***House Bill No. 8002***

## *June Special Session, Public Act No. 07-2*

### *AN ACT IMPLEMENTING THE PROVISIONS OF THE BUDGET CONCERNING HUMAN SERVICES AND PUBLIC HEALTH.*

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

Section 1. Subsections (a) and (b) of section 17b-321 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) On or before July 1, 2005, and on or before July first biennially thereafter, the Commissioner of Social Services shall determine the amount of the user fee and promptly notify the commissioner and nursing homes of such amount. The user fee shall be (1) the sum of each nursing home's anticipated nursing home net revenue, including, but not limited to, its estimated net revenue from any increases in Medicaid payments, during the twelve-month period ending on June thirtieth of the succeeding calendar year, (2) which sum shall be multiplied by a percentage as determined by the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Social Services, provided before January 1, 2008, such percentage shall not exceed six per cent and on and after January 1, 2008, such percentage shall not exceed five and one-half per cent, and (3) which product shall be divided by the sum of each nursing home's anticipated resident days during the twelve-month period ending on June thirtieth of the succeeding calendar year. The Commissioner of Social Services, in anticipating nursing home net revenue and resident days, shall use the most recently available nursing home net revenue and resident day information. On or before July 1, 2007, 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 appropriations and the budgets of state agencies and human services on the detrimental effects, if any, that a biennial determination of the user fee may have on private payors.

(b) Upon approval of the waiver of federal requirements for uniform and broad-based user fees in accordance with 42 CFR 433. 68 pursuant to section 17b-323, the Commissioner of Social Services shall redetermine the amount of the user fee and promptly notify the commissioner and nursing homes of such amount. The user fee shall be (1) the sum of each nursing home's anticipated nursing home net revenue, including, but not limited to, its estimated net revenue from any increases in Medicaid payments, during the twelve-month period ending on June thirtieth of the succeeding calendar year but not including any such anticipated net revenue of any nursing home exempted from such user fee due to waiver of federal requirements pursuant to section 17b-323, (2) which sum shall be multiplied by a percentage as determined by the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Social

Services, provided before January 1, 2008, such percentage shall not exceed six per cent and on and after January 1, 2008, such percentage shall not exceed five and one-half per cent, and (3) which product shall be divided by the sum of each nursing home's anticipated resident days, but not including the anticipated resident days of any nursing home exempted from such user fee due to waiver of federal requirements pursuant to section 17b-323. Notwithstanding the provisions of this subsection, the amount of the user fee for each nursing home licensed for more than two hundred thirty beds or owned by a municipality shall be equal to the amount necessary to comply with federal provider tax uniformity waiver requirements as determined by the Commissioner of Social Services. The Commissioner of Social Services may increase retroactively the user fee for nursing homes not licensed for more than two hundred thirty beds and not owned by a municipality to the effective date of waiver of said federal requirements to offset user fee reductions necessary to meet the federal waiver requirements. On or before July 1, 2005, and biennially thereafter, the Commissioner of Social Services shall determine the amount of the user fee in accordance with this subsection. The Commissioner of Social Services, in anticipating nursing home net revenue and resident days, shall use the most recently available nursing home net revenue and resident day information. On or before July 1, 2007, 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 appropriations and the budgets of state agencies and human services on the detrimental effects, if any, that a biennial determination of the user fee may have on private payors.

Sec. 2. Subsections (a) and (b) of section 17b-104 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The Commissioner of Social Services shall administer the program of state supplementation to the Supplemental Security Income Program provided for by the Social Security Act and state law. The commissioner may delegate any powers and authority to any deputy, assistant, investigator or supervisor, who shall have, within the scope of the power and authority so delegated, all of the power and authority of the Commissioner of Social Services. **[**On and after January 1, 1994, the**]** The commissioner shall establish a standard of need based on the cost of living in this state for the temporary family assistance program and the state-administered general assistance program. The commissioner shall make a reinvestigation, at least every twelve months, of all cases receiving aid from the state, except that such reinvestigation may be conducted every twenty-four months for recipients of assistance to the elderly or disabled with stable circumstances, and shall maintain all case records of the several programs administered by the Department of Social Services so that such records show, at all times, full information with respect to eligibility of the applicant or recipient. In the determination of need under any public assistance program, such income or earnings shall be disregarded as federal law requires, and such income or earnings may be disregarded as federal law permits. The commissioner shall encourage and promulgate such incentive earning programs as are permitted by federal law and regulations.

(b) On July 1, **[**1988**]** 2007, and annually thereafter, the commissioner shall increase the payment standards over those of the previous fiscal year under the **[**aid to families with dependent children program,**]** temporary family assistance program and the state-administered general assistance program by the percentage increase, if any, in the most recent calendar year average in the consumer price index for urban consumers over the average for the previous calendar year, provided the annual increase, if any, shall not exceed five per cent. **[**, except that the payment standards for the fiscal years ending June 30, 1992, June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June 30, 2002, June 30, 2003, June 30, 2004, June 30, 2005, June 30, 2006, and

June 30, 2007, shall not be increased. On January 1, 1994, the payment standards shall be equal to the standards of need in effect July 1, 1993. **]**

Sec. 3. Subsection (a) of section 17b-106 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) On January 1, 2006, and on each January first thereafter, the Commissioner of Social Services shall increase the unearned income disregard for recipients of the state supplement to the federal Supplemental Security Income Program by an amount equal to the federal cost-of-living adjustment, if any, provided to recipients of federal Supplemental Security Income Program benefits for the corresponding calendar year. On July 1, 1989, and annually thereafter, the commissioner shall increase the adult payment standards over those of the previous fiscal year for the state supplement to the federal Supplemental Security Income Program by the percentage increase, if any, in the most recent calendar year average in the consumer price index for urban consumers over the average for the previous calendar year, provided the annual increase, if any, shall not exceed five per cent, except that the adult payment standards for the fiscal years ending June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June 30, 2002, June 30, 2003, June 30, 2004, June 30, 2005, June 30, 2006, **[**and**]** June 30, 2007, June 30, 2008, and June 30, 2009, shall not be increased. Effective October 1, 1991, the coverage of excess utility costs for recipients of the state supplement to the federal Supplemental Security Income Program is eliminated. Notwithstanding the provisions of this section, the commissioner may increase the personal needs allowance component of the adult payment standard as necessary to meet federal maintenance of effort requirements.

Sec. 4. Section 17b-265e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) There is established a fund to be known as the "Medicare Part D Supplemental Needs Fund" which shall be an account within the General Fund under the Department of Social Services. **[**The Commissioner of Social Services shall, within available appropriations, designate moneys to said fund. **]** Moneys available in said fund shall be utilized by the Department of Social Services to provide **[**financial**]** assistance to Medicare Part D beneficiaries who are enrolled in the ConnPACE program or who are full benefit dually eligible Medicare Part D beneficiaries, as defined in section 17b-265d, and **[**who lack the financial means to obtain medically necessary**]** whose medical needs require that they obtain nonformulary prescription drugs. A beneficiary requesting such **[**financial**]** assistance from the department shall be required to make a satisfactory showing of the medical necessity of obtaining such nonformulary prescription drug to the department. If the department, in consultation with the prescribing physician, determines that the prescription is medically necessary, the department shall cover the cost of the original prescription and any prescribed refills of the original prescription, less any applicable copayments. The department **[**may**]** shall require as a condition of receiving such **[**financial**]** assistance that a beneficiary establish, to the satisfaction of the department, that the beneficiary has made good faith efforts to: (1) Enroll in a Medicare Part D plan recommended by the commissioner or the commissioner's agent; and (2) utilize the exception process established by the prescription drug plan in which the beneficiary is enrolled. **[**The department shall expeditiously review all requests for financial assistance pursuant to this section and shall notify the beneficiary as to whether the request for financial assistance has been granted not later than two hours after receiving the request from the beneficiary. **]** The commissioner shall implement policies and procedures to administer the provisions of this section and to ensure that all requests for, and determinations made concerning **[**financial**]** assistance available pursuant to this section are expeditiously processed.

(b) Assistance provided in accordance with the provisions of subsection (a) of this section shall be subject to available funds. All expenditures for prescription drugs under subsection (a) of this section shall be charged to the Medicare Part D Supplemental Needs Fund. For each fiscal year, such expenditures shall not exceed the amount appropriated to the Department of Social Services in section 1 of public act 06-186 for the Medicare Part D Supplemental Needs Fund.

**[**(b)**]** (c) The Department of Social Services shall, in accordance with the provisions of this section, pay claims for prescription drugs for Medicare Part D beneficiaries, who are also either Medicaid or ConnPACE recipients and who are denied coverage by the Medicare Part D plan in which such beneficiary is enrolled because a prescribed drug is not on the formulary utilized by such Medicare Part D plan. Payment shall initially be made by the department for a thirty-day supply, subject to any applicable copayment. The beneficiary shall appoint the commissioner as such beneficiary's representative for the purpose of appealing any denial of Medicare Part D benefits and for any other purpose allowed under said act and deemed necessary by the commissioner.

**[**(c)**]** (d) Notwithstanding any provision of the general statutes, not later than July 1, 2006, the Commissioner of Social Services shall **[**contract with an entity specializing in Medicare appeals and reconsideration for the purpose of having such entity exhaust remedies**]** implement a plan for pursuing payment under Medicare Part D by Part D plans for prescriptions denied as nonformulary drugs, including remedies available through reconsideration by an independent review entity, review by an administrative law judge, the Medicare Appeals Council or Federal District Court. Reimbursement secured **[**by such entity**]** from the Medicare Part D plan shall be returned to the Department of Social Services.

**[**(d)**]** (e) The **[**entity contracting with the**]** Department of Social Services, pursuant to subsection **[**(c)**]** (d) of this section, **[**shall submit**]** may authorize appeals beyond the independent review entity. **[**only upon authorization from the department. **]** Upon determination by the department that it is not cost-effective to pursue further appeals, the department shall pay for the denied nonformulary drug for the remainder of the calendar year, provided the beneficiary remains enrolled in the Part D plan that denied coverage. Pending the outcome of the appeals process, the department shall continue to pay claims for the nonformulary drug denied by the Part D plan until the earlier of approval of such drug by the Part D plan or for the remainder of the calendar year.

Sec. 5. Section 17b-369 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

The Commissioner of Social Services, pursuant to Section 6071 of the Deficit Reduction Act of 2005, may submit an application to the Secretary of Health and Human Services to establish a Money Follows the Person demonstration project. **[**In the event the state is selected to participate in the demonstration project and the Department of Social Services elects to participate in such project, such**]** Such project shall serve not more than **[**one**]** seven hundred persons and shall be designed to achieve the objectives set forth in Section 6071(a) of the Deficit Reduction Act of 2005. Services available under the demonstration project shall include, but not be limited to, personal care assistance services. The commissioner may apply for a Medicaid research and demonstration waiver under Section 1115 of the Social Security Act, if such waiver is necessary to implement the demonstration project. The commissioner may, if necessary, modify any existing Medicaid home or community-based waiver if such modification is required to implement the demonstration project.

Sec. 6. Section 17b-285 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

**[**An**]** Notwithstanding any provision of the general statutes, an institutionalized person or person in need of institutional care who applies for Medicaid **[**shall**]** may assign to the Commissioner of Social Services the right of support derived from the assets of the community spouse of such person **[**, provided the spouse of such person is unwilling or unable to provide the information necessary to determine eligibility for Medicaid**]** but only if (1) the assets of the institutionalized person or person in need of institutional care do not exceed the Medicaid program asset limit; and (2) the institutionalized person or person in need of institutional care cannot locate the community spouse; or the community spouse is unable to provide information regarding his or her own assets. If such **[**applicant**]** assignment is made or if the institutionalized person or person in need of institutional care lacks the ability to execute such an assignment due to physical or mental impairment, the commissioner may **[**bring a support proceeding against such applicant's spouse without such assignment**]** seek recovery of any medical assistance paid on behalf of the institutionalized person or person in need of institutional care up to the amount of the community spouse's assets that are in excess of the community spouse protected amount as of the initial month of Medicaid eligibility.

Sec. 7. Section 17b-261 of the general statutes, as amended by section 3 of public act 07-185, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(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 (d) 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(c) of the Social Security Act, 42 USC 1396p(c), 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 of equal size with no income under the temporary family assistance program in the appropriate region of residence. Except as provided in section 17b-277, as amended by this act, the medical assistance program shall provide coverage to persons under the age of nineteen with family income up to one hundred eighty-five per cent of the federal poverty level without an asset limit and to persons under 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 income up to one hundred eighty-five 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. All contracts entered into on and after July 1, 1997, pursuant to this section shall include provisions for collaboration of managed care

organizations with the Nurturing Families Network established pursuant to section 17a-56. 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, **[**(3) the availability of HUSKY Plan, Part B health insurance benefits for persons who are not eligible for assistance pursuant to this subsection or who are subsequently determined ineligible for assistance pursuant to this subsection,**]** and **[**(4)**]** (3) the availability of, and eligibility for, services provided by the Nurturing Families Network established pursuant to section 17a-56. 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.

(b) For the purposes of the Medicaid program, the Commissioner of Social Services shall consider parental income and resources as available to a child under eighteen years of age who is living with his or her parents and is blind or disabled for purposes of the Medicaid program, or to any other child under twenty-one years of age who is living with his or her parents.

(c) For the purposes of determining eligibility for the Medicaid program, an available asset is one that is actually available to the applicant or one that the applicant has the legal right, authority or power to obtain or to have applied for the applicant's general or medical support. If the terms of a trust provide for the support of an applicant, the refusal of a trustee to make a distribution from the trust does not render the trust an unavailable asset. Notwithstanding the provisions of this subsection, the availability of funds in a trust or similar instrument funded in whole or in part by the applicant or the applicant's spouse shall be determined pursuant to the Omnibus Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of this subsection shall not apply to special needs trust, as defined in 42 USC 1396p(d)(4)(A).

(d) The transfer of an asset in exchange for other valuable consideration shall be allowable to the extent the value of the other valuable consideration is equal to or greater than the value of the asset transferred.

(e) The Commissioner of Social Services shall seek a waiver from federal law to permit federal financial participation for Medicaid expenditures for families with incomes of one hundred forty-three per cent of the temporary family assistance program payment standard.

(f) To the extent permitted by federal law, Medicaid eligibility shall be extended for one year to a family that becomes ineligible for medical assistance under Section 1931 of the Social Security Act due to income from employment by one of its members who is a caretaker relative or due to receipt of child support income. A family receiving extended benefits on July 1, 2005, shall receive the balance of such extended benefits, provided no such family shall receive more than twelve additional months of such benefits.

