



General Assembly

February Session, 2000

Amendment

LCO No. 5463

Offered by:

REP. DYSON, 94th Dist.

To: House Bill No. 5928

File No. 573

Cal. No. 446

***"An Act Concerning The Expenditures Of The
Department Of Social Services."***

1 Strike out everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. (NEW) (a) The Commissioner of Social Services shall,
4 within available appropriations, establish a pilot program to provide
5 additional financial benefits for persons with severe physical
6 disabilities (1) who are unable to transfer independently in the event of
7 an emergency, (2) who apply for or receive aid under the state
8 supplement program, and (3) who reside with individuals who
9 provide transfer assistance to such persons. Benefits shall be provided
10 under the program only if the individual providing such transfer
11 assistance is not related to the person with a severe physical disability.
12 Under the program, payments shall be made in an amount equal to the
13 amount of the increased benefit the person would receive under the
14 state supplement program if the individual providing such transfer
15 assistance were not living with the person with a severe physical
16 disability. For the purposes of this section, "transfer assistance" means

17 help provided to a person with a severe physical disability by an
18 individual who physically lifts such person or utilizes a hooyer lift,
19 transfer board or other device in order to move such person between
20 surfaces or to or from a bed, chair or wheelchair within such person's
21 residence.

22 (b) The Commissioner of Social Services shall adopt regulations in
23 accordance with the provisions of chapter 54 of the general statutes to
24 administer the program established under subsection (a) of this
25 section. Said commissioner may implement the program while in the
26 process of adopting such regulations, provided notice of intent to
27 adopt the regulations is published in the Connecticut Law Journal
28 within twenty days after implementation.

29 Sec. 2. (NEW) The Commissioner of Public Health, the
30 Commissioner of Social Services and the chief executive officer of The
31 University of Connecticut Health Center, shall establish a pilot
32 program for the delivery of dental services to children of low-income
33 families in two regions of the state. Such program shall provide for the
34 design and implementation of a model integrated system of children's
35 dental care in such regions, including dental disease prevention and
36 service intervention components, and shall provide for measurable
37 outcomes.

38 Sec. 3. (NEW) (a) The Commissioner of Social Services and the
39 Commissioner of Children and Families shall develop and administer
40 an integrated behavioral health service delivery system for children
41 and youth with serious emotional disturbances who meet the criteria
42 established in accordance with subdivision (1) of subsection (a) of
43 section 5 of this act and who are eligible to receive services from the
44 HUSKY Plan, Part A or Part B, the HUSKY Plus program for intensive
45 behavioral health needs or voluntary services provided through the
46 Department of Children and Families. All necessary changes to the IV-
47 E, Title XIX and Title XXI state plans shall be made to maximize federal
48 financial participation.

49 (b) Not later than October 1, 2000, said commissioners shall enter
50 into a memorandum of understanding for the purpose of the joint
51 administration of an integrated behavioral health service delivery
52 system. Such memorandum of understanding shall establish
53 mechanisms to administer combined funding, establish standards for,
54 and monitor implementation of, the integrated behavioral health
55 service delivery system and specify that (1) the Department of Social
56 Services, which is the agency designated as the single state agency for
57 the administration of the Medicaid program pursuant to Title XIX of
58 the Social Security Act, manage all Medicaid and HUSKY Plan
59 modifications, waiver amendments, federal reporting and claims
60 processing and provide financial management, and (2) the Department
61 of Children and Families, which is the state agency responsible for
62 administering and evaluating a comprehensive and integrated state-
63 wide program of services for children and youth who are seriously
64 emotionally disturbed, define the services to be included in the
65 continuum of care and develop state-wide training programs on the
66 systems of care approach for providers, families and other persons.

67 (c) Not later than October 1, 2000, said commissioners shall
68 complete the memorandum of understanding, establish fiscal and
69 programmatic eligibility guidelines, develop fiscal and programmatic
70 outcome measures and develop a plan to evaluate the administration
71 of behavioral health services.

72 (d) Said commissioners may commence a project of limited scope
73 and duration in the state fiscal year commencing July 1, 2000, to
74 implement the provisions of this section in those locations where the
75 commissioners determine that services are well-developed and a high
76 degree of cooperation exists among providers.

77 (e) Said commissioners shall consult with the Commissioner of
78 Mental Health and Addiction Services and the Commissioner of
79 Mental Retardation during the development of the integrated
80 behavioral health service delivery system in order to ensure
81 coordination of a delivery system of behavioral health services across

82 the life span of children, youth and adults with behavioral health
83 needs.

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

87 Sec. 4. (NEW) Not later than January 1, 2001, and annually
88 thereafter, each local system of care shall, within available
89 appropriations, (1) complete a local needs assessment which shall
90 include objectives and outcome measures, (2) specify the number of
91 children requiring behavioral health services, (3) specify the number of
92 children actually receiving community-based and residential services
93 and the type and frequency of such services, and (4) complete an
94 annual self-evaluation process and a review of discharge summaries.
95 Each local system of care shall submit its local needs assessment to the
96 Commissioner of Children and Families and the Commissioner of
97 Social Services. For the purposes of this section, "local system of care"
98 means community-based organizations that work in teams to deliver
99 behavioral health services in a manner that assists children and youth
100 with behavioral health problems and provides their families with
101 access to the full range of services tailored to the physical, emotional,
102 social and educational needs of each individual in or near the
103 communities in which they reside.

104 Sec. 5. (a) Not later than October 1, 2000, the Commissioner of Social
105 Services and the Commissioner of Children and Families shall submit
106 a report to the joint standing committees of the General Assembly
107 having cognizance of matters relating to appropriations and the
108 budgets of state agencies, human services and public health that
109 specifies a behavioral health program plan to: (1) Determine the
110 clinical and functional criteria that will be used to identify those
111 children and youth in the target population specified in subsection (a)
112 of section 3 of this act who will receive services from the integrated
113 behavioral health service delivery system; (2) estimate state and
114 federal funds for behavioral health services under the HUSKY Plan,

