross income financial eligibility rules set forth in section 1902(e)(14) of the Social Security Act and the implementing regulations to determine eligibility for HUSKY A, HUSKY B and HUSKY D applicants, as defined in section 17b-290, as amended by this act. Persons who are determined ineligible for assistance pursuant to this section shall be provided a written statement notifying such persons of their ineligibility and advising such persons of [the availability of HUSKY Plan, Part B health insurance benefits] their potential eligibility for one of the other insurance affordability programs as defined in 42 CFR 435.4.

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

The Commissioner of Social Services shall provide coverage for

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isolation care and emergency services provided by the state's mobile field hospital to persons participating in the HUSKY [Plan Part A and Part B and fee for services Medicaid programs] Health program under this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Can withstand repeated use;

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

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

(D) Is nondisposable;

(10) "Eligible beneficiary" means a child who meets the requirements [specified] in section 17b-292, as amended by this act, [except a child excluded under the provisions of Subtitle J of Public Law 105-33 or a child of any municipal employee eligible for employer-sponsored insurance on or after October 30, 1997, provided a child of such a municipal employee may be eligible for coverage under

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the HUSKY Plan, Part B if dependent coverage was terminated due to an extreme economic hardship on the part of the employee, as determined by the commissioner] and the requirements specified in Section 2110(b)(2)(B) of the Social Security Act as amended by Section 10203(b)(2)(D) of the Affordable Care Act;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[(22)] (23) "WIC" means the federal Special Supplemental Food Program for Women, Infants and Children administered by the

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Department of Public Health pursuant to section 19a-59c.

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

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

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

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

(b) Any contract entered into with an administrative services organization, pursuant to subsection (a) of this section, shall include a provision to reduce inappropriate use of hospital emergency department services. Such provision may include intensive case

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management services and a cost-sharing requirement.

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

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

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

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

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

(d) The Commissioner of Social Services shall require an administrative services organization with access to complete client claim adjudicated history to analyze and annually report, not later than February first, to the Department of Social Services and the Council on Medical Assistance Program Oversight, on Medicaid clients' use of hospital emergency departments. The report shall

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include, but not be limited to: (1) A breakdown of the number of unduplicated clients who visited an emergency department, and (2) for frequent users of emergency departments, (A) the number of visits categorized into specific ranges as determined by the Department of Social Services, (B) the time and day of the visit, (C) the reason for the visit, (D) whether hospital records indicate such user has a primary care provider, (E) whether such user had an appointment with a community provider after the date of the hospital emergency department visit, and (F) the cost of the visit to the hospital and to the state Medicaid program. The Department of Social Services shall monitor its reporting requirements for administrative services organizations to ensure all contractually obligated reports, including any emergency department provider analysis reports, are completed and disseminated as required by contract.

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

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

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

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to chemotherapy or radiation treatment.

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

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

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

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

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

(e) A newborn child who otherwise meets the eligibility criteria for [the HUSKY Plan, Part] HUSKY B shall be eligible for benefits retroactive to his or her date of birth, provided an application is filed on behalf of the child not later than thirty days after such date. Any uninsured child born in a hospital in this state or in a border state

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hospital shall be enrolled on an expedited basis in [the HUSKY Plan, Part] HUSKY B, provided (1) the parent or caretaker relative of such child resides in this state, and (2) the parent or caretaker relative of such child authorizes enrollment in the program. The commissioner shall pay any premium cost such [family] household would otherwise incur for the first four months of coverage.

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

[(g) The commissioner shall provide for a single point of entry servicer for applicants and enrollees under the HUSKY Plan, Part A and Part B. The commissioner, in consultation with the servicer, shall establish a centralized unit to be responsible for processing all applications for assistance under the HUSKY Plan, Part A and Part B. The department, through its servicer, shall ensure that a child who is determined to be eligible for benefits under the HUSKY Plan, Part A,

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or the HUSKY Plan, Part B has uninterrupted health insurance coverage for as long as the parent or guardian elects to enroll or re-enroll such child in the HUSKY Plan, Part A or Part B. The commissioner, in consultation with the servicer, and in accordance with the provisions of section 17b-297, shall jointly market both Part A and Part B together as the HUSKY Plan and shall develop and implement public information and outreach activities with community programs. Such servicer shall electronically transmit data with respect to enrollment and disenrollment in the HUSKY Plan, Part A and Part B to the commissioner.

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

(i) The single point of entry servicer shall send all applications and supporting documents to the commissioner for determination of eligibility. The servicer shall enroll eligible beneficiaries in the applicant's choice of an administrative services organization. If there is more than one administrative services organization, upon enrollment in an administrative services organization, an eligible HUSKY Plan, Part A or Part B beneficiary shall remain enrolled in such organization

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for twelve months from the date of such enrollment unless (1) an eligible beneficiary demonstrates good cause to the satisfaction of the commissioner of the need to enroll in a different organization, or (2) the beneficiary no longer meets program eligibility requirements.