(g) An institutionalized spouse applying for Medicaid and having a spouse living in the community shall be required, to the maximum extent permitted by law, to divert income to such community spouse in order to raise the community spouse's income to the level of the minimum monthly needs allowance, as described in Section 1924 of the Social Security Act. Such diversion of income shall occur before the community spouse is allowed to retain assets in excess of the community spouse protected amount described in Section 1924 of the Social Security Act. The Commissioner of Social Services, pursuant to section 17b-10, may implement the provisions of this subsection while in the process of adopting regulations, provided the commissioner prints notice of intent to adopt the regulations in the Connecticut Law Journal within twenty

days of adopting such policy. Such policy shall be valid until the time final regulations are effective.

**[**(h) The Commissioner of Social Services shall, to the extent permitted by federal law, or, pursuant to an approved waiver of federal law submitted by the commissioner, in accordance with the provisions of section 17b-8, impose the following cost-sharing requirements under the HUSKY Plan, on all parent and needy caretaker relatives with incomes exceeding one hundred per cent of the federal poverty level: (1) A twenty-five-dollar premium per month per parent or needy caretaker relative; and (2) a copayment of one dollar per visit for outpatient medical services delivered by an enrolled Medicaid or HUSKY Plan provider. The commissioner may implement policies and procedures necessary to administer the provisions of this subsection while in the process of adopting such policies and procedures as regulations, provided the commissioner publishes notice of the intent to adopt regulations in the Connecticut Law Journal not later than twenty days after implementation. Policies and procedures implemented pursuant to this subsection shall be valid until the time final regulations are adopted. **]**

**[**(i)**]** (h) Medical assistance shall be provided, in accordance with the provisions of subsection (e) of section 17a-6, to any child under the supervision of the Commissioner of Children and Families who is not receiving Medicaid benefits, has not yet qualified for Medicaid benefits or is otherwise ineligible for such benefits because of institutional status. To the extent practicable, the Commissioner of Children and Families shall apply for, or assist such child in qualifying for, the Medicaid program.

**[**(j)**]** (i) The Commissioner of Social Services shall provide Early and Periodic Screening, Diagnostic and Treatment program services, as required and defined as of December 31, 2005, by 42 USC 1396a(a)(43), 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal regulations, to all persons who are under the age of twenty-one and otherwise eligible for medical assistance under this section.

Sec. 8. (NEW) (*Effective July 1, 2007*) (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 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 A caretaker relative 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 employment 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.

(c) The Commissioner of Social Services, pursuant to section 17b-10 of the general statutes, 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 notice of the intent to adopt the regulation in the Connecticut Law Journal 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. 9. Section 17b-277 of the general statutes, as amended by section 4 of public act 07-185, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

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

(b) The commissioner shall expedite eligibility for appropriate pregnant women applicants for the Medicaid program. The process for making expedited eligibility determinations concerning needy pregnant women shall ensure that emergency applications for assistance, as determined by the commissioner, shall be processed no later than twenty-four hours after receipt of all required information from the applicant, and that nonemergency applications for assistance, as determined by the commissioner, shall be processed no later than five calendar days after the date of receipt of all required information from the applicant.

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

**[**(c)**]** (d) Presumptive eligibility for medical assistance shall be implemented for any uninsured newborn child born in a hospital in this state or a border state hospital, 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.

**[**(d)**]** (e) The commissioner shall submit biannual reports to the council, established pursuant to section 17b-28, on the department's compliance with the administrative processing requirements set forth in subsection (b) of this section.

Sec. 10. Section 13 of public act 07-185 is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(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. The goal of the system shall be to improve health outcomes for all children enrolled in the HUSKY Plan and to reduce racial and ethnic health disparities among children. Such system shall ensure that services under the federal Early and Periodic Screening, Diagnosis and Treatment program are provided to children enrolled in the HUSKY Plan, Part A.

(b) The plan shall:

(1) Establish a coordinated system for preventive health services for HUSKY Plan, Part A and Part B beneficiaries including, but not limited to, services under the federal Early and Periodic Screening,

Diagnosis and Treatment program, **[**vision care**]** ophthalmologic and optometric services, oral health care, care 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 **[**electronically**]** the utilization of services in the system of preventive health services by HUSKY Plan, Part A and Part 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 of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, insurance and public health on **[**the implementation of**]** 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. 11. Subdivision (4) of subsection (f) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(4) For the fiscal year ending June 30, 1992, (A) no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1991; (B) no facility whose rate, if determined pursuant to this subsection, would exceed one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is five and one-half per cent more than the rate it received for the rate year ending June 30, 1991; and (C) no facility whose rate, if determined pursuant to this subsection, would be less than one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is six and one-half per cent more than the rate it received for the rate year ending June 30, 1991. For the fiscal year ending June 30, 1993, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1992, or six per cent more than the rate it received for the rate year ending June 30, 1992. For the fiscal year ending June 30, 1994, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1993, or six per cent more than the rate it received for the rate year ending June 30, 1993. For the fiscal year ending June 30, 1995, no facility shall receive a rate that is more than five per cent less than the rate it received for the rate year ending June 30, 1994, or six per cent more than the rate it received for the rate year ending June 30, 1994. For the fiscal years ending June 30, 1996, and June 30, 1997, no facility shall receive a rate that is more than three per cent more than the rate it received for the prior rate year. For the fiscal year ending June 30, 1998, a facility shall receive a rate increase that is not more than two per cent more than the rate that the facility received in the prior year. For the fiscal year ending June 30, 1999, a facility shall receive a rate increase that is not more than three per cent more than the rate that the facility received in the prior year and that is not less than one per cent more than the rate that the facility received in the prior year, exclusive of rate increases associated with a wage, benefit and staffing enhancement rate

adjustment added for the period from April 1, 1999, to June 30, 1999, inclusive. For the fiscal year ending June 30, 2000, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 1999, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2000, shall receive a rate increase equal to one per cent applied to the rate the facility received for the fiscal year ending June 30, 1999, exclusive of the facility's wage, benefit and staffing enhancement rate adjustment. For the fiscal year ending June 30, 2000, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2000, shall receive a rate increase that is more than one per cent more than the rate the facility received in the fiscal year ending June 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 2000, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2001, shall receive a rate increase equal to two per cent applied to the rate the facility received for the fiscal year ending June 30, 2000, subject to verification of wage enhancement adjustments pursuant to subdivision (15) of this subsection. For the fiscal year ending June 30, 2001, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2001, shall receive a rate increase that is more than two per cent more than the rate the facility received for the fiscal year ending June 30, 2000. For the fiscal year ending June 30, 2002, each facility shall receive a rate that is two and one-half per cent more than the rate the facility received in the prior fiscal year. For the fiscal year ending June 30, 2003, each facility shall receive a rate that is two per cent more than the rate the facility received in the prior fiscal year, except that such increase shall be effective January 1, 2003, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until December 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate increased two per cent effective June 1, 2003. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until December 31, 2004, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective January 1, 2005, each facility shall receive a rate that is one per cent greater than the rate in effect December 31, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in this subdivision, but in no event earlier than July 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, for the fiscal year ending June 30, 2006, the department shall compute the rate for each facility based upon its 2003 cost report filing or **[,]** a subsequent cost year filing for facilities having an interim rate for the period ending June 30, 2005, as provided under section 17-311-55 of the regulations of Connecticut state agencies. For each facility not having an interim rate for the period ending June 30, 2005, the rate for the period ending June 30, 2006, shall be determined beginning with the higher of the computed rate based upon its 2003 cost report filing or the rate in effect for the period ending June 30, 2005. Such rate shall then be increased by eleven dollars and eighty cents per day except that in no event shall the rate for the period ending June 30, 2006, be thirty-two dollars more than the rate in effect for the period ending June 30, 2005, and for any facility with a rate below one hundred ninety-five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not

be greater than two hundred seventeen dollars and forty-three cents per day and for any facility with a rate equal to or greater than one hundred ninety-five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one-half per cent. For each facility with an interim rate for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven dollars and eighty cents per day plus the per day cost of the user fee payments made pursuant to section 17b-320 divided by annual resident service days, except for any facility with an interim rate below one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not be greater than two hundred seventeen dollars and forty-three cents per day and for any facility with an interim rate equal to or greater than one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one-half per cent. Such July 1, 2005, rate adjustments shall remain in effect unless (i) the federal financial participation matching funds associated with the rate increase are no longer available; or (ii) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, each facility shall receive a rate that is three per cent greater than the rate in effect for the period ending June 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the rate period ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. For the fiscal year ending June 30, 2008, each facility shall receive a rate that is two and nine-tenths per cent greater than the rate in effect for the period ending June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, than for the rate period ending June 30, 2007, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2009, due to interim rate status or agreement with the department shall be issued such lower rate. The Commissioner of Social Services shall add fair rent increases to any other rate increases established pursuant to this subdivision for a facility which has undergone a material change in circumstances related to fair rent. Interim rates may take into account reasonable costs incurred by a facility, including wages and benefits.

Sec. 12. Subsection (g) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(g) For the fiscal year ending June 30, 1993, any intermediate care facility for the mentally retarded with an operating cost component of its rate in excess of one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any intermediate care facility for the mentally retarded with an operating cost component of its rate that is less than one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to thirty per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred forty per cent of the median of operating cost components in effect January 1, 1992. Any facility with real property other than land placed in service prior to October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding October 1, 1993. For the fiscal

year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request, allow actual debt service, comprised of principal and interest, in excess of property costs allowed pursuant to section 17-311-52 of the regulations of Connecticut state agencies, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. For the fiscal year ending June 30, 1995, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, no rate shall exceed three hundred seventy-five dollars per day unless the commissioner, in consultation with the Commissioner of Mental Retardation, determines after a review of program and management costs, that a rate in excess of this amount is necessary for care and treatment of facility residents. For the fiscal year ending June 30, 2002, rate period, the Commissioner of Social Services shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2000 costs to include a three and one-half per cent inflation factor. For the fiscal year ending June 30, 2003, rate period, the commissioner shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2001 costs to include a one and one-half per cent inflation factor, except that such increase shall be effective November 1, 2002, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until October 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate updated effective November 1, 2002, in accordance with applicable statutes and regulations. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until September 30, 2004. Effective October 1, 2004, each facility shall receive a rate that is five per cent greater than the rate in effect September 30, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is four per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (A) The federal financial participation matching funds associated with the rate increase are no longer available; or (B) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than three per cent greater than the rate in effect for the facility on September 30, 2006, except **[**for**]** any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement

with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal year ending June 30, 2008, each facility shall receive a rate that is two and nine-tenths per cent greater than the rate in effect for the period ending June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, than for the rate period ending June 30, 2007, due to interim rate status, or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2009, due to interim rate status or agreement with the department, shall be issued such lower rate.

Sec. 13. Subsection (a) of section 17b-244 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The room and board component of the rates to be paid by the state to private facilities and facilities operated by regional education service centers which are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid program as intermediate care facilities for persons with mental retardation, shall be determined annually by the Commissioner of Social Services, except that rates effective April 30, 1989, shall remain in effect through October 31, 1989. Any facility with real property other than land placed in service prior to July 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding July 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request by such facility, allow actual debt service, comprised of principal and interest, on the loan or loans in lieu of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, whether actual debt service is higher or lower than such allowed property costs, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. In the case of facilities financed through the Connecticut Housing Finance Authority, the commissioner shall allow actual debt service, comprised of principal, interest and a reasonable repair and replacement reserve on the loan or loans in lieu of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, whether actual debt service is higher or lower than such allowed property costs, provided such debt service terms and amounts are determined by the commissioner at the time the loan is entered into to be reasonable in relation to the useful life and base value of the property. The commissioner may allow fees associated with mortgage refinancing provided such refinancing will result in state reimbursement savings, after comparing costs over the terms of the existing proposed loans. For the fiscal year ending June 30, 1992, the inflation factor used to determine rates shall be one-half of the gross national product percentage increase for the period between the midpoint of the cost year through the midpoint of the rate year. For fiscal year ending June 30, 1993, the inflation factor used to determine rates shall be two-thirds of the gross national product percentage increase from the midpoint of the cost year to the midpoint of the rate year. For the fiscal years ending June 30, 1996, and June 30, 1997, no inflation factor shall be applied in determining rates. The Commissioner of Social Services shall prescribe uniform forms on which such facilities shall report their costs. Such rates shall be determined on the basis of a reasonable payment for necessary services. Any increase in grants, gifts, fund-raising or endowment income used for the payment of operating costs by a private facility in the fiscal year ending June 30, 1992, shall be excluded by the commissioner from the income of the facility in determining the rates to be paid to the facility for the fiscal year ending June 30, 1993, provided any operating costs funded by such increase shall not obligate the state to increase expenditures in subsequent fiscal years. Nothing contained in this section shall

authorize a payment by the state to any such facility in excess of the charges made by the facility for comparable services to the general public. The service component of the rates to be paid by the state to private facilities and facilities operated by regional education service centers which are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid programs as intermediate care facilities for persons with mental retardation, shall be determined annually by the Commissioner of Mental Retardation in accordance with section 17b-244a. For the fiscal year ending June 30, 2008, no facility shall receive a rate that is more than two per cent greater than the rate in effect for the facility on June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, no facility shall receive a rate that is more than two per cent greater than the rate in effect for the facility on June 30, 2008, except any facility that would have been issued a lower rate effective July 1, 2008, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2008.

Sec. 14. Section 17b-192 of the general statutes, as amended by section 2 of public act 07-185, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The Commissioner of Social Services shall implement a state medical assistance component of the state-administered general assistance program for persons ineligible for Medicaid. Eligibility criteria concerning income shall be the same as the medically needy component of the Medicaid program, except that earned monthly gross income of up to one hundred fifty dollars shall be disregarded. Unearned income shall not be disregarded. No person who has family assets exceeding one thousand dollars shall be eligible. No person shall be eligible for assistance under this section if such person made, during the three months prior to the month of application, an assignment or transfer or other disposition of property for less than fair market value. The number of months of ineligibility due to such disposition shall be determined by dividing the fair market value of such property, less any consideration received in exchange for its disposition, by five hundred dollars. Such period of ineligibility shall commence in the month in which the person is otherwise eligible for benefits. Any assignment, transfer or other disposition of property, on the part of the transferor, shall be presumed to have been made for the purpose of establishing eligibility for benefits or services unless such person provides convincing evidence to establish that the transaction was exclusively for some other purpose.