115 Part A and Part B and Title IV-E according to the criteria to be
116 developed under subdivision (1) of this subsection; (3) enhance the
117 local systems of care established under section 17a-127 of the general
118 statutes as the primary providers of services under the integrated
119 behavioral health service delivery system; (4) define and establish lead
120 service agencies to coordinate the local systems of care; (5) contract
121 with an administrative services organization or other organizations to
122 provide data and fiduciary management for the lead service agencies;
123 (6) deliver high quality care in the least restrictive environment; (7)
124 determine the feasibility of allowing for a hardship exemption under
125 the provisions of section 17b-299 of the general statutes for eligible
126 children who meet the criteria to be developed under subdivision (1)
127 of this subsection; (8) determine the feasibility of allowing eligible
128 children whose parents have a household income which exceeds three
129 hundred per cent of the federal poverty level to purchase health
130 insurance coverage under the HUSKY Plan, Part B; (9) develop a
131 strategy for enhancing home and community-based services in order
132 to allow children and youth in out-of-home placements to return to
133 their families and communities; (10) establish mechanisms for the
134 continuous evaluation and quality improvement of the integrated
135 behavioral health service delivery system, including periodic
136 evaluation of behavioral health programs and services and research on
137 child outcomes; (11) establish a program for training staff and
138 providers regarding the changes in the system of care principles and
139 structures and in all aspects of the delivery of care under the integrated
140 behavioral health service delivery system; and (12) establish
141 procedures for compiling all data and conducting all needs
142 assessments as are necessary for planning an integrated behavioral
143 health service delivery system.

144 (b) Not later than October 1, 2000, the Commissioner of Children
145 and Families shall submit a report to the joint standing committee of
146 the General Assembly having cognizance of matters relating to human
147 services on the feasibility of establishing a Bureau of Behavioral Health
148 within the Department of Children and Families.

149 Sec. 6. Section 17a-1 of the general statutes is repealed and the
150 following is substituted in lieu thereof:

151 As used in sections 17a-1 to 17a-26, inclusive, as amended, 17a-28 to
152 17a-49, inclusive, as amended, 17a-127, as amended by this act, and
153 46b-120:

154 (1) "Commissioner" means the Commissioner of Children and
155 Families;

156 (2) "Council" means the State Advisory Council on Children and
157 Families;

158 (3) "Department" means the Department of Children and Families;

159 (4) "Child" means any person under sixteen years of age;

160 (5) "Youth" means any person sixteen to eighteen years of age;

161 (6) "Delinquent child" shall have the meaning ascribed thereto in
162 section 46b-120;

163 (7) "Child or youth with mental illness" means a child or youth who
164 is suffering from one or more mental disorders as defined in the most
165 recent edition of the American Psychiatric Association's "Diagnostic
166 and Statistical Manual of Mental Disorders";

167 (8) "Child or youth with emotional disturbance" means a child or
168 youth who has a clinically significant emotional or behavioral
169 disorder, as determined by a trained mental health professional, that
170 disrupts the academic or developmental progress, family or
171 interpersonal relationships of such child or youth or is associated with
172 present distress or disability or a risk of suffering death, pain or
173 disability;

174 (9) "Individual system of care plan" means a written plan developed
175 by the Commissioner of Children and Families for a child or youth
176 who is mentally ill, [or] emotionally disturbed or seriously emotionally

177 disturbed or who is at placement risk which shall be developed when
178 such child or youth needs services from at least two public agencies
179 and which shall be designed to meet the needs of the child or youth
180 and his family;

181 (10) "Family" means a child or youth who is mentally ill, [or]
182 emotionally disturbed or seriously emotionally disturbed or who is at
183 placement risk together with (A) one or more biological or adoptive
184 parents, except for a biological parent whose parental rights have been
185 terminated, (B) one or more persons to whom legal custody or
186 guardianship has been given, or (C) one or more adult family members
187 who have a primary responsibility for providing continuous care to
188 such child or youth;

189 (11) "Child or youth at placement risk" means a mentally ill, [or]
190 emotionally disturbed or seriously emotionally disturbed child or
191 youth who is at risk of placement out of his home or is in placement
192 out of his home for the primary purpose of receiving mental health
193 treatment;

194 (12) "Parent" means a biological or adoptive parent, except a
195 biological parent whose parental rights have been terminated; [and]

196 (13) "Guardian" means a person who has a judicially created
197 relationship between a child and such person which is intended to be
198 permanent and self-sustaining as evidenced by the transfer to such
199 person of the following parental rights with respect to the child: (A)
200 The obligation of care and control; (B) the authority to make major
201 decisions affecting the child's welfare, including, but not limited to,
202 consent determinations regarding marriage, enlistment in the armed
203 forces and major medical, psychiatric or surgical treatment; (C) the
204 obligation of protection of the child; (D) the obligation to provide
205 access to education; and (E) custody of the child; and

206 (14) "Serious emotional disturbance" and "seriously emotionally
207 disturbed" means, with regard to a child or youth, that the child or
208 youth (A) has a range of diagnosable mental, behavioral or emotional

209 disorders of sufficient duration to meet diagnostic criteria specified in
210 the most recent edition of the American Psychiatric Association's
211 "Diagnostic and Statistical Manual of Mental Disorders" and (B)
212 exhibits behaviors that substantially interfere with or limit the child's
213 or youth's ability to function in the family, school or community and
214 are not a temporary response to a stressful situation.

215 Sec. 7. Section 17a-127 of the general statutes is repealed and the
216 following is substituted in lieu thereof:

217 (a) The following shall be established for the purposes of
218 developing and implementing an individual system of care plan:

219 (1) Within available appropriations, a child specific team may be
220 developed by the family of a child or adolescent at placement risk and
221 include, but not be limited to, family members, the child or adolescent
222 if appropriate, clergy, school personnel, representatives of local or
223 regional agencies providing programs and services for children and
224 youth, a family advocate, and other community or family
225 representatives. The team shall designate one member to be the team
226 coordinator. The team coordinator shall make decisions affecting the
227 implementation of an individual system of care plan with the consent
228 of the team, except as otherwise provided by law. If a case manager,
229 other than the case manager from the Department of Children and
230 Families, has been assigned to the child and is not designated as the
231 team coordinator, such case manager shall not make decisions
232 affecting the implementation of the individual system of care plan
233 without the consent of the team, except as otherwise provided by law;

234 (2) Within available appropriations, case review committees may be
235 developed by each regional office of the Department of Children and
236 Families and shall be comprised of at least three parents of children or
237 adolescents with mental illness, emotional disturbance or serious
238 emotional disturbance and representatives of local or regional agencies
239 and service providers including, but not limited to, the regional
240 administrator of the office of the Department of Children and Families