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

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

[(k)] (h) The commissioner shall implement [the HUSKY Plan, Part] HUSKY B while in the process of adopting necessary policies and procedures in regulation form in accordance with the provisions of

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section 17b-10.

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

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

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

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

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be the steering committee for such program, except that such committee shall include representatives of the Departments of Social Services and Children and Families.

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

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

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

[(f)] (d) The commissioner shall adopt regulations, in accordance with chapter 54, to establish a procedure for the appeal of a denial of coverage under [any of] the HUSKY Plus [programs] program. Such regulations shall provide that (1) an appeal of a denial of coverage for

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

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

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

[(i)] Not later than December 1, 1997, or not less than fifteen days before submission of the state children's health insurance plan to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, insurance and appropriations and the budgets of state agencies, whichever is sooner, the commissioner shall submit to said joint standing committees of the General Assembly any part of the state children's health insurance plan that refers to the HUSKY Plus programs. Such submission shall address acuity standards and diagnostic eligibility criteria, the service benefit package and coordination between the HUSKY Plan, Part B and the HUSKY Plus programs and coordination with other state agencies. Within fifteen days of receipt of such submission, said joint

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standing committees of the General Assembly may advise the commissioner of their approval, denial or modifications, if any, of the submission. If the joint standing committees do not concur, the committee chairmen shall appoint a committee on conference which shall be comprised of three members from each joint standing committee. At least one member appointed from each committee shall be a member of the minority party. The report of the committee on conference shall be made to each committee, which shall vote to accept or reject the report. The report of the committee on conference may not be amended. If a joint standing committee rejects the report of the committee on conference, the submission shall be deemed approved. If the joint standing committees accept the report, the committee having cognizance of matters relating to appropriations and the budgets of state agencies shall advise the commissioner of their approval or modifications, if any, of the submission, provided if the committees do not act within fifteen days, the submission shall be deemed approved.]

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

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

Sec. 27. Section 17b-295 of the general statutes is repealed and the

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following is substituted in lieu thereof (*Effective from passage*):

(a) The commissioner shall impose cost-sharing requirements, including the payment of a premium or copayment, in connection with services provided under [the HUSKY Plan, Part] HUSKY B, to the extent permitted by federal law. Copayments under [the HUSKY Plan, Part] HUSKY B [,] shall be the same as those in effect for active state employees enrolled in a point-of-enrollment health care plan, provided the [family's] household's annual combined premiums and copayments do not exceed the maximum annual aggregate cost-sharing requirement. The cost-sharing requirements imposed by the commissioner shall be in accordance with the following limitations:

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

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

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

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

(2) The limitations adopted by the commissioner pursuant to

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subdivision (1) of this subsection shall not preclude coverage of any item of durable medical equipment or service that is medically necessary.

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

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

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

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

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

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

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

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

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

(b) The plan shall:

(1) Establish a coordinated system for preventive health services for [HUSKY Plan, Part A and Part B] HUSKY A and B beneficiaries including, but not limited to, services under the federal Early and Periodic Screening, [Diagnosis] Diagnostic and Treatment Program, ophthalmologic and optometric services, oral health care, care

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coordination, chronic disease management and periodicity schedules based on standards specified by the American Academy of Pediatrics;

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

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

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

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

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

(a) The Commissioner of Social Services, in collaboration with the Commissioners of Public Health and Children and Families, shall establish a child health quality improvement program for the purpose of promoting the implementation of evidence-based strategies by

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providers participating in the HUSKY [Plan, Part A and Part B] Health program to improve the delivery of and access to children's health services. Such strategies shall focus on physical, dental and mental health services and shall include, but need not be limited to: (1) Methods for early identification of children with special health care needs; (2) integration of care coordination and care planning into children's health services; (3) implementation of standardized data collection to measure performance improvement; and (4) implementation of family-centered services in patient care, including, but not limited to, the development of parent-provider partnerships. The Commissioner of Social Services shall seek the participation of public and private entities that are dedicated to improving the delivery of health services, including medical, dental and mental health providers, academic professionals with experience in health services research and performance measurement and improvement, and any other entity deemed appropriate by the Commissioner of Social Services, to promote such strategies. The commissioner shall ensure that such strategies reflect new developments and best practices in the field of children's health services. As used in this section, "evidence-based strategies" means policies, procedures and tools that are informed by research and supported by empirical evidence, including, but not limited to, research developed by organizations such as the American Academy of Pediatrics, the American Academy of Family Physicians, the National Association of Pediatric Nurse Practitioners and the Institute of Medicine.