(b) Each person eligible for state-administered general assistance shall be entitled to receive medical care through a federally qualified health center or other primary care provider as determined by the commissioner. The Commissioner of Social Services shall determine appropriate service areas and shall, in the commissioner's discretion, contract with community health centers, other similar clinics, and other primary care providers, if necessary, to assure access to primary care services for recipients who live farther than a reasonable distance from a federally qualified health center. The commissioner shall assign and enroll eligible persons in federally qualified health centers and with any other providers contracted for the program because of access needs. Each person eligible for state-administered general assistance shall be entitled to receive hospital services. Medical services under the program shall be limited to the services provided by a federally qualified health center, hospital, or other provider contracted for the program at the commissioner's discretion because of access needs. The commissioner shall ensure that ancillary services and specialty services are provided by a federally qualified health center, hospital, or other providers contracted for the program at the commissioner's discretion. Ancillary services include, but are not limited to, radiology, laboratory, and other diagnostic services not available from a recipient's assigned primary-

care provider, and durable medical equipment. Specialty services are services provided by a physician with a specialty that are not included in ancillary services. **[**In no event shall ancillary**]** Ancillary or specialty services provided under the program shall not exceed such services provided under the state-administered general assistance program on July 1, 2003, except for nonemergency medical transportation and vision care services which may be provided for a limited duration. Notwithstanding any provision of this subsection, the commissioner may, when determined cost effective, provide or require a contractor to provide home health services or skilled nursing facility coverage for state-administered general assistance recipients being discharged from a chronic disease hospital.

(c) Pharmacy services shall be provided to recipients of state-administered general assistance through the federally qualified health center to which they are assigned or through a pharmacy with which the health center contracts. Recipients who are assigned to a community health center or similar clinic or primary care provider other than a federally qualified health center or to a federally qualified health center that does not have a contract for pharmacy services shall receive pharmacy services at pharmacies designated by the commissioner. The Commissioner of Social Services or the managed care organization or other entity performing administrative functions for the program as permitted in subsection (d) of this section, shall require prior authorization for coverage of drugs for the treatment of erectile dysfunction. The commissioner or the managed care organization or other entity performing administrative functions for the program may limit or exclude coverage for drugs for the treatment of erectile dysfunction for persons who have been convicted of a sexual offense who are required to register with the Commissioner of Public Safety pursuant to chapter 969.

(d) The Commissioner of Social Services shall contract with federally qualified health centers or other primary care providers as necessary to provide medical services to eligible state-administered general assistance recipients pursuant to this section. The commissioner shall, within available appropriations, make payments to such centers based on their pro rata share of the cost of services provided or the number of clients served, or both. The Commissioner of Social Services shall, within available appropriations, make payments to other providers based on a methodology determined by the commissioner. The Commissioner of Social Services may reimburse for extraordinary medical services, provided such services are documented to the satisfaction of the commissioner. For purposes of this section, the commissioner may contract with a managed care organization or other entity to perform administrative functions, including a grievance process for recipients to access review of a denial of coverage for a specific medical service, and to operate the program in whole or in part. Provisions of a contract for medical services entered into by the commissioner pursuant to this section shall supersede any inconsistent provision in the regulations of Connecticut state agencies. A recipient who has exhausted the grievance process established through such contract and wishes to seek further review of the denial of coverage for a specific medical service may request a hearing in accordance with the provisions of section 17b-60.

(e) Each federally qualified health center participating in the program shall enroll in the federal Office of Pharmacy Affairs Section 340B drug discount program established pursuant to 42 USC 256b to provide pharmacy services to recipients at Federal Supply Schedule costs. Each such health center may establish an on-site pharmacy or contract with a commercial pharmacy to provide such pharmacy services.

(f) The Commissioner of Social Services shall, within available appropriations, make payments to hospitals for inpatient services based on their pro rata share of the cost of services provided or the number of clients served, or both. The Commissioner of Social Services shall, within available appropriations, make payments for any ancillary or specialty services provided to state-administered general assistance recipients

under this section based on a methodology determined by the commissioner.

(g) On or before January 1, 2008, the Commissioner of Social Services shall seek a waiver of federal law for the purpose of extending health insurance coverage under Medicaid to persons with income not in excess of one hundred per cent of the federal poverty level who otherwise qualify for medical assistance under the state-administered general assistance program. The provisions of section 17b-8 shall apply to this section.

(h) The commissioner, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policy shall be valid until the time final regulations are adopted.

Sec. 15. Section 17b-733 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

The Department of Social Services shall be the lead agency for child day care services in Connecticut. The department shall: (1) Identify, annually, existing child day care services and maintain an inventory of all available services; (2) provide technical assistance to corporations and private agencies in the development and expansion of child day care services for families at all income levels, including families of their employees and clients; (3) study and identify funding sources available for child day care including federal funds and tax benefits; (4) study the cost and availability of liability insurance for child day care providers; (5) provide, in conjunction with the Departments of Education and Higher Education, ongoing training for child day care providers including preparing videotaped workshops and distributing them to cable stations for broadcast on public access stations, and seek private donations to fund such training; (6) encourage child day care services to obtain accreditation; (7) develop a range of financing options for child care services, including the use of a tax-exempt bond program, a loan guarantee program and establishing a direct revolving loan program; (8) promote the colocation of child day care and school readiness programs pursuant to section 4b-31; (9) establish a performance-based evaluation system; (10) develop for recommendation to the Governor and the General Assembly measures to provide incentives for the private sector to develop and support expanded child day care services; (11) provide, within available funds and in conjunction with the temporary family assistance program as defined in section 17b-680, child day care to public assistance recipients; (12) develop and implement, with the assistance of the Child Day Care Council and the Departments of Public Health, Social Services, Education, Higher Education, Children and Families, Economic and Community Development and Consumer Protection, a state-wide coordinated child day care and early childhood education training system (A) for child day care centers, group day care homes and family day care homes that provide child day care services, and (B) that makes available to such providers and their staff, within available appropriations, scholarship assistance, career counseling and training, advancement in career ladders, as defined in section 4-124bb, through seamless articulation of levels of training, program accreditation support and other initiatives recommended by the Departments of Social Services, Education and Higher Education; (13) plan and implement a unit cost reimbursement system for state-funded child day care services such that, on and after January 1, 2008, any increase in reimbursement shall be based on a requirement that such centers meet the staff qualifications, as defined in subsection (b) of section 10-16p; (14) develop, within available funds, initiatives to increase compensation paid to child day care providers for educational opportunities, including, but not limited to, (A) incentives for educational advancement paid to persons employed by child day care centers receiving state or federal

funds, and (B) support for the establishment and implementation by the Labor Commissioner of apprenticeship programs for child day care workers pursuant to sections 31-22m to 31-22q, inclusive, which programs shall be jointly administered by labor and management trustees; (15) evaluate the effectiveness of any initiatives developed pursuant to subdivision (14) of this section in improving staff retention rates and the quality of education and care provided to children; and (16) report annually to the Governor and the General Assembly on the status of child day care in Connecticut. Such report shall include (A) an itemization of the allocation of state and federal funds for child care programs; (B) the number of children served under each program so funded; (C) the number and type of such programs, providers and support personnel; (D) state activities to encourage partnership between the public and private sectors; (E) average payments issued by the state for both part-time and full-time child care; (F) range of family income and percentages served within each range by such programs; and (G) age range of children served.

Sec. 16. (NEW) (*Effective July 1, 2007*) Notwithstanding any provision of the general statutes, not later than November 1, 2007, the Department of Social Services shall develop a plan to 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. Such plan shall be submitted to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. Not later than thirty days after the date of receipt of such plan, said joint standing committees of the General Assembly shall hold a joint public hearing to review such plan. Said joint standing committees of the General Assembly may advise the commissioner of their approval or denial or modifications, if any, of the plan. Primary care providers participating in the primary care case management system 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. 17. Section 17b-292 of the general statutes, as amended by section 6 of public act 07-185, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

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

(b) A child who resides in a household with a family income over **[**four**]** three hundred per cent of the federal poverty level may be eligible for unsubsidized benefits under the HUSKY Plan, Part 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 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 has other insurance coverage for the services or such equipment.

(e) A newborn child who otherwise meets the eligibility criteria for the HUSKY Plan, Part 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 hospital shall be enrolled on an expedited basis in the HUSKY Plan, Part 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 would otherwise incur for the first **[**two**]** four months of coverage to the managed care organization selected by the parent or caretaker relative to provide coverage for such child.

(f) The commissioner shall implement presumptive eligibility for children applying for Medicaid. 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 to grant presumptive eligibility. Qualified entities shall ensure that, at the time a presumptive eligibility determination is made, a completed application for Medicaid is submitted to the department 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 **[**enter into a contract with an entity to be**]** 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 **[**contract with the**]** servicer, shall ensure that a child who is determined to be eligible for benefits under the HUSKY Plan, Part A, 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, as amended by this act, 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 and managed care enrollment brokerage 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 managed care plan. Upon enrollment in a managed care plan, an eligible HUSKY Plan Part A or Part B beneficiary shall remain enrolled in such managed care plan 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 managed care plan, 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 **[**determine if the child continues to be eligible for the plan. The commissioner or the servicer 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 HUSKY Plan Part A or Part B. The determination of eligibility shall be coordinated with health plan open enrollment periods.

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

(l) 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. 18. Subsection (a) of section 17b-137 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) (1) (A) Any person who has in his possession or control any property of any person applying for or presently or formerly receiving aid or care or child support enforcement services, as defined in subdivision (2) of subsection (b) of section 46b-231, from the state or who is indebted to such applicant or recipient or has knowledge of any insurance, including health insurance or property currently or formerly belonging to him, or information pertaining to eligibility for such aid or care or services, and any officer who has control of the books and accounts of any corporation which has possession or control of any property belonging to any person applying for or receiving such aid or care or services or who is indebted to him, or has knowledge of any insurance, including health insurance or any person having in his employ any such person, shall, upon presentation by the Commissioner of Social Services, or the Commissioner of Administrative Services, or the Commissioner of Public Safety, or a support enforcement officer of the Superior Court, or any person deputized by any of them, of a certificate, signed by him, stating that such applicant, recipient or employee has applied for or is receiving or has received such aid or care or services from the state, make full disclosure to said commissioner, such officer or such deputy of any such property, insurance, wages, indebtedness or information. Notwithstanding the provisions of this subparagraph, any health insurer, including a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, which may or may not be financially at risk for the cost of a health care item or service, shall, upon request of the

Commissioner of Social Services, or the commissioner's designee, provide any and all information in a manner and format prescribed by the commissioner, or the commissioner's designee, to identify, determine or establish third-party coverage, including, all information necessary to determine during what period a person, his or her spouse or his or her dependents may be, or may have been, covered by a health insurer and the nature of the coverage that is or was provided by the health insurer, including the name, address and identifying number of the plan. Such information shall also be provided by such health insurer to all third-party administrators, pharmacy benefit managers, dental benefit managers or other entities with which the health insurer has an arrangement to adjudicate claims for a health care item or service.

(B) At the request of the Commissioner of Social Services, **[**insurance companies licensed to do business in Connecticut**]** any health insurer, including a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, which may or may not be financially at risk for the cost of a health care item or service, shall be required, **[**when compatible data elements are available,**]** to conduct, or to allow the commissioner, or the commissioner's designee, to conduct automated data matches to identify insurance coverage for recipients and the parents of recipients who are minors. Upon completion of such matches the commissioner shall reimburse such companies for the reasonable documented costs of conducting the matches.

(2) (A) Such disclosure may be obtained in like manner of the property, wages or indebtedness of any person who is either: (i) Liable for the support of any such applicant or recipient, including the parents of any child receiving aid or services through the Department of Children and Families, or one adjudged or acknowledged to be the father of an illegitimate child; or (ii) the subject of an investigation in a IV-D support case, as defined in subdivision (13) of subsection (b) of section 46b-231. Any company or officer who has control of the books and accounts of any corporation shall make full disclosure to the IV-D agency, as defined in subdivision (12) of subsection (b) of section 46b-231, or to the support enforcement officer of the Superior Court of any such property, wages or indebtedness in all support cases, including IV-D support cases, as defined in subdivision (13) of subsection (b) of section 46b-231.

(B) The Commissioner of Social Services, the Commissioner of Administrative Services, the Commissioner of Public Safety or a support enforcement officer of the Superior Court, or any person deputized by any of them, may compel, by subpoena, the attendance and testimony under oath of any person who refuses to disclose in accordance with the provisions of this section, or of any person who is either: (i) Liable for the support of any such applicant or recipient; or (ii) the subject of an investigation in a IV-D support case, as defined in subdivision (13) of subsection (b) of section 46b-231, who refuses to disclose his own financial circumstances, and may so compel the production of books and papers pertaining to such information.

(C) The Commissioner of Social Services may subpoena the financial records of any financial institution concerning property of any person applying for or presently or formerly receiving aid or care from the state or who is indebted to such applicant or recipient. The Commissioner of Social Services may subpoena such records of any parent or parents of any child applying for or presently or formerly receiving assistance under the aid to families with dependent children program, the temporary family assistance program or the state-administered general assistance program.

(D) The commissioner, or a support enforcement officer of the Superior Court, or the person deputized by the commissioner or officer shall set a time and place for any examination under this subdivision, and any

person summoned who, without reasonable excuse, fails to appear and testify or to produce such books and papers shall be fined fifty dollars for each such offense.

Sec. 19. (NEW) (*Effective July 1, 2007*) Any health insurer, including a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, and which may or may not be financially at risk for the cost of a health care item or service, shall, as a condition of doing business in the state, be required to: (1) Provide, with respect to an individual who is eligible for, or is provided, medical assistance under the Medicaid state plan, to all third-party administrators, pharmacy benefit managers, dental benefit managers or other entities with which the health insurer has a contract or arrangement to adjudicate claims for a health care item or service, and to the Commissioner of Social Services, or the commissioner's designee, any and all information in a manner and format prescribed by the commissioner, or commissioner's designee, necessary to determine when the individual, his or her spouse or the individual's dependents may be or have been covered by a health insurer and the nature of the coverage that is or was provided by such health insurer including the name, address and identifying number of the plan; (2) accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the health insurer for an item or service for which payment has been made under the Medicaid state plan; (3) respond to any inquiry by the commissioner, or the commissioner's designee, regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the item or service; and (4) agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if (A) the claim is submitted by the state or its agent within the three-year period beginning on the date on which the item or service was furnished; and (B) any legal action by the state to enforce its rights with respect to such claim is commenced within six years of the state's submission of such claim.

Sec. 20. Section 17b-265 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) In accordance with 42 USC 1396k, the Department of Social Services shall be subrogated to any right of recovery or indemnification **[**which**]** that an applicant or recipient of medical assistance or any legally liable relative of such applicant or recipient has against **[**a private**]** an insurer or other legally liable third party **[**, as defined in 42 CFR 433. 136,**]** including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, for the cost of all health care items or services furnished to the applicant or recipient, including, but not limited to, hospitalization, pharmaceutical services, physician services, nursing services, behavioral health services, long-term care services and other medical services, not to exceed the amount expended by the department for such care and treatment of the applicant or recipient. In the case of such a recipient who is an enrollee in a managed care organization under a Medicaid managed care contract with the state or a legally liable relative of such an enrollee, the department shall be subrogated to any right of recovery or indemnification which the enrollee or legally liable relative has against such a private insurer or other third party for the medical costs incurred by the managed care organization on behalf of an enrollee.