241 or his designee, a superintendent of schools or his designee, a director
242 of a local children's mental health agency or his designee, the district
243 director of the district office of the Department of Social Services or his
244 designee, representatives from the Departments of Mental Retardation
245 and Mental Health and Addiction Services who are knowledgeable of
246 the needs of a child or adolescent at placement risk, a representative
247 from a local housing authority and a representative from the court
248 system. The functions of the case review committees shall include, but
249 not be limited to: (A) The determination of whether or not a child or
250 adolescent meets the definition of a child or adolescent at placement
251 risk; (B) assisting children or families without a child specific team in
252 the formation of such a team; and (C) resolution of the development or
253 implementation of an individual system of care plan not developed,
254 implemented or agreed upon by a child specific team. Such functions
255 shall be completed in one hundred twenty days or less from the date of
256 referral to the case review committee. In the event of the need for an
257 individual system of care plan for a child or adolescent with no
258 identifiable community, a representative of the child or adolescent
259 shall make a referral to the state coordinated care committee,
260 established pursuant to subdivision (3) of this subsection, which shall
261 designate responsibility for the development of an individual system
262 of care plan to a case review committee. The case review committee
263 shall also monitor the implementation of an individual system of care
264 plan when appropriate. The Department of Children and Families may
265 assign a system coordinator to each case review committee. The duties
266 of the system coordinator shall include, but not be limited to,
267 assistance and consultation to child specific teams and assistance with
268 the development of case review committees and child specific teams.

269 (3) A coordinated care committee shall be developed by the
270 Commissioner of Children and Families and shall be comprised of a
271 parent of a child or adolescent with [serious] mental illness, emotional
272 disturbance or serious emotional disturbance who is currently serving
273 or has served on a case review committee, a person who is now or has
274 been a recipient of services for a child or adolescent at placement risk,

275 representatives of the Departments of Children and Families,
276 Education, Mental Health and Addiction Services, Social Services and
277 Mental Retardation who are knowledgeable of the needs of a child or
278 adolescent at placement risk, and a representative of the Office of
279 Protection and Advocacy for Persons with Disabilities who is
280 knowledgeable of the needs of a child or adolescent at placement risk.

281 (b) The commissioner, in consultation with the coordinated care
282 committee, shall submit a report on the findings and recommendations
283 of programs for children and youth at placement risk, including
284 recommendations for budget options or programmatic changes
285 necessary to enhance the system of care for such child or youth and his
286 family, to the joint standing committee and the select committee of the
287 General Assembly having cognizance of matters relating to children,
288 on or before January 1, 1998, and annually thereafter.

289 (c) The provisions of this section shall not be construed to grant an
290 entitlement to any child or youth at placement risk to receive
291 particular services under this section in an individual system of care
292 plan if such child or youth is not otherwise eligible to receive such
293 services from any state agency or to receive such services pursuant to
294 any other provision of law.

295 (d) The Commissioner of Children and Families may adopt
296 regulations in accordance with chapter 54 for the purpose of
297 implementing the provisions of this section.

298 Sec. 8. (NEW) (a) The Commissioner of Public Health shall allow
299 state-funded congregate housing facilities to provide assisted living
300 services through licensed assisted living services agencies, as defined
301 in section 19a-490 of the general statutes.

302 (b) In order to facilitate the development of assisted living services
303 in state-funded congregate housing facilities, the Commissioner of
304 Public Health may waive any provision of the regulations for assisted
305 living services agencies, as defined in section 19a-490 of the general
306 statutes, which provide services in state-funded congregate housing

307 facilities. No waiver of such regulations shall be made if the
308 commissioner determines that the waiver would: (1) Endanger the life,
309 safety or health of any resident receiving assisted living services in a
310 state-funded congregate housing facility; (2) impact the quality or
311 provision of services provided to a resident in a state-funded
312 congregate housing facility; (3) revise or eliminate the requirements for
313 an assisted living services agency's quality assurance program; (4)
314 revise or eliminate the requirements for an assisted living services
315 agency's grievance and appeals process; or (5) revise or eliminate the
316 assisted living services agency's requirements relative to a client's bill
317 of rights and responsibilities. The commissioner, upon the granting of
318 a waiver of any provision of such regulations, may impose conditions
319 which assure the health, safety and welfare of residents receiving
320 assisted living services in a state-funded congregate housing facility.
321 The commissioner may revoke such a waiver upon a finding that the
322 health, safety or welfare of any such resident is jeopardized.

323 (c) The Commissioner of Public Health may adopt regulations, in
324 accordance with the provisions of chapter 54 of the general statutes, to
325 implement the provisions of this section. Said commissioner may
326 implement the waiver of provisions as specified in subsection (b) of
327 this section while in the process of adopting criteria for the waiver
328 process in regulation form, provided notice of intent to adopt the
329 regulations is published in the Connecticut Law Journal within twenty
330 days after implementation. Such criteria shall be valid until the time
331 final regulations are effective.

332 Sec. 9. Section 8-206e of the general statutes, as amended by section
333 33 of public act 99-279, is repealed and the following is substituted in
334 lieu thereof:

335 (a) The Commissioner of Economic and Community Development
336 shall, within available appropriations, establish a demonstration
337 housing assistance and counseling program to offer advice on matters
338 concerning landlord and tenant relations and the financing of owner-
339 occupied and rental housing purchases, improvements and

340 renovations. The program shall provide: (1) Educational services
341 designed to inform landlords and tenants of their respective rights and
342 responsibilities; (2) dispute mediation services for landlords and
343 tenants; (3) information on securing housing-related financing,
344 including mortgage loans, home improvement loans, energy assistance
345 and weatherization assistance; and (4) such other housing-related
346 counseling and assistance as the commissioner shall provide by
347 regulations.

348 (b) The Commissioner of Economic and Community Development
349 may, within available appropriations, enter into a contract or contracts
350 to provide financial assistance in the form of grants-in-aid to nonprofit
351 corporations, as defined in section 8-39, to carry out the purposes of
352 subsection (a) of this section.

353 (c) The Commissioner of Economic and Community Development
354 shall adopt regulations in accordance with the provisions of chapter 54
355 to carry out the purposes of subsections (a) and (b) of this section.