(b) Not later than July 1, 2008, and annually thereafter, the Commissioner of Social Services shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations, and to the Council on Medical Assistance Program Oversight on (1) the implementation of any strategies developed pursuant to subsection (a) of this section, and (2)

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the efficacy of such strategies in improving the delivery of and access to health services for children enrolled in the HUSKY [Plan] Health program.

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

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

The [commissioner] Commissioner of Social Services shall implement the policies and procedures necessary to carry out the provisions of sections [17b-292 to 17b-303, inclusive, 17b-257b, 17b-261 and section 16 of public act 97-1 of the October 29 special session] 17b-292, as amended by this act, 17b-294a, as amended by this act, 17b-295, as amended by this act, 17b-297a, as amended by this act, 17b-297b, as amended by this act, and 17b-300, as amended by this act, while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published [in the Connecticut Law Journal within] on the Department of Social Services' Internet web site and the eRegulations System not later than twenty days after implementation. Such policies and procedures shall be valid until the time final regulations are effective.

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

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

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

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

(i) The provision for health care coverage may include an order for either parent to name any child as a beneficiary of any medical or dental insurance or benefit plan carried by such parent or available to such parent at a reasonable cost, as described in clause (iv) of this subparagraph. If such order requires the parent to maintain insurance available through an employer, the order shall be enforced using a National Medical Support Notice as provided in section 46b-88.

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

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either parent to: (I) Apply for and maintain coverage on behalf of the child under [the HUSKY Plan, Part] HUSKY B; or (II) provide cash medical support, as described in clauses (v) and (vi) of this subparagraph. An order under this clause shall be made only if the cost to the parent obligated to maintain coverage under [the HUSKY Plan, Part] HUSKY B, or provide cash medical support is reasonable as described in clause (iv) of this subparagraph. An order under subclause (I) of this clause shall be made only if insurance coverage as described in clause (i) of this subparagraph is unavailable at reasonable cost to either parent, or inaccessible to the child.

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

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

(v) Cash medical support means: (I) An amount ordered to be paid toward the cost of premiums for health insurance coverage provided

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

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

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

The Commissioners of Social Services and Public Health shall enter

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

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

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

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

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

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

(2) "Program" means the animal population control program;

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(3) "Account" means the animal population control account;

(4) "Participating veterinarian" means any veterinarian who has been certified to participate in the program by the commissioner;

(5) "Pound" means any state or municipal facility where impounded, quarantined or stray dogs and cats are kept or any veterinary hospital or commercial kennel where such dogs or cats are kept by order of a municipality;

(6) "Eligible owner" means a person who has purchased or adopted a dog or cat from a pound and who is a resident of this state;

(7) "Medically unfit" means (A) unsuitable for a surgical procedure due to any medical condition that may place a dog or cat at life-threatening risk if a surgical procedure is performed on such animal, as determined by a participating veterinarian, or (B) unsuitable for sterilization due to insufficiency in age, as determined by a participating veterinarian, of a dog or cat under the age of six months;

(8) "Neuter" means the surgical procedure of castration on a male dog or cat;

(9) "Spay" means the surgical procedure of ovariohysterectomy on a female dog or cat;

(10) "Voucher" means a nontransferable document provided by the commissioner and issued by a pound to an eligible owner authorizing payment of a predetermined amount from the animal population control account to a participating veterinarian;

(11) "Feral cat" means a cat of the species *Felis catus* that is unowned, that exists in a wild or untamed state or has returned to an untamed state from domestication and whose behavior is suggestive of a wild animal; and

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(12) "Low-income person" means a recipient of or a person eligible for one of the following public assistance programs:

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

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

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

(D) The HUSKY Plan Part A;]

(C) HUSKY A, C or D;

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

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

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

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

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

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(b) The information on the department's Internet web site shall reference the availability and general eligibility requirements of (1) programs administered by the Department of Social Services, including, but not limited to, the Medicaid program and [the HUSKY Plan, Part A and Part B] HUSKY A and B, (2) health insurance coverage provided by the Comptroller under subsection (i) of section 5-259, (3) health insurance coverage available under comprehensive health care plans issued pursuant to part IV of this chapter, and (4) other health insurance coverage offered through local, state or federal agencies or through entities licensed in this state. The commissioner shall update the information on the web site at least quarterly.