(b) An applicant or recipient or legally liable relative, by the act of the applicant or recipient receiving medical assistance, shall be deemed to have made a subrogation assignment and an assignment of claim for benefits to the department. The department shall inform an applicant of such assignments at the time of application. Any entitlements from a contractual agreement with an applicant or recipient, legally liable relative or a state or federal program for such medical services, not to exceed the amount expended by the department, shall be so assigned. Such entitlements shall be directly reimbursable to the department by third party payors. The Department of Social Services may assign its right to subrogation or its entitlement to benefits to a designee or a health care provider participating in the Medicaid program and providing services to an applicant or recipient, in order to assist the provider in obtaining payment for such services. **[**A**]** In accordance with subsection (b) of section 38a-472, a provider that has received an assignment from the department shall notify the **[**private**]** recipient's health insurer or other legally liable third party including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, of the assignment upon rendition of services to the applicant or recipient. Failure to so notify the **[**private**]** health insurer or other legally liable third party shall render the provider ineligible for payment from the department. The provider shall notify the department of any request by the applicant or recipient or legally liable relative or representative of such applicant or recipient for billing information. This subsection shall not be construed to affect the right of an applicant or recipient to maintain an independent cause of action against such third party tortfeasor.

(c) Claims for recovery or indemnification submitted by the department, or the department's designee, shall not be denied solely on the basis of the date of the submission of the claim, the type or format of the claim or the failure to present proper documentation at the point-of-service that is the basis of the claim, if (1) the claim is submitted by the state within the three-year period beginning on the date on which the item or service was furnished; and (2) any action by the state to enforce its rights with respect to such claim is commenced within six years of the state's submission of the claim.

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

**[**(c)**]** (e) Notwithstanding the provisions of subsection (c) of section 38a-553, no **[**(1) individual or group accident, health or accident and health policy or medical expense policy or medical service plan contract, delivered, issued for delivery or renewed in this state on or after July 1, 1984, or (2) self-insured or self-funded plan subject to the provisions of the Employee Retirement Income Security Act of 1974**]** self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care plan, or any plan offered or administered by a health care center, pharmacy benefit manager, dental benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, shall contain any

provision [which] that has the effect of denying or limiting enrollment benefits or excluding coverage because services are rendered to an insured or beneficiary who is eligible for or who received medical assistance under this chapter. No insurer, as defined in section 38a-497a, shall impose requirements on the state Medicaid agency, which has been assigned the rights of an individual eligible for Medicaid and covered for health benefits from an insurer, that differ from requirements applicable to an agent or assignee of another individual so covered.

[(d)] (f) The Commissioner of Social Services shall not pay for any services provided under this chapter if the individual eligible for medical assistance has coverage for the services under an accident or health insurance policy.

Sec. 21. (NEW) (*Effective from passage*) No pharmacy shall claim payment from the Department of Social Services under a medical assistance program administered by the department or the Medicare Part D Supplemental Needs Fund, established pursuant to section 17b-265e of the general statutes, for prescription drugs dispensed to individuals who have other prescription drug insurance coverage unless such coverage has been exhausted and the individual is otherwise eligible for such a medical assistance program or assistance from the Medicare Part D Supplemental Needs Fund. The department shall recoup from the submitting pharmacy any claims submitted to and paid by the department when other insurance coverage is available. The department shall investigate a pharmacy that consistently submits ineligible claims for payment to determine whether the pharmacy is in violation of its medical assistance provider agreement or is committing fraud or abuse in the program and based on the findings of such investigation, may take action against such pharmacy, in accordance with state and federal law.

Sec. 22. Subdivision (11) of subsection (f) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(11) For the fiscal [year] years ending June 30, 1992, [and any succeeding fiscal year] through June 30, 2007, one-half of the initial amount payable in June by the state to a facility pursuant to this subsection shall be paid to the facility in June and the balance of such amount shall be paid in July.

Sec. 23. (NEW) (*Effective July 1, 2008*) (a) There is established the Charter Oak Health Plan for the purpose of providing access to health insurance coverage for state residents who have been uninsured for at least six months and who are ineligible for other publicly funded health insurance plans. The Commissioner of Social Services may enter into contracts for the provision of comprehensive health care for such uninsured state residents. The commissioner shall conduct outreach to facilitate enrollment in the plan.

(b) The commissioner shall impose cost-sharing requirements in connection with services provided under the Charter Oak Health Plan. Such requirements may include, but not be limited to: (1) A monthly premium; (2) an annual deductible not to exceed one thousand dollars; (3) a coinsurance payment not to exceed twenty per cent after the deductible amount is met; (4) tiered copayments for prescription drugs determined by whether the drug is generic or brand name, formulary or nonformulary and whether purchased through mail order; (5) no fee for emergency visits to hospital emergency rooms; (6) a copayment not to exceed one hundred fifty dollars for nonemergency visits to hospital emergency rooms; and (7) a lifetime benefit not to exceed one million dollars.

(c) The Commissioner of Social Services shall provide premium assistance to eligible state residents whose gross annual income does not exceed three hundred per cent of the federal poverty level. Such premium

assistance shall be limited to: (1) One hundred seventy-five dollars per month for individuals whose gross annual income is below one hundred fifty per cent of the federal poverty level; (2) one hundred fifty dollars per month for individuals whose gross annual income is at or above one hundred fifty per cent of the federal poverty level but not more than one hundred eighty-five per cent of the federal poverty level; (3) seventy-five dollars per month for individuals whose gross annual income is above one hundred eighty-five per cent of the federal poverty level but not more than two hundred thirty-five per cent of the federal poverty level; and (4) fifty dollars per month for individuals whose gross annual income is above two hundred thirty-five per cent of the federal poverty level but not more than three hundred per cent of the federal poverty level. Individuals insured under the Charter Oak Health Plan shall pay their share of payment for coverage in the plan directly to the insurer.

(d) The Commissioner of Social Services shall determine minimum requirements on the amount, duration and scope of benefits under the Charter Oak Health Plan, except that there shall be no preexisting condition exclusion. Each participating insurer shall provide an internal grievance process by which an insured may request and be provided a review of a denial of coverage under the plan.

(e) The Commissioner of Social Services may contract with the following entities for the purposes of this section: (1) A health care center subject to the provisions of chapter 698a of the general statutes; (2) a consortium of federally qualified health centers and other community-based providers of health services which are funded by the state; or (3) other consortia of providers of health care services established for the purposes of this section. Providers of comprehensive health care services as described in subdivisions (2) and (3) of this subsection shall not be subject to the provisions of chapter 698a of the general statutes. Any such provider shall be certified by the commissioner to participate in the Charter Oak Health Plan in accordance with criteria established by the commissioner, including, but not limited to, minimum reserve fund requirements.

(f) The Commissioner of Social Services shall seek proposals from entities described in subsection (e) of this section based on the cost sharing and benefits described in subsections (b) and (c) of this section. The commissioner may approve an alternative plan in order to make coverage options available to those eligible to be insured under the plan.

(g) The Commissioner of Social Services, pursuant to section 17b-10 of the general statutes, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies shall be valid until the time final regulations are adopted and may include: (1) Exceptions to the requirement that a resident be uninsured for at least six months to be eligible for the Charter Oak Health Plan; and (2) requirements for open enrollment and limitations on the ability of enrollees to change plans between such open enrollment periods.

Sec. 24. (NEW) (*Effective July 1, 2007*) Each local or regional board of education shall require each pupil enrolled in the schools under its jurisdiction to annually report whether the pupil has health insurance. The Commissioner of Social Services, or the commissioner's designee, shall provide information to each local or regional board of education on state-sponsored health insurance programs for children, including application assistance for such programs. Each local or regional board of education shall provide such information to the pupil's parent or guardian.

Sec. 25. Section 17a-317 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) **[**There is**]** Effective July 1, 2008, there shall be established a Department on Aging which shall be under the direction and supervision of the Commissioner on Aging who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, with the powers and duties prescribed in said sections. The commissioner shall be knowledgeable and experienced with respect to the conditions and needs of elderly persons and shall serve on a full-time basis.

(b) The Commissioner on Aging shall administer all laws under the jurisdiction of the Department on Aging and shall employ the most efficient and practical means for the provision of care and protection of elderly persons. The commissioner shall have the power and duty to do the following: (1) Administer, coordinate and direct the operation of the department; (2) adopt and enforce regulations, in accordance with chapter 54, as necessary to implement the purposes of the department as established by statute; (3) establish rules for the internal operation and administration of the department; (4) establish and develop programs and administer services to achieve the purposes of the department; (5) contract for facilities, services and programs to implement the purposes of the department; (6) act as advocate for necessary additional comprehensive and coordinated programs for elderly persons; (7) assist and advise all appropriate state, federal, local and area planning agencies for elderly persons in the performance of their functions and duties pursuant to federal law and regulation; (8) plan services and programs for elderly persons; (9) coordinate outreach activities by public and private agencies serving elderly persons; and (10) consult and cooperate with area and private planning agencies.

(c) The functions, powers, duties and personnel of the Division of Elderly Services of the Department of Social Services, or any subsequent division or portion of a division with similar functions, powers, personnel and duties, shall be transferred to the Department on Aging pursuant to the provisions of sections 4-38d, 4-38e and 4-39.

(d) Any order or regulation of the Department of Social Services or the Commission on Aging that is in force on **[**January 1, 2007**]** July 1, 2008, shall continue in force and effect as an order or regulation until amended, repealed or superseded pursuant to law.

Sec. 26. Section 17b-790a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The Commissioner of Social Services, within available appropriations, shall establish a food assistance program for individuals entering the United States prior to April 1, 1998, whose immigrant status meets the eligibility requirements of the federal Food Stamp Act of 1977, as amended, but who are no longer eligible for food stamps solely due to their immigrant status under Public Law 104-193. Individuals who enter the United States after April 1, 1998, must have resided in the state for six months prior to becoming eligible for the state program. The commissioner may administer such program in accordance with the provisions of the federal food stamp program, except those pertaining to the determination of immigrant status under Public Law 104-193.

**[**(b) The amount of the initial assistance provided to individuals under this section shall be determined at the commissioner's discretion, based on one of the following methodologies: (1) A calculated benefit amount for each case; (2) a basic benefit amount for all cases; or (3) a continuation of the benefit amount previously

received under the federal Food Stamp Act of 1977, as amended, prior to discontinuance. Individuals may be eligible for retroactive payments back to April 1, 1998. **]**

**[**(c) Not later than April 1, 1999, the**]** (b) The commissioner shall provide assistance to an individual under this section in an amount equal to seventy-five per cent of the amount the individual would be eligible to receive under the federal Food Stamp Act of 1977, as amended.

**[**(d)**]** (c) The commissioner shall terminate assistance under this section to any individual whose federal food stamp benefits have been restored.

**[**(e)**]** (d) The commissioner shall implement the policies and procedures necessary to carry out the provisions of this section 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 twenty days after implementation. Such policies and procedures shall be valid until the time final regulations are effective.

Sec. 27. Section 17b-239 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The rate to be paid by the state to hospitals receiving appropriations granted by the General Assembly and to freestanding chronic disease hospitals, providing services to persons aided or cared for by the state for routine services furnished to state patients, shall be based upon reasonable cost to such hospital, or the charge to the general public for ward services or the lowest charge for semiprivate services if the hospital has no ward facilities, imposed by such hospital, whichever is lowest, except to the extent, if any, that the commissioner determines that a greater amount is appropriate in the case of hospitals serving a disproportionate share of indigent patients. Such rate shall be promulgated annually by the Commissioner of Social Services. Nothing contained in this section shall authorize a payment by the state for such services to any such hospital in excess of the charges made by such hospital for comparable services to the general public. Notwithstanding the provisions of this section, for the rate period beginning July 1, 2000, rates paid to freestanding chronic disease hospitals and freestanding psychiatric hospitals shall be increased by three per cent. For the rate period beginning July 1, 2001, a freestanding chronic disease hospital or freestanding psychiatric hospital shall receive a rate that is two and one-half per cent more than the rate it received in the prior fiscal year and such rate shall remain effective until December 31, 2002. Effective January 1, 2003, a freestanding chronic disease hospital or freestanding psychiatric hospital shall receive a rate that is two per cent more than the rate it received in the prior fiscal year. Notwithstanding the provisions of this subsection, for the period commencing July 1, 2001, and ending June 30, 2003, the commissioner may pay an additional total of no more than three hundred thousand dollars annually for services provided to long-term ventilator patients. For purposes of this subsection, "long-term ventilator patient" means any patient at a freestanding chronic disease hospital on a ventilator for a total of sixty days or more in any consecutive twelve-month period. Effective **[**July 1, 2004**]** July 1, 2007, each freestanding chronic disease hospital shall receive a rate that is **[**two**]** four per cent more than the rate it received in the prior fiscal year.

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

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

(d) The state shall also pay to such hospitals for each outpatient clinic and emergency room visit a reasonable rate to be established annually by the commissioner for each hospital, such rate to be determined by the reasonable cost of such services. The emergency room visit rates in effect June 30, 1991, shall remain in effect through June 30, 1993, except those which would have been decreased effective July 1, 1991, or July 1, 1992, shall be decreased. Nothing contained herein shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public. For those outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios in effect June 30, 1991, shall be reduced effective July 1, 1991, by the most recent annual increase in the consumer price index for medical care. For those outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios computed to be effective July 1, 1994, shall be reduced by the most recent annual increase in the consumer price index for medical care. The emergency room visit rates in effect June 30, 1994, shall remain in effect through December 31, 1994. The Commissioner of Social Services shall establish a fee schedule for outpatient hospital services to be effective on and after January 1, 1995. Except with respect to the rate periods beginning July 1, 1999, and July 1, 2000, such fee schedule shall be adjusted annually beginning July 1, 1996, to reflect necessary increases in the cost of services. Notwithstanding the provisions of this subsection, the fee schedule for the rate period beginning July 1, 2000, shall be increased by ten and one-half per cent, effective June 1, 2001. Notwithstanding the provisions of this subsection, outpatient rates in effect as of June 30, 2003, shall remain in effect through June 30, 2005. Effective July 1, 2006, subject to available appropriations, the commissioner shall increase outpatient service fees for services that may include clinic, emergency room, magnetic resonance imaging, and computerized axial tomography. Not later than October 1, 2006, the commissioner shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies, identifying such fee increases and the associated cost increase estimates.

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing criteria for defining emergency and nonemergency visits to hospital emergency rooms. All nonemergency visits to hospital emergency rooms shall be paid at the hospital's outpatient clinic services rate. Nothing

contained in this subsection or the regulations adopted hereunder shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public.