356 [(d) Not later than January 1, 1989, the Commissioner of Economic
357 and Community Development shall submit to the General Assembly a
358 report containing an evaluation of the operation and effectiveness of
359 the demonstration program authorized under this section.]

360 (d) The Commissioner of Economic and Community Development
361 shall establish a demonstration program in one United States
362 Department of Housing and Urban Development, Section 202, elderly
363 housing development and one United States Department of Housing
364 and Urban Development, Section 236, elderly housing development to
365 provide assisted living services for persons who are residents of the
366 state.

367 (e) The Commissioner of Economic and Community Development
368 shall establish criteria for making disbursements under the provisions
369 of subsection (d) of this section which shall include, but are not limited
370 to: (1) Size of the United States Department of Housing and Urban
371 Development, Section 202 and Section 236, elderly housing

372 developments; (2) geographic locations in which the developments are
373 located; (3) anticipated social and health value to the resident
374 population; (4) each Section 202 and Section 236 housing
375 development's designation as a managed residential community, as
376 defined in section 19-13-D105 of the regulations of Connecticut state
377 agencies; and (5) the potential community development benefit to the
378 relevant municipality. Such criteria may specify who may apply for
379 grants, the geographic locations determined to be eligible for grants,
380 and the eligible costs for which a grant may be made.

381 (f) The Commissioner of Economic and Community Development
382 may adopt regulations, in accordance with the provisions of chapter
383 54, to implement the provisions of subsections (d) and (e) of this
384 section.

385 Sec. 10. Section 17b-342 of the general statutes, as amended by
386 section 12 of public act 99-279, is repealed and the following is
387 substituted in lieu thereof:

388 (a) The Commissioner of Social Services shall administer the
389 Connecticut home-care program for the elderly state-wide in order to
390 prevent the institutionalization of elderly persons (1) who are
391 recipients of medical assistance, (2) who are eligible for such
392 assistance, [or] (3) who would be eligible for medical assistance if
393 residing in a nursing facility, or (4) who meet the criteria for the state-
394 funded portion of the program under subsection (i) of this section. For
395 purposes of this section, a long-term care facility is a facility which has
396 been federally certified as a skilled nursing facility or intermediate care
397 facility. The commissioner shall make any revisions in the state
398 Medicaid plan required by Title XIX of the Social Security Act prior to
399 implementing the program. The annualized cost of the community-
400 based services provided to such persons under the program shall not
401 exceed sixty per cent of the weighted average cost of care in skilled
402 nursing facilities and intermediate care facilities. The program shall be
403 structured so that the net cost to the state for long-term facility care in
404 combination with the community-based services under the program

405 shall not exceed the net cost the state would have incurred without the
406 program. The commissioner shall investigate the possibility of
407 receiving federal funds for the program and shall apply for any
408 necessary federal waivers. A recipient of services under the program,
409 and the estate and legally liable relatives of the recipient, shall be
410 responsible for reimbursement to the state for such services to the
411 same extent required of a recipient of assistance under the state
412 supplement program, medical assistance program, temporary family
413 assistance program or food stamps program. Only a United States
414 citizen or a noncitizen who meets the citizenship requirements for
415 eligibility under the Medicaid program shall be eligible for home-care
416 services under this section, except a qualified alien, as defined in
417 Section 431 of Public Law 104-193, admitted into the United States on
418 or after August 22, 1996, or other lawfully residing immigrant alien
419 determined eligible for services under this section prior to July 1, 1997,
420 shall remain eligible for such services until July 1, 2001. Qualified
421 aliens or other lawfully residing immigrant aliens not determined
422 eligible prior to July 1, 1997, shall be eligible for services under this
423 section subsequent to six months from establishing residency until July
424 1, 2001. Notwithstanding the provisions of this subsection, any
425 qualified alien or other lawfully residing immigrant alien who is a
426 victim of domestic violence or who has mental retardation shall be
427 eligible for assistance pursuant to this section.

428 (b) The commissioner shall solicit bids through a competitive
429 process and shall contract with an access agency, approved by the
430 Office of Policy and Management and the Department of Social
431 Services as meeting the requirements for such agency as defined by
432 regulations adopted pursuant to subsection (e) of this section, that
433 submits proposals which meet or exceed the minimum bid
434 requirements. In addition to such contracts, the commissioner may use
435 department staff to provide screening, coordination, assessment and
436 monitoring functions for the program.

437 (c) The community-based services covered under the program shall
438 include, but not be limited to, the following services to the extent that

439 they are not available under the state Medicaid plan, occupational
440 therapy, homemaker services, companion services, meals on wheels,
441 adult day care, transportation, mental health counseling, [case] care
442 management, [and] elderly foster care, minor home modifications and
443 assisted living services provided in state-funded congregate housing
444 and in other assisted living pilot or demonstration projects established
445 under state law. Recipients of state-funded services and persons who
446 are determined to be functionally eligible for community-based
447 services who have an application for medical assistance pending shall
448 have the cost of home health and community-based services covered
449 by the program, provided they comply with all medical assistance
450 application requirements. Access agencies shall not use department
451 funds to purchase community-based services or home health services
452 from themselves or any related parties.

453 (d) Physicians, hospitals, long-term care facilities and other licensed
454 health care facilities may disclose, and, as a condition of eligibility for
455 the program, elderly persons, their guardians, and relatives shall
456 disclose, upon request from the Department of Social Services, such
457 financial, social and medical information as may be necessary to enable
458 the department or any agency administering the program on behalf of
459 the department to provide services under the program. Long-term care
460 facilities shall supply the Department of Social Services with the names
461 and addresses of all applicants for admission. Any information
462 provided pursuant to this subsection shall be confidential and shall not
463 be disclosed by the department or administering agency.

464 (e) The commissioner shall adopt regulations, in accordance with
465 the provisions of chapter 54, to define "access agency", to implement
466 and administer the program, to establish uniform state-wide standards
467 for the program and a uniform assessment tool for use in the screening
468 process and to specify conditions of eligibility.

469 (f) The commissioner may require long-term care facilities to inform
470 applicants for admission of the program established under this section
471 and to distribute such forms as [he] the commissioner prescribes for

472 the program. Such forms shall be supplied by and be returnable to the
473 department.