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

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

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

(11) Collaborate with the Department of Social Services, to the extent possible, to allow an enrollee who loses premium tax credit

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eligibility under Section 36B of the Internal Revenue Code and is eligible for HUSKY [Plan, Part] A or any other state or local public program, to remain enrolled in a qualified health plan;

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

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

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

(A) The provision for health care coverage may include an order for either parent to name any child as a beneficiary of any medical or dental insurance or benefit plan carried by such parent or available to such parent at a reasonable cost, as described in subparagraph (D) of

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this subdivision. If such order in a IV-D support case requires the parent to maintain insurance available through an employer, the order shall be enforced using a National Medical Support Notice as provided in section 46b-88.

(B) The provision for health care coverage may include an order for either parent to: (i) Apply for and maintain coverage on behalf of the child under [the HUSKY Plan, Part] HUSKY B; or (ii) provide cash medical support, as described in subparagraphs (E) and (F) of this subdivision. An order under this subparagraph shall be made only if the cost to the parent obligated to maintain the coverage under [the HUSKY Plan, Part B,] HUSKY B or provide cash medical support is reasonable, as described in subparagraph (D) of this subdivision. An order under clause (i) of this subparagraph shall be made only if insurance coverage as described in subparagraph (A) of this subdivision is unavailable at reasonable cost to either parent, or inaccessible to the child.

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

(D) Health care coverage shall be deemed reasonable in cost if: (i) The parent obligated to maintain such coverage would qualify as a low-income obligor under the child support guidelines established pursuant to section 46b-215a, based solely on such parent's income, and the cost does not exceed five per cent of such parent's net income; or (ii) the parent obligated to maintain such coverage would not qualify as a low-income obligor under such guidelines and the cost does not exceed seven and one-half per cent of such parent's net income. In either case, net income shall be determined in accordance with the child support guidelines established pursuant to section 46b-

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215a. If a parent obligated to maintain insurance must obtain coverage for himself or herself to comply with the order to provide coverage for the child, reasonable cost shall be determined based on the combined cost of coverage for such parent and such child.

(E) Cash medical support means: (i) An amount ordered to be paid toward the cost of premiums for health insurance coverage provided by a public entity, including [the HUSKY Plan, Part A or Part B] HUSKY A or B, except as provided in subparagraph (F) of this subdivision, or by another parent through employment or otherwise, or (ii) an amount ordered to be paid, either directly to a medical provider or to the person obligated to pay such provider, toward any ongoing extraordinary medical and dental expenses of the child that are not covered by insurance or reimbursed in any other manner, provided such expenses are documented and identified specifically on the record. Cash medical support, as described in clauses (i) and (ii) of this subparagraph may be ordered in lieu of an order under subparagraph (A) of this subdivision to be effective until such time as health insurance that is accessible to the child and reasonable in cost becomes available, or in addition to an order under subparagraph (A) of this subdivision, provided the combined cost of insurance and cash medical support is reasonable, as defined in subparagraph (D) of this subdivision. An order for cash medical support shall be payable to the state or the custodial party, as their interests may appear, provided an order under clause (i) of this subparagraph shall be effective only as long as health insurance coverage is maintained. Any unreimbursed medical and dental expenses not covered by an order issued pursuant to clause (ii) of this subparagraph are subject to an order for unreimbursed medical and dental expenses pursuant to subparagraph (C) of this subdivision.

(F) Cash medical support to offset the cost of any insurance payable under [the HUSKY Plan, Part A or Part B] HUSKY A or B, shall not be

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ordered against a noncustodial parent who is a low-income obligor, as defined in the child support guidelines established pursuant to section 46b-215a, or against a custodial parent of children covered under [the HUSKY Plan, Part A or Part B] HUSKY A or B.

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

(c) When one of the parties, or a child of the parties, is receiving or has received aid or care from the state under its aid to families with dependent children or temporary family assistance program, HUSKY [Plan, Part] A, or foster care program as provided in Title IV-E of the Social Security Act, or when one of the parties has applied for child support enforcement services under Title IV-D of the Social Security Act as provided in section 17b-179, such motion to modify shall be filed with the Family Support Magistrate Division for determination in accordance with subsection (m) of section 46b-231.

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

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

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

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

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

(e) On or after May 1, 2000, the payment to the Commissioner of

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Social Services of (1) any monetary sanction imposed by the commissioner on a managed care organization under the provisions of a contract between the commissioner and such organization entered into pursuant to this section or sections [17b-289 to 17b-304, inclusive] 17b-290, as amended by this act, 17b-292, as amended by this act, 17b-294a, as amended by this act, 17b-295, as amended by this act, 17b-297a, as amended by this act, 17b-297b, as amended by this act, and 17b-300, as amended by this act, or (2) any sum agreed upon by the commissioner and such an organization as settlement of a claim brought by the commissioner or the state against such an organization for failure to comply with the terms of a contract with the commissioner or fraud affecting the Department of Social Services shall be deposited in an account designated for use by the department for expenditures for children's health programs and services.

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

Approved June 19, 2015