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

(g) Effective June 1, 2001, the commissioner shall establish inpatient hospital rates in accordance with the method specified in regulations adopted pursuant to this section and applied for the rate period beginning October 1, 2000, except that the commissioner shall update each hospital's target amount per discharge to the actual allowable cost per discharge based upon the 1999 cost report filing multiplied by sixty-two and one-half per cent if such amount is higher than the target amount per discharge for the rate period beginning October 1, 2000, as adjusted for the ten per cent incentive identified in Section 4005 of Public Law 101-508. If a hospital's rate is increased pursuant to this subsection, the hospital shall not receive the ten per cent incentive identified in Section 4005 of Public Law 101-508. For rate periods beginning October 1, 2001, through September 30, 2006, the commissioner shall not apply an annual adjustment factor to the target amount per discharge. Effective April 1, 2005, the revised target amount per discharge for each hospital with a target amount per discharge less than three thousand seven hundred fifty dollars shall be three thousand seven hundred fifty dollars. **[**Effective October 1, 2006, subject to available appropriations, the commissioner shall establish an increased target amount per discharge of not less than four thousand dollars for each hospital with a target amount per discharge less than four thousand dollars for the rate period ending September 30, 2006, and the commissioner may apply an annual adjustment factor to the target amount per discharge for hospitals that are not increased as a result of the revised target amount per discharge. Not later than October 1, 2006, the commissioner shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies identifying the increased target amount per discharge and the associated cost increase estimates. **]** Effective October 1, 2007, the commissioner, in consultation with the Secretary of the Office of Policy and Management, shall establish, within available appropriations, an increased target amount per discharge of not less than four thousand two hundred fifty dollars for each hospital with a target amount per discharge less than four thousand two hundred fifty dollars for the rate period ending September 30, 2007, and the commissioner may apply an annual adjustment factor to the target amount per discharge for hospitals that are not increased as a result of this adjustment. Not later than October 1, 2008, the commissioner shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies identifying any increased target amount per discharge established or annual adjustment factor applied on or after October 1, 2006, and the associated cost increase estimates related to such actions.

Sec. 28. (*Effective July 1, 2007*) For the fiscal year ending June 30, 2008, the Commissioner of Social Services, in consultation with the Secretary of the Office of Policy and Management, may expend up to thirty million dollars appropriated for Hospital Hardship to provide grants to hospitals. Such grants shall be provided as necessary to avoid the substantial deterioration of a given hospital's financial condition that may adversely affect patient care and for the continued operation of the hospital when such continued operation is determined necessary by the Commissioner of Social Services, in consultation with the Commissioner of Public Health, the Commissioner of the Office of Health Care Access and the executive director of the Connecticut Health and Educational Facilities Authority. The Commissioner of Social Services in determining eligibility for such grants shall, at a minimum, consider: (1) Hospital utilization by patients eligible for state assistance programs; (2) hospital licensure and certification compliance history; and (3) reasonableness of actual and projected revenues and expenses. A hospital applying for such grant shall submit an application on such forms as may be prescribed by the Commissioner of Social Services along with a plan that describes the hospital's operating savings and nongovernmental revenue enhancements. The Commissioner of Social Services may accept or require modification to any such plan submitted by a hospital. Each hospital shall file quarterly reports to the Commissioner of Social Services pertaining to plan implementation. The Commissioner of Social Services may cease grant payments if a hospital fails to report in accordance with this section. The Commissioner of Social Services shall, in accordance with section 11-4a of the general statutes, provide written quarterly reports to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. Such quarterly reports shall identify each hospital requesting a grant, the amount of the requested grant for each hospital and the action taken by the Commissioner of Social Services.

Sec. 29. (NEW) (*Effective July 1, 2007*) (a) The Commissioner of Social Services shall, within available appropriations, establish and operate a state-funded pilot program to allow not more than fifty persons with disabilities (1) who are age eighteen to sixty-four, inclusive, (2) who are inappropriately institutionalized or at risk of inappropriate institutionalization, and (3) whose assets, if single, do not exceed the minimum community spouse protected amount pursuant to section 4022. 05 of the Department of Social Services uniform policy manual or, if married, the couple's assets do not exceed one hundred fifty per cent of said community spouse protected amount to be eligible to receive the same services that are provided under the state-funded home care program for the elderly, established pursuant to subsection (i) of section 17b-342 of the general statutes. At the discretion of the Commissioner of Social Services, such persons may also be eligible to receive services that are necessary to meet needs attributable to disabilities in order to allow such persons to avoid institutionalization.

(b) Any person participating in the pilot program whose income exceeds two hundred per cent of the federal poverty level shall contribute to the cost of care in accordance with the methodology established for recipients of medical assistance pursuant to sections 5035. 20 and 5035. 25 of the department's uniform policy manual.

(c) The annualized cost of services provided to an individual under the pilot program shall not exceed fifty per cent of the weighted average cost of care in nursing homes in the state.

(d) If the number of persons eligible for the pilot program established pursuant to this section exceeds fifty persons or if the cost of the program exceeds available appropriations, the commissioner shall establish a waiting list designed to serve applicants by order of application date.

Sec. 30. (NEW) (*Effective October 1, 2007*) As used in this section and sections 31 to 38, inclusive, of this

act:

(1) "Activities of daily living" means activities or tasks, that are essential for a person's healthful and safe existence, including, but not limited to, bathing, dressing, grooming, eating, meal preparation, shopping, housekeeping, transfers, bowel and bladder care, laundry, communication, self-administration of medication and ambulation.

(2) "Assisted living services" means nursing services and assistance with activities of daily living provided to residents living within a managed residential community having supportive services that encourage persons primarily fifty-five years of age or older to maintain a maximum level of independence.

(3) "Assisted living services agency" means an entity, licensed by the Department of Public Health pursuant to chapter 368v of the general statutes that provides, among other things, nursing services and assistance with activities of daily living to a population that is chronic and stable.

(4) "Managed residential community" means a for-profit or not-for-profit facility consisting of private residential units that provides a managed group living environment consisting of housing and services for persons who are primarily fifty-five years of age or older. "Managed residential community" does not include any state-funded congregate housing facilities.

(5) "Department" means the Department of Public Health.

(6) "Private residential unit" means a private living environment designed for use and occupancy by a resident within a managed residential community that includes a full bathroom and access to facilities and equipment for the preparation and storage of food.

(7) "Resident" means a person residing in a private residential unit of a managed residential community pursuant to the terms of a written agreement for occupancy of such unit.

Sec. 31. (NEW) (*Effective October 1, 2007*) (a) All managed residential communities operating in the state shall:

(1) Provide a written residency agreement to each resident in accordance with section 37 of this act;

(2) Afford residents the ability to access services provided by an assisted living services agency. Such services shall be provided in accordance with a service plan developed in accordance with section 36 of this act;

(3) Upon the request of a resident, arrange, in conjunction with the assisted living services agency, for the provision of ancillary medical services on behalf of a resident, including physician and dental services, pharmacy services, restorative physical therapies, podiatry services, hospice care and home health agency services, provided the ancillary medical services are not administered by employees of the managed residential community, unless the resident chooses to receive such services;

(4) Provide a formally established security program for the protection and safety of residents that is designed to protect residents from intruders;

(5) Afford residents the rights and privileges guaranteed under title 47a of the general statutes;

(6) Comply with the provisions of subsection (c) of section 19-13-D105 of the regulations of Connecticut state agencies; and

(7) Be subject to oversight and regulation by the Department of Public Health.

(b) No managed residential community shall control or manage the financial affairs or personal property of any resident.

Sec. 32. (NEW) (*Effective April 1, 2008*) The Department of Public Health shall receive and investigate any complaint alleging that a managed residential community is engaging in, or has engaged in activities, practices or omissions that would constitute a violation of sections 31 to 38, inclusive, of this act, the regulations adopted pursuant to section 38 of this act, or any other regulation applicable to managed residential communities, including the Public Health Code. The department shall include in its biennial review of a managed residential community, conducted in accordance with section 33 of this act, a review of the nature and type of any complaint received concerning the managed residential community, as well as the department's final determination made with respect to such complaint.

Sec. 33. (NEW) (*Effective April 1, 2008*) (a) The Department of Public Health shall conduct biennial reviews of all managed residential communities. Biennial reviews conducted by the department in accordance with the provisions of this section, shall be in addition to, and not in lieu of, any inspections of such communities by state or local officials to ensure compliance with the Public Health Code, the State Building Code, the State Fire Code or any local zoning ordinance. In addition to the biennial review, the department may conduct at any time a review of a managed residential community when the department has probable cause to believe that a managed residential community is operating in violation of the provisions of sections 31 to 38, inclusive, of this act, the regulations adopted pursuant to section 38 of this act, or any other regulation applicable to managed residential communities, including the Public Health Code. The purpose of any biennial or investigatory review shall be to ensure that a managed residential community is operating in compliance with the provisions of sections 31 to 38, inclusive, of this act, the regulations adopted pursuant to section 38 of this act or any other regulation applicable to managed residential communities, including the Public Health Code. A biennial review shall include: (1) An inspection of all common areas of the managed residential community, including any common kitchen or meal preparation area located within the community; and (2) an inspection of private residential units, but only if prior to such inspection the residents occupying such units provide written consent to the inspection. In the course of conducting a biennial or investigatory review, an inspector may interview any manager, staff member or resident of the managed residential community. Interviews with any resident shall require the consent of the resident, be confidential and shall be conducted privately.

(b) The department shall establish an administrative procedure for the preparation, completion and transmittal of written reports prepared as part of any review undertaken pursuant to this section or section 32 of this act. If after undertaking any such review the department determines that a managed residential community is in violation of the provisions of sections 31 to 38, inclusive, of this act, the department shall provide written notice of its determination of an alleged violation to the managed residential community. Such written notice shall advise the managed residential community of its right to request an administrative hearing in accordance with sections 4-176e to 4-181a, inclusive, of the general statutes to contest such determination. A managed residential community shall request such hearing, in writing, not later than fifteen days after the date of receipt of the notice of an alleged violation from the department. The department may issue such remedial orders as deemed necessary by the department to ensure compliance

with the provisions of sections 31 to 38, inclusive, of this act. Remedial orders available to the department shall include, but not be limited to, the imposition of a civil penalty against a managed residential community in an amount not to exceed five thousand dollars per violation. The department shall stay the imposition of any remedial order or civil penalty pending the outcome of an administrative hearing. The department shall maintain and make available for public inspection all completed reports, responses from managed residential communities and any remedial orders issued in accordance with the provisions of this section.

(c) Upon the failure of a managed residential community to comply with a remedial order issued by the department, the Attorney General, at the request of the Commissioner of Public Health, may bring an action in the superior court for the judicial district of Hartford to enforce such order. All actions brought by the Attorney General pursuant to the provisions of this section shall have precedence in the order of trial as provided in section 52-191 of the general statutes. The court may issue such orders as are necessary to obtain compliance with the order of the department.

Sec. 34. (NEW) (*Effective October 1, 2007*) (a) A managed residential community shall have a written bill of rights that prescribes the rights afforded to each resident. A designated staff person from the managed residential community shall provide and explain the bill of rights to the resident at the time that such resident enters into a residency agreement at the managed residential community. The bill of rights shall include, but not be limited to, that each resident has the right to:

(1) Live in a clean, safe and habitable private residential unit;

(2) Be treated with consideration, respect and due recognition of personal dignity, individuality and the need for privacy;

(3) Privacy within a private residential unit, subject to rules of the managed residential community reasonably designed to promote the health, safety and welfare of the resident;

(4) Retain and use one's own personal property within a private residential unit so as to maintain individuality and personal dignity provided the use of personal property does not infringe on the rights of other residents or threaten the health, safety and welfare of other residents;

(5) Private communications, including receiving and sending unopened correspondence, telephone access and visiting with persons of one's choice;

(6) Freedom to participate in and benefit from community services and activities so as to achieve the highest possible level of independence, autonomy and interaction within the community;

(7) Directly engage or contract with licensed health care professionals and providers of one's choice to obtain necessary health care services in one's private residential unit, or such other space in the managed residential community as may be made available to residents for such purposes;

(8) Manage one's own financial affairs;

(9) Exercise civil and religious liberties;

(10) Present grievances and recommend changes in policies, procedures and services to the manager or

staff of the managed residential community, government officials or any other person without restraint, interference, coercion, discrimination or reprisal from the managed residential community, including access to representatives of the department or the Office of the Long-Term Care Ombudsman;

(11) Upon request, obtain from the managed residential community the name of the service coordinator or any other persons responsible for resident care or the coordination of resident care;

(12) Confidential treatment of all records and communications to the extent required by state and federal law;

(13) Have all reasonable requests responded to promptly and adequately within the capacity of the managed residential community and with due consideration given to the rights of other residents;

(14) Be fully advised of the relationship that the managed residential community has with any assisted living services agency, health care facility or educational institution to the extent that such relationship relates to resident medical care or treatment and to receive an explanation about the relationship;

(15) Receive a copy of any rules or regulations of the managed residential community;

(16) Privacy when receiving medical treatment or other services within the capacity of the managed residential community;

(17) Refuse care and treatment and participate in the planning for the care and services the resident needs or receives, provided the refusal of care and treatment may preclude the resident from being able to continue to reside in the managed residential community; and

(18) All rights and privileges afforded to tenants under title 47a of the general statutes.

(b) A managed residential community shall post in a prominent place in the managed residential community the resident's bill of rights, including those rights set forth in subsection (a) of this section. The posting of the resident's bill of rights shall include contact information for the Department of Public Health and the Office of the State Long-Term Care Ombudsman, including the names, addresses and telephone numbers of persons within such agencies who handle questions, comments or complaints concerning managed residential community.

Sec. 35. (NEW) (*Effective October 1, 2007*) No managed residential community shall enter into a written residency agreement with any individual who requires twenty-four hour skilled nursing care, unless such individual establishes to the satisfaction of both the managed residential community and the assisted living services agency that the individual has, or has arranged for, such twenty-four hour care and maintains such care as a condition of residency if an assisted living services agency determines that such care is necessary.

Sec. 36. (NEW) (*Effective October 1, 2007*) (a) An assisted living services agency shall develop and maintain an individualized service plan for any resident of a managed residential community that receives assisted living services. Such agency shall develop the individualized service plan after consultation with the resident and following an assessment of the resident by a registered nurse. The individualized service plan shall set forth in lay terms the needs of the resident for assisted living services, the providers or intended providers of needed services, the scope, type and frequency of such services, an itemized cost of such services and any other information that Department of Public Health may require. The individualized

service plan and any periodic revisions thereto shall be confidential, in writing, signed by the resident, or the resident's legal representative, and a representative of the assisted living services agency and available for inspection by the resident and the department.