474 (g) The commissioner shall report annually, by June first, to the joint
475 standing committee of the General Assembly having cognizance of
476 matters relating to human services on the program in such detail,
477 depth and scope as said committee requires to evaluate the effect of the
478 program on the state and program participants. Such report shall
479 include information on (1) the number of persons diverted from
480 placement in a long-term care facility as a result of the program, (2) the
481 number of persons screened, (3) the average cost per person in the
482 program, (4) the administration costs, (5) the estimated savings, and (6)
483 a comparison between costs under the different contracts.

484 (h) An individual who is otherwise eligible for services pursuant to
485 this section shall, as a condition of participation in the program, apply
486 for medical assistance benefits pursuant to section 17b-260 when
487 requested to do so by the department and shall accept such benefits if
488 determined eligible.

489 (i) (1) On and after July 1, 1992, the Commissioner of Social Services
490 shall, within available appropriations, administer a state-funded
491 portion of the program for persons (A) who are sixty-five years of age
492 and older; (B) who are inappropriately institutionalized or at risk of
493 inappropriate institutionalization; (C) whose income is less than or
494 equal to the amount allowed under the federally funded portion of the
495 program established pursuant to subsection (a) of this section; and (D)
496 whose assets, if single, do not exceed the minimum community spouse
497 protected amount pursuant to Section 4022.05 of the department's
498 uniform policy manual or, if married, the couple's assets do not exceed
499 one hundred fifty per cent of said community spouse protected
500 amount.

501 [(2) The commissioner shall establish a sliding fee scale for required
502 contributions to the cost of services provided under the program for
503 program participants whose income is equal to or greater than one

504 hundred fifty per cent of the federal poverty level. The sliding fee scale
505 shall be based on a formula which establishes the midpoint of each
506 twenty-five per cent income increase over the poverty level and
507 assesses a fee based on a percentage of the midpoint for all eligible
508 persons whose income is within that range. The percentage of the
509 midpoint shall start at eleven per cent and shall increase by one per
510 cent for each income range.]

511 (2) Any person whose income exceeds two hundred per cent of the
512 federal poverty level shall contribute to the cost of care in accordance
513 with the methodology established for recipients of medical assistance
514 pursuant to sections 5035.20 and 5035.25 of the department's uniform
515 policy manual.

516 (3) On and after June 30, 1992, the program shall serve persons
517 receiving state-funded home and community-based services from the
518 department, persons receiving services under the promotion of
519 independent living for the elderly program operated by the
520 Department of Social Services, regardless of age, and persons receiving
521 services on June 19, 1992, under the home care demonstration project
522 operated by the Department of Social Services. Such persons receiving
523 state-funded services whose income and assets exceed the limits
524 established pursuant to subdivision (1) of this subsection may continue
525 to participate in the program, but shall be required to pay the total cost
526 of care, including case management costs.

527 (4) Services shall not be increased for persons who received services
528 under the promotion of independent living for the elderly program
529 over the limits in effect under said program in the fiscal year ending
530 June 30, 1992, unless a person's needs increase and the person is
531 eligible for Medicaid.

532 (5) The annualized cost of services provided to an individual under
533 the state-funded portion of the program shall not exceed fifty per cent
534 of the weighted average cost of care in nursing homes in the state,
535 except an individual who received services costing in excess of such

536 amount under the Department of Social Services in the fiscal year
537 ending June 30, 1992, may continue to receive such services, provided
538 the annualized cost of such services does not exceed eighty per cent of
539 the weighted average cost of such nursing home care. The
540 commissioner may allow the cost of services provided to an individual
541 to exceed the maximum cost established pursuant to this subdivision
542 in a case of extreme hardship, as determined by the commissioner,
543 provided in no case shall such cost exceed that of the weighted cost of
544 such nursing home care.

545 (j) The Commissioner of Social Services may implement revised
546 criteria for the operation of the program while in the process of
547 adopting such criteria in regulation form, provided the commissioner
548 prints notice of intention to adopt the regulations in the Connecticut
549 Law Journal within twenty days of implementing the policy. Such
550 criteria shall be valid until the time final regulations are effective.

551 Sec. 11. (NEW) (a) The Department of Social Services shall be the
552 sole agency to determine eligibility for assistance and services under
553 programs operated and administered by said department. No order of
554 a probate court shall limit the ability or authority of the department to
555 determine the eligibility of applicants or recipients for such assistance
556 or services.

557 (b) A probate court shall provide notice to the Commissioner of
558 Social Services of all proceedings in which the Department of Social
559 Services may have an interest by reason of an individual's receipt of or
560 application for assistance or services from the department. In addition,
561 a probate court shall send to the commissioner copies of all
562 applications involving the transfer of assets or income from an
563 institutionalized spouse to a community spouse, with attachments, and
564 notice of all such proceedings. Such notice and copies, as appropriate,
565 shall be sent to the Commissioner of Social Services not less than thirty
566 days prior to the date of the proceeding. Any order issued by the
567 probate court following proceedings for which notice was not
568 provided in accordance with the provisions of this subsection shall not

569 be binding on the department.

570 (c) Notwithstanding the provisions of subsections (a) and (b) of this
571 section, the department shall give effect to an order of a probate court
572 for spousal support of a community spouse provided the order was
573 entered at least three years prior to the date of any application for
574 medical assistance by either spouse. Any order issued by the probate
575 court within three years of the date an application for medical
576 assistance shall not be given effect by the department unless the
577 applicant or spouse makes a showing satisfactory to the department
578 that the order was obtained exclusively for a purpose other than to
579 qualify for medical assistance.

580 Sec. 12. Subsection (d) of section 45a-655 of the general statutes is
581 repealed and the following is substituted in lieu thereof:

582 (d) In the case of any person receiving public assistance, state-
583 administered general assistance or Medicaid, the conservator of the
584 estate shall apply toward the cost of care of such person any assets
585 exceeding limits on assets set by statute or regulations adopted by the
586 Commissioner of Social Services. Notwithstanding the provisions of
587 subsections (a) and (b) of this section, in the case of an institutionalized
588 person who has applied for or is receiving such medical assistance, no
589 conservator shall apply and no court shall approve the application of
590 (1) the net income of the ward to the support of the ward's spouse in
591 an amount that exceeds the monthly income allowed a community
592 spouse as determined by the Department of Social Services pursuant to
593 42 USC 1396r-5(d)(2)-(4) or (2) any portion of the property of the ward
594 to the support, maintenance and medical treatment of the ward's
595 spouse in an amount that exceeds the amount determined allowable by
596 the department pursuant to 42 USC 1396r-5(f)(1) and (2),
597 notwithstanding the provisions of 42 USC 1396r-5(f)(2)(A)(iv), unless
598 [(A) such limitations on income or property would result in significant
599 financial duress or (B) an amount exceeding such limitations is
600 necessary to generate income] the Department of Social Services has
601 found, through a fair hearing pursuant to 42 USC 1396r-5(e), that (A)

602 the community spouse needs additional income due to exceptional
603 circumstances resulting in significant financial duress, or (B) the
604 community spouse resource allowance is inadequate to raise the
605 community spouse's income to the minimum monthly maintenance
606 needs allowance.

607 Sec. 13. Subsection (a) of section 17b-8 of the general statutes is
608 repealed and the following is substituted in lieu thereof:

609 (a) The Commissioner of Social Services shall submit an application
610 for a federal waiver of any assistance program requirements, except
611 such application pertaining to routine operational issues, to the joint
612 standing committee of the General Assembly having cognizance of
613 matters relating to appropriations and the budgets of state agencies
614 and to the joint standing committee of the General Assembly having
615 cognizance of matters relating to human services prior to the
616 submission of such application to the federal government. Within
617 [fifteen] thirty days of their receipt of such application, the joint
618 standing committees may advise the commissioner of their approval,
619 denial or modifications, if any, of his application.

620 Sec. 14. Subsection (h) of section 21a-70 of the general statutes is
621 repealed and the following is substituted in lieu thereof:

622 (h) No manufacturer or wholesaler shall sell any drugs except to the
623 state or any political subdivision thereof, to another manufacturer or
624 wholesaler, to any hospital recognized by the state as a general or
625 specialty hospital, to any institution having a full-time pharmacist who
626 is actively engaged in the practice of pharmacy in such institution not
627 less than thirty-five hours a week, to a chronic and convalescent
628 nursing home having a pharmacist actively engaged in the practice of
629 pharmacy based upon the ratio of one-tenth of one hour per patient
630 per week but not less than twelve hours per week, to a practicing
631 physician, podiatrist, dentist, optometrist or veterinarian or to a
632 licensed pharmacy or a store to which a permit to sell nonlegend drugs
633 has been issued as provided in section 20-624, as amended. The

634 commissioner may adopt such regulations as are necessary to
635 administer and enforce the provisions of this section.

636 Sec. 15. Subsection (a) of section 17b-239 of the general statutes is
637 repealed and the following is substituted in lieu thereof:

638 (a) The rate to be paid by the state to hospitals receiving
639 appropriations granted by the General Assembly and to freestanding
640 chronic disease hospitals, providing services to persons aided or cared
641 for by the state for routine services furnished to state patients, shall be
642 based upon reasonable cost to such hospital, or the charge to the
643 general public for ward services or the lowest charge for semiprivate
644 services if the hospital has no ward facilities, imposed by such
645 hospital, whichever is lowest, except to the extent, if any, that the
646 commissioner in his discretion determines that a greater amount is
647 appropriate in the case of hospitals serving a disproportionate share of
648 indigent patients. Such rate shall be promulgated annually by the
649 Commissioner of Social Services. Nothing contained herein shall
650 authorize a payment by the state for such services to any such hospital
651 in excess of the charges made by such hospital for comparable services
652 to the general public. [Notwithstanding the provisions of this section,
653 on and after July 1, 1995, rates paid to freestanding chronic disease
654 hospitals shall not exceed rates paid in rate periods ending in 1995 plus
655 the inflation factor annually applied in determining acute care
656 inpatient hospital rates under the Medicaid program. A freestanding
657 chronic disease hospital having more than an average of fifty per cent
658 of its inpatient days paid for by the department may request that the
659 commissioner use the actual charge based on utilized service for the
660 rate period ending in 1995 in lieu of the rate paid for the period when
661 determining the rates to be paid on and after July 1, 1995.]
662 Notwithstanding the provisions of this section, for the rate period
663 beginning July 1, 2000, rates paid to freestanding chronic disease
664 hospitals and freestanding psychiatric hospitals shall be increased by
665 three per cent. For the rate period beginning July 1, 2001, and each
666 succeeding rate period, rates paid to freestanding chronic and
667 convalescent disease hospitals and freestanding psychiatric hospitals

668 shall be equal to but not exceed rates for the preceding rate period,
669 plus an inflation factor equal to the Medicare market basket inflation
670 rate as published in the previous September federal register of each
671 year with the wage portion of such market basket adjusted for the
672 Hartford metropolitan statistical area.

673 Sec. 16. Section 17b-242 of the general statutes, as amended by
674 public act 99-130, is repealed and the following is substituted in lieu
675 thereof:

676 (a) The Department of Social Services shall determine the rates to be
677 paid to home health care agencies and homemaker-home health aide
678 agencies by the state or any town in the state for persons aided or
679 cared for by the state or any such town. For the period from February
680 1, 1991, to January 31, 1992, inclusive, payment for each service to the
681 state shall be based upon the rate for such service as determined by the
682 Office of Health Care Access, except that for those providers whose
683 Medicaid rates for the year ending January 31, 1991, exceed the median
684 rate, no increase shall be allowed. For those providers whose rates for
685 the year ending January 31, 1991, are below the median rate, increases
686 shall not exceed the lower of the prior rate increased by the most
687 recent annual increase in the consumer price index for urban
688 consumers or the median rate. In no case shall any such rate exceed the
689 eightieth percentile of rates in effect January 31, 1991, nor shall any rate
690 exceed the charge to the general public for similar services. Rates
691 effective February 1, 1992, shall be based upon rates as determined by
692 the Office of Health Care Access, except that increases shall not exceed
693 the prior year's rate increased by the most recent annual increase in the
694 consumer price index for urban consumers and rates effective
695 February 1, 1992, shall remain in effect through June 30, 1993. Rates
696 effective July 1, 1993, shall be based upon rates as determined by the
697 Office of Health Care Access pursuant to the provisions of subsection
698 (b) of section 19a-635, except if the Medicaid rates for any service for
699 the period ending June 30, 1993, exceed the median rate for such
700 service, the increase effective July 1, 1993, shall not exceed one per
701 cent. If the Medicaid rate for any service for the period ending June 30,