(b) An assisted living services agency shall maintain written policies and procedures for the initial evaluation and regular, periodic reassessment of the functional and health status and service requirements of each resident who requires assisted living services.

Sec. 37. (NEW) (*Effective October 1, 2007*) A managed residential community shall enter into a written residency agreement with each resident that clearly sets forth the rights and responsibilities of the resident and the managed residential community, including the duties set forth in section 19a-562 of the general statutes. The residency agreement shall be set forth in plain language and printed in not less than fourteen-point type. The residency agreement shall be signed by the managed residential community's authorized agent and by the resident, or the resident's legal representative, prior to the resident taking possession of a private residential unit and shall include, at a minimum:

(1) An itemization of assisted living services, transportation services, recreation services and any other services and goods, lodging and meals to be provided on behalf of the resident by the managed residential community;

(2) A full and fair disclosure of all charges, fees, expenses and costs to be borne by the resident;

(3) A schedule of payments and disclosure of all late fees or potential penalties;

(4) The grievance procedure with respect to enforcement of the terms of the residency agreement;

(5) The managed residential community's covenant to comply with all municipal, state and federal laws and regulations regarding consumer protection and protection from financial exploitation;

(6) The managed residential community's covenant to afford residents all rights and privileges afforded under title 47a of the general statutes;

(7) The conditions under which the agreement can be terminated by either party;

(8) Full disclosure of the rights and responsibilities of the resident and the managed residential community in situations involving serious deterioration in the health of the resident, hospitalization of the resident or death of the resident, including a provision that specifies that in the event that a resident of the community dies, the estate or family of such resident shall only be responsible for further payment to the community for a period of time not to exceed fifteen days following the date of death of such resident as long as the private residential unit formerly occupied by the resident has been vacated; and

(9) Any adopted rules of the managed residential community reasonably designed to promote the health, safety and welfare of residents.

Sec. 38. (NEW) (*Effective October 1, 2007*) (a) A managed residential community shall meet the requirements of all applicable federal and state laws and regulations, including, but not limited to, the Public Health Code, State Building Code and the State Fire Safety Code, and federal and state laws and regulations governing handicapped accessibility.

(b) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54 of the general statutes, to carry out the provisions of sections 30 to 38, inclusive, of this act.

Sec. 39. Subsection (e) of section 8-206e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(e) The Commissioner of Economic and Community Development shall establish criteria for making disbursements under the provisions of subsection (d) of this section which shall include, but are not limited to: (1) Size of the United States Department of Housing and Urban Development, Section 202 and Section 236 elderly housing developments; (2) geographic locations in which the developments are located; (3) anticipated social and health value to the resident population; (4) each Section 202 and Section 236 housing development's designation as a managed residential community, as defined in section **[**19-13-D105 of the regulations of Connecticut state agencies**]** 30 of this act; and (5) the potential community development benefit to the relevant municipality. Such criteria may specify who may apply for grants, the geographic locations determined to be eligible for grants, and the eligible costs for which a grant may be made. For the purposes of the demonstration program, multiple properties with overlapping board membership or ownership may be considered a single applicant.

Sec. 40. Subsection (a) of section 17b-365 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) The Commissioner of Social Services may, within available appropriations, establish and operate a pilot program to allow individuals to receive assisted living services, provided by an assisted living services agency licensed by the Department of Public Health in accordance with chapter 368v. In order to be eligible for the program, an individual shall: (1) Reside in a managed residential community, as defined **[**by the regulations of the Department of Public Health**]** in section 30 of this act; (2) be ineligible to receive assisted living services under any other assisted living pilot program established by the General Assembly; and (3) be eligible for services under the Medicaid waiver portion of the Connecticut home-care program for the elderly established under section 17b-342. The total number of individuals enrolled in said pilot program, when combined with the total number of individuals enrolled in the pilot program established pursuant to section 17b-366, as amended by this act, shall not exceed seventy-five individuals. The Commissioner of Social Services shall operate said pilot program in accordance with the Medicaid rules established pursuant to 42 USC 1396p(c), as from time to time amended.

Sec. 41. Subsection (a) of section 17b-366 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) The Commissioner of Social Services may, within available appropriations, establish and operate a pilot program to allow individuals to receive assisted living services, provided by an assisted living services agency licensed by the Department of Public Health, in accordance with chapter 368v. In order to be eligible for the pilot program, an individual shall: (1) Reside in a managed residential community, as defined **[**by the regulations of the Department of Public Health**]** in section 30 of this act; (2) be ineligible to receive assisted living services under any other assisted living pilot program established by the General Assembly; and (3) be eligible for services under the state-funded portion of the Connecticut home-care program for the elderly established under section 17b-342. The total number of individuals enrolled in said pilot program, when combined with the total number of individuals enrolled in the pilot program established pursuant to section 17b-365, shall not exceed seventy-five individuals. The Commissioner of

Social Services shall operate said pilot program in accordance with the Medicaid rules established pursuant to 42 USC 1396p(c), as from time to time amended.

Sec. 42. Subsections (a) and (b) of section 17b-417 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) The Office of the Long-Term Care Ombudsman shall develop and implement a pilot program, within available appropriations, to provide assistance and education to residents of managed residential communities, as defined in section **[**19-13-D105 of the regulations of Connecticut state agencies**]** 30 of this act, who receive assisted living services from an assisted living services agency licensed by the Department of Public Health in accordance with chapter 368v. The assistance and education provided under such pilot program shall include, but not be limited to: (1) Assistance and education for residents who are temporarily discharged to a hospital or long-term care facility and return to a managed residential community; (2) assistance and education for residents with issues relating to an admissions contract for a managed residential community; and (3) assistance and education for residents to assure adequate and appropriate services are being provided including, but not limited to, adequate and appropriate services for individuals with cognitive impairments.

(b) The Office of the Long-Term Care Ombudsman shall develop and implement the pilot program in cooperation with managed residential communities and assisted living services agencies. Priority of assistance and education shall be given to residents of managed residential communities who participate in subsidized assisted living programs authorized under sections 8-206e, as amended by this act, 17b-347e, 17b-365, as amended by this act, 17b-366, as amended by this act, and 19a-6c. To the extent allowed by available appropriations, the Long-Term Care Ombudsman shall also provide assistance and education under the pilot program to residents in managed residential communities who do not participate in said subsidized assisted living programs.

Sec. 43. Section 19a-6c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) The Commissioner of Public Health shall allow state-funded congregate housing facilities to provide assisted living services through licensed assisted living services agencies, as defined in section 19a-490.

(b) In order to facilitate the development of assisted living services in state-funded congregate housing facilities, the Commissioner of Public Health may waive any provision of the regulations for assisted living services agencies, as defined in section 19a-490, which provide services in state-funded congregate housing facilities. No waiver of such regulations shall be made if the commissioner determines that the waiver would: (1) Endanger the life, safety or health of any resident receiving assisted living services in a state-funded congregate housing facility; (2) impact the quality or provision of services provided to a resident in a state-funded congregate housing facility; (3) revise or eliminate the requirements for an assisted living services agency's quality assurance program; (4) revise or eliminate the requirements for an assisted living services agency's grievance and appeals process; or (5) revise or eliminate the assisted living services agency's requirements relative to a client's bill of rights and responsibilities. The commissioner, upon the granting of a waiver of any provision of such regulations, may impose conditions which assure the health, safety and welfare of residents receiving assisted living services in a state-funded congregate housing facility. The commissioner may revoke such a waiver upon a finding (A) that the health, safety or welfare of any such resident is jeopardized, or (B) that such facility has failed to comply with such conditions as the

commissioner may impose pursuant to this subsection.

(c) The provisions of sections 30 to 38, inclusive, of this act shall not apply to any state-funded congregate housing facility.

**[**(c)**]** (d) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section. Said commissioner may implement the waiver of provisions as specified in subsection (b) of this section until January 1, 2002, while in the process of adopting criteria for the waiver process in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal within twenty days after implementation.

Sec. 44. Section 17b-295 of the general statutes, as amended by section 7 of public act 07-185, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(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 B, to the extent permitted by federal law, and 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 gross annual income. The commissioner may impose a premium requirement on families whose income exceeds two hundred thirty-five per cent of the federal poverty level as a component of the family's cost-sharing responsibility, provided: (A) The family's annual combined premiums and copayments do not exceed the maximum annual aggregate cost-sharing requirement, and (B) premium requirements **[**for a family with income that exceeds two hundred thirty-five per cent of the federal poverty level but does not exceed three hundred per cent of the federal poverty level**]** shall not exceed the sum of thirty dollars per month per child, with a maximum premium of fifty dollars per month per family. **[**, and (C) premium requirements for a family with income that exceeds three hundred per cent of the federal poverty level but does not exceed four hundred per cent of the federal poverty level who does not have any access to employer- sponsored health insurance coverage shall not exceed the sum of fifty dollars per child, with a maximum premium of seventy-five dollars per month. **]** The commissioner shall not impose a premium requirement on families whose income exceeds one hundred eighty-five per cent of the federal poverty level but does not exceed two hundred thirty-five per cent of the federal poverty level; and

(2) The commissioner shall require each managed care plan to 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 B.

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

Sec. 45. Section 27-118 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

When any veteran dies, not having sufficient estate to pay the necessary expenses of **[**his**]** the veteran's last

sickness and burial, as determined by the commissioner after consultation with the probate court for the district in which the veteran resided, the state shall pay the sum of [one hundred fifty] one thousand eight hundred dollars toward such funeral expenses, and the burial shall be in some cemetery or plot not used exclusively for the burial of the pauper dead, and the same amount shall be paid if the body is cremated, but no amount shall be paid for the expenses for burial or cremation unless claim therefor is made within one year from the date of death, [; provided,] except that in cases of death occurring abroad, such claim may be made within one year after the remains of such veteran have been interred in this country. No provision of this section shall prevent the payment of the sum above named for the burial of any person, otherwise entitled to the same, on account of such burial being made outside the limits of this state. Upon satisfactory proof by the person who has paid or provided for the funeral or burial expense to the commissioner of the identity of the deceased, the time and place of [his] the deceased's death and burial and the approval thereof by the commissioner, said sum of [one hundred fifty] one thousand eight hundred dollars shall be paid by the Comptroller to the person who has paid the funeral or burial expense or, upon assignment by such person, to the funeral director who has provided the funeral. Whenever the Comptroller has lawfully paid any sum toward the expenses of the burial of any deceased veteran and it afterwards appears that the deceased left any estate, the Comptroller may present a claim in behalf of the state against the estate of such deceased veteran for the sum so paid, and the claim shall be a preferred claim against such estate and shall be paid to the Treasurer of the state. The commissioner, upon the advice of the Attorney General, may make application for administration upon the estate of any such deceased veteran if no other person authorized by law makes such application within sixty days after such payment has been made by the Comptroller.

Sec. 46. (NEW) (*Effective July 1, 2008*) (a) The Department of Veterans' Affairs may establish and maintain, within available resources, a registry of data on members of the armed forces, as defined in section 27-103 of the general statutes, who have completed a period of active service. The department may develop surveys for members or their health care providers to voluntarily provide data during or after such active service. The surveys and data shall be collected and maintained in accordance with the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (P. L. 104-191) (HIPAA), as amended from time to time, or regulations adopted thereunder.

(b) The surveys and data shall be related to members' illnesses and potential correlations to environmental hazards, including, but not limited to, vaccinations, infections, chemicals, pesticides, microwaves, depleted uranium, pyridostigmine bromide, and chemical and biological warfare agents. Within available resources, the department may use the data in the registry to (1) study the potential short-term and long-term effects of such hazards on such members, and (2) inform, customize and coordinate the provision of health care services to such members.

(c) No individually identifiable health information may be released by the department without the consent of the member to whom the information pertains in accordance with the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (P. L. 104-191) (HIPAA), as amended from time to time, or regulations adopted thereunder.

(d) The surveys and data in the registry shall be subject to disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes, except that no individually identifiable health information may be disclosed.

Sec. 47. Section 19a-111a of the general statutes is repealed and the following is substituted in lieu thereof

(*Effective October 1, 2007*):

(a) The **[**Commissioner**]** Department of Public Health shall be the lead state agency for lead poisoning prevention in this state. The Commissioner of Public Health shall (1) identify the state and local agencies in this state with responsibilities related to lead poisoning prevention, and (2) schedule a meeting of such state agencies and representative local agencies at least once annually in order to coordinate lead poisoning prevention efforts in this state.

(b) The commissioner shall establish a lead poisoning prevention program **[**. Such program shall**]** to provide screening, diagnosis, consultation, inspection and treatment services, including, but not limited to, the prevention and elimination of lead poisoning through research, abatement, education and epidemiological and clinical activities. Such program shall include, but need not be limited to, the screening services provided pursuant to section 48 of this act.

**[**(b)**]** (c) Within available appropriations, the **[**Commissioner of Public Health**]** commissioner may contract with individuals, groups or agencies for the provision of necessary services and enter into assistance agreements with municipalities, cities, boroughs or district departments of health or special service districts for the development and implementation of comprehensive lead poisoning prevention programs consistent with the provisions of sections 19a-110 to 19a-111c, inclusive.

Sec. 48. (NEW) (*Effective January 1, 2009*) (a) Each primary care provider giving pediatric care in this state, excluding a hospital emergency department and its staff: (1) Shall conduct lead screening at least annually for each child nine to thirty-five months of age, inclusive, in accordance with the Childhood Lead Poisoning Prevention Screening Advisory Committee Recommendations for Childhood Lead Screening in Connecticut; (2) shall conduct lead screening for any child thirty-six to seventy-two months of age, inclusive, who has not been previously screened or for any child under seventy-two months of age, if clinically indicated as determined by the primary care provider in accordance with the Childhood Lead Poisoning Prevention Screening Advisory Committee Recommendations for Childhood Lead Screening in Connecticut; (3) shall conduct a medical risk assessment at least annually for each child thirty-six to seventy-one months of age, inclusive, in accordance with the Childhood Lead Poisoning Prevention Screening Advisory Committee Recommendations for Childhood Lead Screening in Connecticut; (4) may conduct a medical risk assessment at any time for any child thirty-six months of age or younger who is determined by the primary care provider to be in need of such risk assessment in accordance with the Childhood Lead Poisoning Prevention Screening Advisory Committee Recommendations for Childhood Lead Screening in Connecticut.

(b) The requirements of this section do not apply to any child whose parents or guardians object to blood testing as being in conflict with their religious tenets and practice.