1993, is below the median rate, the increase effective July 1, 1993, shall not exceed the lower of the prior rate increased by one and one-half times the most recent annual increase in the consumer price index for urban consumers or the median rate plus one per cent. The Commissioner of Social Services shall establish a fee schedule for home health services to be effective on and after July 1, 1994. The commissioner may annually increase any fee in the fee schedule based on an increase in the cost of services. [The fee schedule may be phased in over a two-year period during which no agency shall be paid for a service in an amount which varies by more than ten per cent from the payment made for the service in the preceding fiscal year.] The commissioner shall increase the fee schedule for home health services provided under the Connecticut home-care program for the elderly established under section 17b-342, as amended, effective July 1, 2000, by two per cent over the fee schedule for home health services for the previous year. The commissioner may increase any fee payable to a home health care agency or homemaker-home health aide agency upon the application of such an agency evidencing extraordinary costs related to (1) serving persons with AIDS; (2) high-risk maternal and child health care; (3) escort services; or (4) extended hour services. In no case shall any rate or fee exceed the charge to the general public for similar services. A home health care agency or homemaker-home health aide agency which, due to any material change in circumstances, is aggrieved by a rate determined pursuant to this subsection may, within ten days of receipt of written notice of such rate from the Commissioner of Social Services, request in writing a hearing on all items of aggrievement. The commissioner shall, upon the receipt of all documentation necessary to evaluate the request, determine whether there has been such a change in circumstances and shall conduct a hearing if appropriate. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. The commissioner may implement policies and procedures to carry out the provisions of this subsection while in the process of adopting regulations, provided notice of intent to adopt the regulations is published in the Connecticut

737 Law Journal within twenty days of implementing the policies and
738 procedures. Such policies and procedures shall be valid for not longer
739 than nine months.

740 (b) The Department of Social Services shall monitor the rates
741 charged by home health care agencies and homemaker-home health
742 aide agencies. Such agencies shall file annual cost reports and service
743 charge information with the department.

744 Sec. 17. Section 17b-343 of the general statutes is repealed and the
745 following is substituted in lieu thereof:

746 The Commissioner of Social Services shall establish annually the
747 maximum allowable rate to be paid by said agencies for homemaker
748 services, chore person services, companion services, respite care, meals
749 on wheels, adult day care services, case management and assessment
750 services, transportation, mental health counseling and elderly foster
751 care, except that the maximum allowable rates in effect July 1, 1990,
752 shall remain in effect during the fiscal years ending June 30, 1992, and
753 June 30, 1993. The Commissioner of Social Services shall prescribe
754 uniform forms on which agencies providing such services shall report
755 their costs for such services. Such rates shall be determined on the
756 basis of a reasonable payment for necessary services rendered. The
757 maximum allowable rates established by the Commissioner of Social
758 Services for the Connecticut home-care program for the elderly
759 established under section 17b-342, as amended, shall constitute the
760 rates required under this section until revised in accordance with this
761 section. The Commissioner of Social Services shall establish a fee
762 schedule, to be effective on and after July 1, 1994, for homemaker
763 services, chore person services, companion services, respite care, meals
764 on wheels, adult day care services, case management and assessment
765 services, transportation, mental health counseling and elderly foster
766 care. The commissioner may annually increase any fee in the fee
767 schedule based on an increase in the cost of services. The
768 commissioner shall increase the fee schedule effective July 1, 2000, by
769 not less than five per cent, for adult day care services. Nothing

770 contained in this section shall authorize a payment by the state to any
771 agency for such services in excess of the amount charged by such
772 agency for such services to the general public.

773 Sec. 18. Subsection (a) of section 17b-261 of the general statutes, as
774 amended by section 16 of public act 99-279, is repealed and the
775 following is substituted in lieu thereof:

776 (a) Medical assistance shall be provided for any otherwise eligible
777 person whose income, including any available support from legally
778 liable relatives and the income of the person's spouse or dependent
779 child, is not more than one hundred forty-three per cent, pending
780 approval of a federal waiver applied for pursuant to subsection (d) of
781 this section, of the benefit amount paid to a person with no income
782 under the temporary family assistance program in the appropriate
783 region of residence and if such person is an institutionalized
784 individual as defined in Section 1917(c) of the Social Security Act, 42
785 USC 1396p(c), and has not made an assignment or transfer or other
786 disposition of property for less than fair market value for the purpose
787 of establishing eligibility for benefits or assistance under this section.
788 Any such disposition shall be treated in accordance with Section
789 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
790 property made on behalf of an applicant or recipient or the spouse of
791 an applicant or recipient by a guardian, conservator, person
792 authorized to make such disposition pursuant to a power of attorney
793 or other person so authorized by law shall be attributed to such
794 applicant, recipient or spouse. A disposition of property ordered by a
795 court shall be evaluated in accordance with the standards applied to
796 any other such disposition for the purpose of determining eligibility.
797 The commissioner shall establish the standards for eligibility for
798 medical assistance at one hundred forty-three per cent of the benefit
799 amount paid to a family unit of equal size with no income under the
800 temporary family assistance program in the appropriate region of
801 residence, pending federal approval, except that the medical assistance
802 program shall provide coverage to persons under the age of nineteen
803 [born after September 30, 1981,] up to one hundred eighty-five per cent

804 of the federal poverty level without an asset limit. On and after [July 1,
805 2000] January 1, 2001, said medical assistance program shall also
806 provide coverage to persons under the age of nineteen and their
807 parents and needy caretaker relatives who qualify for coverage under
808 Section 1931 of the Social Security Act with family income up to one
809 hundred [eighty-five] fifty per cent of the federal poverty level without
810 an asset limit, upon the request of such a person or upon a
811 redetermination of eligibility. Such levels shall be based on the
812 regional differences in such benefit amount, if applicable, unless such
813 levels based on regional differences are not in conformance with
814 federal law. Any income in excess of the applicable amounts shall be
815 applied as may be required by said federal law, and assistance shall be
816 granted for the balance of the cost of authorized medical assistance. All
817 contracts entered into on and after July 1, 1997, pursuant to this section
818 shall include provisions for collaboration of managed care
819 organizations with the Healthy Families Connecticut Program
820 established pursuant to section 17a-56. The Commissioner of Social
821 Services shall provide applicants for assistance under this section, at
822 the time of application, with a written statement advising them of the
823 effect of an assignment or transfer or other disposition of property on
824 eligibility for benefits or assistance.