Sec. 49. Subsection (a) of section 19a-110 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) **[**Each institution licensed under the provisions of sections 19a-490 to 19a-503, inclusive, and each private clinical laboratory licensed under section 19a-30 shall, within**]** Not later than forty-eight hours **[**of receipt of knowledge thereof,**]** after receiving or completing a report of a person found to have a level of lead in the blood equal to or greater than ten micrograms per deciliter of blood or any other abnormal body burden of lead, each institution licensed under sections 19a-490 to 19a-503, inclusive, as amended, and

each clinical laboratory licensed under section 19a-30 shall report to (1) the Commissioner of Public Health, and to the director of health of the town, city or borough in which the person resides: **[**(1)**]** (A) The name, full residence address, date of birth, gender, race and ethnicity of each person found to have a level of lead in the blood equal to or greater than ten micrograms per deciliter of blood or any other abnormal body burden of lead; **[**(2)**]** (B) the name, address and telephone number of the health care provider who ordered the test; **[**(3)**]** (C) the sample collection date, analysis date, type and blood lead analysis result; and **[**(4)**]** (D) such other information as the commissioner may require, and (2) the health care provider who ordered the test, the results of the test. With respect to a child under three years of age, not later than seventy-two hours after the provider receives such results, the provider shall make reasonable efforts to notify the parent or guardian of the child of the blood lead analysis results. Any institution or laboratory making an accurate report in good faith shall not be liable for the act of disclosing said report to the commissioner or to the director of health. The commissioner, after consultation with the Chief Information Officer of the Department of Information Technology, shall determine the method and format of transmission of data contained in said report.

Sec. 50. Subsection (d) of section 19a-110 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2009*):

(d) The director of health of the town, city or borough shall provide or cause to be provided, to the parent or guardian of a child reported, pursuant to subsection (a) of this section, with information describing the dangers of lead poisoning, precautions to reduce the risk of lead poisoning, information about potential eligibility for services for children from birth to three years of age pursuant to sections 17a-248 to 17a-248g, inclusive, and laws and regulations concerning lead abatement. Said information shall be developed by the Department of Public Health and provided to each local and district director of health. With respect to the child reported, the director shall conduct an on-site inspection to identify the source of the lead causing a confirmed venous blood lead level equal to or greater than fifteen micrograms per deciliter but less than twenty micrograms per deciliter in two tests taken at least three months apart and order remediation of such sources by the appropriate persons responsible for the conditions at such source. On and after January 1, 2012, if one per cent or more of children in this state under the age of six report blood lead levels equal to or greater than ten micrograms per deciliter, the director shall conduct such on-site inspection and order such remediation for any child having a confirmed venous blood lead level equal to or greater than ten micrograms per deciliter in two tests taken at least three months apart.

Sec. 51. (NEW) (*Effective January 1, 2009*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2009, shall provide coverage for blood lead screening and risk assessments ordered by a primary care provider pursuant to section 48 of this act.

Sec. 52. Subsection (b) of section 38a-535 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2009*):

(b) **[**Every**]** Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed on or after October 1, 1989, or continued as defined in section 38a-531, on or after October 1, 1990, shall provide benefits for preventive pediatric care for any child covered by the policy or contract at approximately the following age intervals: Every two months from birth to six months of age, every three months from nine to eighteen

months of age and annually from two through six years of age. Any such policy may provide that services rendered during a periodic review shall be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit. On and after January 1, 2009, each such policy shall also provide coverage for blood lead screening and risk assessments ordered by a primary care provider pursuant to section 48 of this act. Such benefits shall be subject to any policy provisions which apply to other services covered by such policy.

Sec. 53. (NEW) (*Effective October 1, 2007*) Not later than January 1, 2008, the Commissioner of Public Health shall review the data collected by the Department of Public Health regarding lead poisoning to determine if the data is recorded in a format that is compatible with the information reported by institutions and laboratories pursuant to section 19a-110 of the general statutes, as amended by this act. If the commissioner finds that such data should be reported in a different manner, the commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, to establish the manner for reporting such data.

Sec. 54. Section 19a-111c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) The owner of any dwelling in which the paint, plaster or other **[**materials**]** material is found to contain toxic levels of lead and in which children under the age of six reside, shall abate, remediate or manage such dangerous materials consistent with regulations adopted pursuant to this section. The Commissioner of Public Health shall adopt regulations, in accordance with **[**the provisions of**]** chapter 54, **[**establishing removal and**]** to establish requirements and procedures for testing, remediation, abatement **[**requirements and procedures for**]** and management of materials containing toxic levels of lead. For the purposes of this section, "remediation" means the use of interim controls, including, but not limited to, paint stabilization, spot point repair, dust control, specialized cleaning and covering of soil with mulch.

(b) The commissioner shall authorize the use of any liquid, cementitious or flexible lead encapsulant product which complies with an appropriate standard for such products developed by the American Society for Testing and Materials or similar testing organization acceptable to the commissioner for the abatement **[**of toxic levels of lead, unless the commissioner disapproves the use of any such product**]** and remediation of lead hazards. The commissioner shall maintain a list of all such approved lead encapsulant products that may be used in this state for the abatement **[**of toxic levels of lead**]** and remediation of lead hazards.

(c) (1) The Commissioner of Public Health may adopt regulations, in accordance with chapter 54, to regulate paint removal from the exterior of any building or structure where the paint removal project may present a health hazard to neighboring premises. The regulations may establish: (A) Definitions, (B) applicability and exemption criteria, (C) procedures for submission of notifications, (D) appropriate work practices, and (E) penalties for noncompliance.

(2) The Commissioner of Public Health may adopt regulations, in accordance with chapter 54, to regulate the standards and procedures for testing, remediation, as defined in this section, abatement and management of materials containing toxic levels of lead in any premises.

Sec. 55. Section 19a-206 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) Town, city and borough directors of health or their authorized agents shall, within their respective jurisdictions, examine all nuisances and sources of filth injurious to the public health, cause such nuisances to be abated or remediated and cause to be removed all filth which in their judgment may endanger the health of the inhabitants. Any owner or occupant of any property who maintains such property, whether real or personal, or any part thereof, in a manner which violates the provisions of the Public Health Code enacted pursuant to the authority of sections 19a-36 and 19a-37 shall be deemed to be maintaining a nuisance or source of filth injurious to the public health. Any local director of health or his authorized agent or a sanitarian authorized by such director may enter all places within his jurisdiction where there is just cause to suspect any nuisance or source of filth exists, and abate or remediate or cause to be abated or remediated such nuisance and remove or cause to be removed such filth.

(b) When any such nuisance or source of filth is found on private property, such director of health shall order the owner or occupant of such property, or both, to remove, **[**or**]** abate or remediate the same within such time as the director directs. If such order is not complied with **[**,**]** within the time fixed by such director: (1) Such director, or any official of such town, city or borough authorized to institute actions on behalf of such town, city or borough, may institute and maintain a civil action for injunctive relief in any court of competent jurisdiction to require the abatement or remediation of such nuisance, the removal of such filth and the restraining and prohibiting of acts which caused such nuisance or filth, and such court shall have power to grant such injunctive relief upon notice and hearing; (2) (A) the owner or occupant of such property, or both, shall be subject to a civil penalty of two hundred fifty dollars per day for each day such nuisance is maintained or such filth is allowed to remain after the time fixed by the director in his order has expired, except that the owner or occupant of such property or any part thereof on which a public eating place is conducted shall not be subject to the provisions of this subdivision, but shall be subject to the provisions of subdivision (3) **[**. Such**]** of this subsection, and (B) such civil penalty may be collected in a civil proceeding by the director of health or any official of such town, city or borough authorized to institute civil actions and shall be payable to the treasurer of such city, town or borough; **[**,**]** and (3) the owner or occupant of such property, or both, shall be subject to the provisions of sections 19a-36, 19a-220 and 19a-230.

(c) If the director institutes an action for injunctive relief seeking the abatement or remediation of a nuisance or the removal of filth, the maintenance of which is of so serious a nature as to constitute an immediate hazard to the health of persons other than the persons maintaining such nuisance or filth, he may, upon a verified complaint stating the facts which show such immediate hazard, apply for an ex parte injunction requiring the abatement or remediation of such nuisance or the removal of such filth and restraining and prohibiting the acts which caused such nuisance or filth to occur, and for a hearing on an order to show cause why such ex parte injunction should not be continued pending final determination on the merits of such action. If the court finds that an immediate hazard to the health of persons other than those persons maintaining such nuisance or source of filth exists, such ex parte injunction shall be issued, provided a hearing on its continuance pending final judgment is ordered held within seven days thereafter and provided further that any persons so enjoined may make a written request to the court or judge issuing such injunction for a hearing to vacate such injunction, in which event such hearing shall be held within three days after such request is filed.

(d) In each town, except in a town having a city or borough within its limits, the town director of health shall have and exercise all the power for preserving the public health and preventing the spread of diseases; and, in any town within which there exists a city or borough, the limits of which are not coterminous with

the limits of such town, such town director of health shall exercise the powers and duties of his office only in such part of such town as is outside the limits of such city or borough, except that when such city or borough has not appointed a director of health, the town director of health shall, for the purposes of this section, exercise the powers and duties of his office throughout the town, including such city or borough, until such city or borough appoints a director of health.

(e) When such nuisance is abated or remediated or the source of filth is removed from private property, such abatement, **[**or**]** remediation or removal shall be at the expense of the owner or, where applicable, the occupant of such property, or both, and damages and costs for such abatement, remediation or removal may be recovered against **[**them**]** the owner or, where applicable, the occupant, or both, by the town, city or borough in a civil action as provided in subsection (b) of this section or in a separate civil action brought by the director of health or any official of such city, town or borough authorized to institute civil actions.

Sec. 56. Section 47a-52 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) As used in this section, "rented dwelling" means any structure or portion thereof which is rented, leased, or hired out to be occupied as the home or residence of one or two families and any mobile manufactured home in a mobile manufactured home park which, although owned by its resident, sits upon a space or lot which is rented, leased or hired out, but shall not include a tenement house as defined in section 19a-355 or in section 47a-1.

(b) "Department of health" means the health authority of each city, borough or town, by whatever name such health authority may be known.

(c) When any defect in the plumbing, sewerage, water supply, drainage, lighting, ventilation, or sanitary condition of a rented dwelling, or of the premises on which it is situated, in the opinion of the department of health of the municipality **[**wherein**]** where such dwelling is located, constitutes a danger to life or health, the department may order the responsible party to correct the same in such manner as it specifies. If the order is not complied with within the time limit set by the department, the person in charge of the department may institute a civil action for injunctive relief, in accordance with chapter 916, to require the abatement of such danger.

(d) Paint on the exposed surfaces of the interior of a rented dwelling shall not be cracked, chipped, blistered, flaking, loose or peeling so as to constitute a health hazard. Testing, remediation, abatement and management of lead-based paint at a rented dwelling or its premises shall be as defined in, and in accordance with, the regulations, if any, adopted pursuant to section 19a-111c, as amended by this act.

**[**(d)**]** (e) When the department of health certifies that any such rented dwelling or premises are unfit for human habitation, by reason of defects which may cause sickness or endanger the health of the occupants, the department may issue an order requiring the rented dwelling, premises or any portion thereof to be vacated within not less than twenty-four hours or more than ten days.

**[**(e)**]** (f) Any person who violates or assists in violating, or fails to comply with, any provision of this section or any legal order of a department of health made under any such provision shall be fined not more than two hundred dollars or imprisoned not more than sixty days or both.

**[**(f)**]** (g) Any person aggrieved by an order issued under this section may appeal, pursuant to section 19a-229, to the Commissioner of Public Health.

Sec. 57. Section 47a-54f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) In each tenement, lodging or boarding house the walls of any court, shaft, hall or room shall be whitewashed or painted a light color whenever, in the opinion of the board of health or enforcing agency, such whitewashing or painting is needed for the better lighting of any room, hall or water closet compartment.

(b) Paint on the **[**accessible**]** exposed surfaces of the interior of a tenement house shall not be cracked, chipped, blistered, flaking, loose, or peeling so as to constitute a health hazard. Testing, remediation, abatement and management of lead-based paint at a tenement house or its premises shall be as defined in, and in accordance with, the regulations, if any, adopted pursuant to section 19a-111c, as amended by this act.

Sec. 58. (NEW) (*Effective October 1, 2007*) (a) On or before January 1, 2009, and annually thereafter, the Commissioner of Public Health shall report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the status of lead poisoning prevention efforts in the state. Such report shall include, but not be limited to, (1) the number of children screened for lead poisoning during the preceding calendar year, (2) the number of children diagnosed with elevated blood levels during the preceding calendar year, and (3) the amount of testing, remediation, abatement and management of materials containing toxic levels of lead in all premises during the preceding calendar year.

(b) On or before January 1, 2011, the Commissioner of Public Health shall (1) evaluate the lead screening and risk assessment conducted pursuant to section 48 of this act and section 19a-110 of the general statutes, as amended by section 50 of this act, and (2) report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the effectiveness of such screening and assessment, including a recommendation as to whether such screening and assessment should be continued as specified in said section 48 and said section 19a-110.

Sec. 59. (NEW) (*Effective July 1, 2007*) The Department of Public Health shall, within available appropriations, establish and administer a program of financial assistance to local health departments for expenses incurred in complying with applicable provisions of sections 19a-110, 19a-111a, 19a-206, 47a-52 and 47a-54f of the general statutes, as amended by this act. The Commissioner of Public Health may adopt, in accordance with chapter 54 of the general statutes, such regulations as the commissioner deems necessary to carry out the purposes of this section.

Sec. 60. (NEW) (*Effective October 1, 2007*) All standards adopted by the federal Occupational Safety and Health Administration, including, but not limited to, standards listed in 29 CFR 1910. 1025 and 1926. 62, as adopted pursuant to chapter 571 of the general statutes, or 29 USC 651 et seq. , as from time to time amended, as appropriate, and only as those standards apply to employers and employees, shall apply to the provisions of sections 19a-111c, 19a-206, 47a-52 and 47a-54f of the general statutes, as amended by this act.

Sec. 61. Section 19a-202 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

Upon application to the Department of Public Health any municipal health department shall annually receive from the state an amount equal to **[**ninety-four**]** one dollar and eighteen cents per capita, provided such municipality (1) employs a full-time director of health, except that if a vacancy exists in the office of director of health or the office is filled by an acting director for more than three months, such municipality shall not be eligible for funding unless the Commissioner of Public Health waives this requirement; (2) submits a public health program and budget which is approved by the Commissioner of Public Health; and (3) appropriates not less than one dollar per capita, from the annual tax receipts, for health department services. Such municipal department of health **[**is authorized to**]** may use additional funds, which the Department of Public Health may secure from federal agencies or any other source and which it may allot to such municipal department of health. The money so received shall be disbursed upon warrants approved by the chief executive officer of such municipality. The Comptroller shall annually in July and upon a voucher of the Commissioner of Public Health, draw the Comptroller's order on the State Treasurer in favor of such municipal department of health for the amount due in accordance with the provisions of this section and under rules prescribed by the commissioner. Any moneys remaining unexpended at the end of a fiscal year shall be included in the budget of such municipal department of health for the ensuing year. This aid shall be rendered from appropriations made from time to time by the General Assembly to the Department of Public Health for this purpose.

Sec. 62. Section 19a-245 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

Upon application to the Department of Public Health, each health district shall annually receive from the state an amount equal to **[**one dollar and ninety-four**]** two dollars and forty-three cents per capita for each town, city and borough of such district which has a population of five thousand or less, and **[**one dollar and sixty-six**]** two dollars and eight cents per capita for each town, city and borough of such district which has a population of more than five thousand, provided (1) the Commissioner of Public Health approves the public health program and budget of such health district, and (2) the towns, cities and boroughs of such district appropriate for the maintenance of the health district not less than one dollar per capita from the annual tax receipts. Such district departments of health are authorized to use additional funds, which the Department of Public Health may secure from federal agencies or any other source and which it may allot to such district departments of health. The district treasurer shall disburse the money so received upon warrants approved by a majority of the board and signed by its chairman and secretary. The Comptroller shall quarterly, in July, October, January and April, upon such application and upon the voucher of the Commissioner of Public Health, draw the Comptroller's order on the State Treasurer in favor of such district department of health for the amount due in accordance with the provisions of this section and under rules prescribed by the commissioner. Any moneys remaining unexpended at the end of a fiscal year shall be included in the budget of the district for the ensuing year. This aid shall be rendered from appropriations made from time to time by the General Assembly to the Department of Public Health for this purpose.

Sec. 63. Section 17b-359 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) For purposes of this section, the terms "mentally ill" and "specialized services" shall be as defined in Subsections (e)(7)(G)(i) and (iii) of Section 1919 of the Social Security Act and federal regulations.

(b) No nursing facility shall admit any person, irrespective of source of payment, who has not undergone a preadmission screening process by which the Department of Mental Health and Addiction Services determines, based upon an independent physical and mental evaluation performed by or under the auspices of the Department of Social Services, whether the person is mentally ill and, if so, whether such person requires the level of services provided by a nursing facility and, if such person is mentally ill and does require such level of services, whether the person requires specialized services. A person who is determined to be mentally ill and not to require nursing facility level services shall not be admitted to a nursing facility. In order to implement the preadmission review requirements of this section and to identify applicants for admission who may be mentally ill and subject to the requirements of this section, nursing facilities may not admit any person, irrespective of source of payment, unless an identification screen developed, or in the case of out-of-state residents approved, by the Department of Social Services has been completed and filed in accordance with federal law.

(c) No payment from any source shall be due to any nursing facility that admits a resident in violation of the preadmission screening requirements of this section.

(d) A nursing facility shall notify the Department of Mental Health and Addiction Services when a resident who is mentally ill undergoes a significant change in condition or when a resident who has not previously been diagnosed as mentally ill undergoes a change in condition which may require specialized services. Upon such notifications, the Department of Mental Health and Addiction Services, under the auspices of the Department of Social Services, shall perform an evaluation to determine whether the resident requires the level of services provided by a nursing facility or requires specialized services for mental illness.

(e) The Department of Mental Health and Addiction Services, in consultation with the Department of Social Services, may no less than annually review, within available appropriations, the status of each resident in a nursing facility who is mentally ill to determine whether the resident requires (1) the level of services provided by a nursing facility, or (2) specialized services for mental illness. Nursing facilities shall grant to the Department of Mental Health and Addiction Services and the Department of Social Services access to nursing facility residents and their medical records for the purposes of this section.

**[**(e)**]** (f) In the case of a mentally ill resident who is determined under subsection (b), (d) or (e) of this section not to require the level of services provided by a nursing facility but to require specialized services for mental illness and who has continuously resided in a nursing facility for at least thirty months before the date of the determination, the resident may elect to remain in the facility or to receive services covered by Medicaid in an alternative appropriate institutional or noninstitutional setting in accordance with the alternative disposition plan submitted by the Department of Social Services to the Secretary of the United States Department of Health and Human Services, and consistent with the Department of Mental Health and Addiction Services requirements for the provision of specialized services.

**[**(f)**]** (g) In the case of a mentally ill resident who is determined under subsection (b), (d) or (e) of this section not to require the level of services provided by a nursing facility but to require specialized services for mental illness and who has not continuously resided in a nursing facility for at least thirty months before the date of the determination, the nursing facility in consultation with the Department of Mental Health and Addiction Services shall arrange for the safe and orderly discharge of the resident from the facility. If the department determines that the provision of specialized services requires an alternate residential placement, the discharge and transfer of the resident shall be made in accordance with the alternative disposition plan submitted by the Department of Social Services and approved by the Secretary of the United States

Department of Health and Human Services, except if an alternate residential placement is not available, the resident shall not be transferred.

**[**(g)**]** (h) In the case of a resident who is determined under subsection (b), (d) or (e) of this subsection not to require the level of services provided by a nursing facility and not to require specialized services, the nursing facility shall arrange for the safe and orderly discharge of the resident from the facility.

**[**(h)**]** (i) Any person seeking admittance to a nursing facility or any resident of a nursing facility who is adversely affected by a determination of the Department of Mental Health and Addiction Services under this section may appeal such determination to the Department of Social Services within fifteen days of the receipt of the notice of a determination by the Department of Mental Health and Addiction Services. If an appeal is taken to the Department of Social Services the determination of the Department of Mental Health and Addiction Services shall be stayed pending determination by the Department of Social Services.

Sec. 64. Section 38a-497 of the general statutes, as amended by section 16 of public act 07-185, is repealed and the following is substituted in lieu thereof (*Effective January 1, 2009*):

Every individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended or renewed in this state on or after **[**October 1, 2007**]** January 1, 2009, shall provide that coverage of a child shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first, the date on which the child marries, **[**ceases to be a resident of the state**]** or attains the age of twenty-six as long as the child is a resident of the state except for full-time attendance at an out-of-state accredited institution of higher education or resides out of state with a custodial parent pursuant to a child custody determination, as defined in section 46b-115a.

Sec. 65. Subsection (b) of section 38a-554 of the general statutes, as amended by section 17 of public act 07-185, is repealed and the following is substituted in lieu thereof (*Effective January 1, 2009*):

(b) The plan shall provide the option to continue coverage under each of the following circumstances until the individual is eligible for other group insurance, except as provided in subdivisions (3) and (4) of this subsection: (1) Notwithstanding any provision of this section, upon layoff, reduction of hours, leave of absence, or termination of employment, other than as a result of death of the employee or as a result of such employee's "gross misconduct" as that term is used in 29 USC 1163(2), continuation of coverage for such employee and such employee's covered dependents for the periods set forth for such event under federal extension requirements established by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (P. L. 99-272), as amended from time to time, (COBRA), except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered dependents until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act; (2) upon the death of the employee, continuation of coverage for the covered dependents of such employee for the periods set forth for such event under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P. L. 99-272), as amended from time to time, (COBRA); (3) regardless of the employee's or dependent's eligibility for other group insurance, during an employee's absence due to illness or injury, continuation of coverage for such employee and such employee's covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence; (4) regardless of an individual's eligibility for other group insurance,

upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which the plan was terminated, provided claim is submitted for coverage within one year of the termination of the plan; (5) the coverage of any covered individual shall terminate: (A) As to a child, the plan shall provide the option for said child to continue coverage for the longer of the following periods: (i) At the end of the month following the month in which the child marries, **[**ceases to reside in the state**]** or attains the age of twenty-six, provided the child is a resident of the state except for full-time attendance at an out-of-state accredited institution of higher education or resides out of state with a custodial parent pursuant to a child custody determination, as defined in section 46b-115a. If on the date specified for termination of coverage on a child, the child is unmarried and incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by the carrier within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter, or (ii) for the periods set forth for such child under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P. L. 99-272), as amended from time to time, (COBRA); (B) as to the employee's spouse, at the end of the month following the month in which a divorce, court-ordered annulment or legal separation is obtained, whichever is earlier, except that the plan shall provide the option for said spouse to continue coverage for the periods set forth for such events under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P. L. 99-272), as amended from time to time, (COBRA); and (C) as to the employee or dependent who is sixty-five years of age or older, as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the federal Social Security Act; (6) as to any other event listed as a "qualifying event" in 29 USC 1163, as amended from time to time, continuation of coverage for such periods set forth for such event in 29 USC 1162, as amended from time to time, provided such plan may require the individual whose coverage is to be continued to pay up to the percentage of the applicable premium as specified for such event in 29 USC 1162, as amended from time to time. Any continuation of coverage required by this section except subdivision (4) or (6) of this subsection may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay up to one hundred two per cent of the entire premium at the group rate if coverage is continued in accordance with subdivision (1), (2) or (5) of this subsection. The employer shall not be legally obligated by sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, to pay such premium if not paid timely by the employee.

Sec. 66. (NEW) (*Effective July 1, 2007*) (a) The Department of Public Health and The University of Connecticut Health Center may, within available appropriations, develop a Connecticut Health Information Network plan to securely integrate state health and social services data, consistent with state and federal privacy laws, within and across The University of Connecticut Health Center, the Office of Health Care Access and the Departments of Public Health, Mental Retardation and Children and Families. Data from other state agencies may be integrated into the network as funding permits and as permissible under federal law.

(b) The Department of Public Health and The Center for Public Health and Health Policy at The University

of Connecticut Health Center shall collaborate with the Departments of Information Technology, Mental Retardation, Children and Families and the Office of Health Care Access to develop the Connecticut Health Information Network plan.

(c) The plan shall: (1) Include research in and describe existing health and human services data; (2) inventory the various health and human services data aggregation initiatives currently underway; (3) include a framework and options for the implementation of a Connecticut Health Information Network, including query functionality to obtain aggregate data on key health indicators within the state; (4) identify and comply with confidentiality, security and privacy standards; and (5) include a detailed cost estimate for implementation and potential sources of funding.

Sec. 67. Subsection (a) of section 30 of public act 07-185 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is established a HealthFirst Connecticut Authority composed of the following members: Two appointed by the speaker of the House of Representatives, one of whom is a health care provider and one of whom represents businesses with fifty or more employees; two appointed by the president pro tempore of the Senate, one of whom has experience in community-based health care and one of whom represents businesses with fewer than fifty employees; one appointed by the majority leader of the House of Representatives who represents consumers; one appointed by the majority leader of the Senate who represents the interests of labor; one appointed by the minority leader of the House of Representatives who represents health insurance companies; one appointed by the minority leader of the Senate who represents hospitals; and two appointed by the Governor, one of whom advocates for health care quality or patient safety and one with experience in information technology. The Insurance Commissioner and the Commissioners of Public Health and Social Services or their designees, the Healthcare Advocate or the Healthcare Advocate's designee and the Comptroller or Comptroller's designee shall be ex-officio, nonvoting members.

Sec. 68. (NEW) (*Effective July 1, 2007*) (a) As used in this section:

(1) "Electronic health information system" means an information processing system, involving both computer hardware and software that deals with the storage, retrieval, sharing and use of health care information, data and knowledge for communication and decision making, and includes: (A) An electronic health record that provides access in real-time to a patient's complete medical record; (B) a personal health record through which an individual, and anyone authorized by such individual, can maintain and manage such individual's health information; (C) computerized order entry technology that permits a health care provider to order diagnostic and treatment services, including prescription drugs electronically; (D) electronic alerts and reminders to health care providers to improve compliance with best practices, promote regular screenings and other preventive practices, and facilitate diagnoses and treatments; (E) error notification procedures that generate a warning if an order is entered that is likely to lead to a significant adverse outcome for a patient; and (F) tools to allow for the collection, analysis and reporting of data on adverse events, near misses, the quality and efficiency of care, patient satisfaction and other healthcare-related performance measures.

(2) "Interoperability" means the ability of two or more systems or components to exchange information and to use the information that has been exchanged and includes: (A) The capacity to physically connect to a network for the purpose of exchanging data with other users; (B) the ability of a connected user to

demonstrate appropriate permissions to participate in the instant transaction over the network; and (C) the capacity of a connected user with such permissions to access, transmit, receive and exchange usable information with other users.

(3) "Standard electronic format" means a format using open electronic standards that: (A) Enable health information technology to be used for the collection of clinically specific data; (B) promote the interoperability of health care information across health care settings, including reporting to local, state and federal agencies; and (C) facilitate clinical decision support.

(b) On or before November 30, 2007, the Department of Public Health, in consultation with the Office of Health Care Access and within available appropriations, shall contract, through a competitive bidding process, for the development of a state-wide health information technology plan. The entity awarded such contract shall be designated the lead health information exchange organization for the state of Connecticut for the period commencing December 1, 2007, and ending June 30, 2009. The state-wide health information technology plan shall include, but not be limited to:

(1) General standards and protocols for health information exchange.

(2) Electronic data standards to facilitate the development of a state-wide, integrated electronic health information system for use by health care providers and institutions that are funded by the state. Such electronic data standards shall (A) include provisions relating to security, privacy, data content, structures and format, vocabulary and transmission protocols, (B) be compatible with any national data standards in order to allow for interstate interoperability, (C) permit the collection of health information in a standard electronic format, and (D) be compatible with the requirements for an electronic health information system.

(3) Pilot programs for health information exchange, and projected costs and sources of funding for such pilot programs.

(c) Not later than December 1, 2008, and annually thereafter, the Department of Public Health, in consultation with Office of Health Care Access, shall report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, government administration and appropriations and the budgets of state agencies on the status of the state-wide health information technology plan.

Sec. 69. (*Effective from passage*) Sections 16 and 17 of public act 07-185 shall take effect January 1, 2009.

Sec. 70. (*Effective July 1, 2007*) During the fiscal year ending June 30, 2008, the Department of Public Health shall, within available appropriations, expand school-based health clinic services for (1) priority school districts pursuant to section 10-266p of the general statutes, and (2) areas designated by the federal Health Resources and Services Administration as health professional shortage areas, medically underserved areas or areas with a medically underserved population.

Sec. 71. (*Effective July 1, 2007*) For the fiscal year ending June 30, 2008, the Commissioner of Public Health, in consultation with the Secretary of the Office of Policy and Management, may (1) make payments to providers for the purpose of addressing funding reductions under Part A and Part B of the federal Ryan White Program, and (2) enter into contracts with health departments located in the Hartford or New Haven Transitional Grant Areas for the purpose of addressing funding reductions under the federal Ryan White

Program.

Sec. 72. Sections 10, 12, 24 to 28, inclusive, and 34 to 43, inclusive, of public act 07-185 and section 89 of public act 07-252 are repealed. (*Effective July 1, 2007*)

Approved June 26, 2007