825 Sec. 19. Section 17b-266 of the general statutes is amended by
826 adding subsection (e) as follows:

827 (NEW) (e) The payment to the Commissioner of Social Services of
828 (1) any monetary sanction imposed by the commissioner on a
829 managed care organization under the provisions of a contract between
830 the commissioner and such organization entered into pursuant to this
831 section or sections 17b-289 to 17b-304, inclusive, or (2) any sum agreed
832 upon by the commissioner and such an organization as settlement of a
833 claim brought by the commissioner or the state against such an
834 organization for failure to comply with the terms of a contract with the
835 commissioner or fraud affecting the Department of Social Services
836 shall be deposited in an account designated for use by the department
837 for expenditures for children's health programs and services.

838 Sec. 20. Section 17b-291 of the general statutes is repealed and the
839 following is substituted in lieu thereof:

840 The commissioner shall submit a state children's health insurance
841 plan to implement the provisions of sections 17b-289 to 17b-303,
842 inclusive, and section 16 of public act 97-1 of the October 29 special
843 session* to the Health Care Financing Administration in accordance
844 with the provisions of Subtitle J of Public Law 105-33. Such plan and
845 any revisions thereto shall be submitted to the joint standing
846 committees of the General Assembly having cognizance of matters
847 relating to human services, public health, insurance and
848 appropriations and the budgets of state agencies. Within [~~fifteen~~] thirty
849 days of receipt of such plan or revisions thereto, said joint standing
850 committees of the General Assembly may advise the commissioner of
851 their approval, denial or modifications, if any, of the plan or any
852 revisions thereto. If the joint standing committees do not concur, the
853 committee chairmen shall appoint a committee on conference which
854 shall be comprised of three members from each joint standing
855 committee. At least one member appointed from each committee shall
856 be a member of the minority party. The report of the committee on
857 conference shall be made to each committee, which shall vote to accept
858 or reject the report. The report of the committee on conference may not
859 be amended. If a joint standing committee rejects the report of the
860 committee on conference, the plan or revisions thereto shall be deemed
861 approved. If the joint standing committees accept the report, the
862 committee having cognizance of matters relating to appropriations and
863 the budgets of state agencies shall advise the commissioner of their
864 approval or modifications, if any, of the plan or revisions thereto,
865 provided if the committees do not act within [~~fifteen~~] thirty days, the
866 plan or revisions thereto shall be deemed approved.

867 Sec. 21. Subsection (h) of section 17b-340 of the general statutes, as
868 amended by section 21 of public act 99-279, is repealed and the
869 following is substituted in lieu thereof:

870 (h) For the fiscal year ending June 30, 1993, any residential care

871 home with an operating cost component of its rate in excess of one
872 hundred thirty per cent of the median of operating cost components of
873 rates in effect January 1, 1992, shall not receive an operating cost
874 component increase. For the fiscal year ending June 30, 1993, any
875 residential care home with an operating cost component of its rate that
876 is less than one hundred thirty per cent of the median of operating cost
877 components of rates in effect January 1, 1992, shall have an allowance
878 for real wage growth equal to sixty-five per cent of the increase
879 determined in accordance with subsection (q) of section 17-311-52 of
880 the regulations of Connecticut state agencies, provided such operating
881 cost component shall not exceed one hundred thirty per cent of the
882 median of operating cost components in effect January 1, 1992.
883 Beginning with the fiscal year ending June 30, 1993, for the purpose of
884 determining allowable fair rent, a residential care home with allowable
885 fair rent less than the twenty-fifth percentile of the state-wide
886 allowable fair rent shall be reimbursed as having allowable fair rent
887 equal to the twenty-fifth percentile of the state-wide allowable fair
888 rent. Beginning with the fiscal year ending June 30, 1997, a residential
889 care home with allowable fair rent less than three dollars and ten cents
890 per day shall be reimbursed as having allowable fair rent equal to
891 three dollars and ten cents per day. Property additions placed in
892 service during the cost year ending September 30, 1996, or any
893 succeeding cost year shall receive a fair rent allowance for such
894 additions as an addition to three dollars and ten cents per day if the
895 fair rent for the facility for property placed in service prior to
896 September 30, 1995, is less than or equal to three dollars and ten cents
897 per day. For the fiscal year ending June 30, 1996, and any succeeding
898 fiscal year, the allowance for real wage growth, as determined in
899 accordance with subsection (q) of section 17-311-52 of the regulations
900 of Connecticut state agencies shall not be applied. For the fiscal year
901 ending June 30, 1996, and any succeeding fiscal year, the inflation
902 adjustment made in accordance with subsection (p) of section
903 17-311-52 of the regulations of Connecticut state agencies shall not be
904 applied to real property costs. Beginning with the fiscal year ending
905 June 30, 1997, minimum allowable patient days for rate computation

906 purposes for a residential care home with twenty-five beds or less shall
907 be eighty-five per cent of licensed capacity. Beginning with the fiscal
908 year ending June 30, 1998, for the purposes of determining the
909 allowable salary of an administrator of a residential care home with
910 sixty beds or less the department shall revise the allowable base salary
911 to thirty thousand dollars to be annually inflated thereafter in
912 accordance with section 17-311-52 of the regulations of Connecticut
913 state agencies and, beginning with the fiscal year ending June 30, 2000,
914 the inflation adjustment for rates made in accordance with subsection
915 (p) of section 17-311-52 of the regulations of state agencies shall be
916 increased by two per cent. Beginning with the fiscal year ending June
917 30, 1999, for the purpose of determining the allowable salary of a
918 related party, the department shall revise the maximum salary to
919 twenty seven thousand eight hundred fifty-six dollars to be annually
920 inflated thereafter in accordance with section 17-311-52 of the
921 regulations of Connecticut state agencies and beginning with the fiscal
922 year ending June 30, 2001, such allowable salary shall be computed on
923 an hourly basis and the maximum number of hours allowed for a
924 related party other than the proprietor shall be increased from forty
925 hours to forty-eight hours per work week.

926 Sec. 22. Section 17b-99 of the general statutes is repealed and the
927 following is substituted in lieu thereof:

928 (a) Any vendor found guilty of vendor fraud under sections 53a-290
929 to 53a-296, inclusive, shall be subject to forfeiture or suspension of any
930 franchise or license held by [him] such vendor from the state in
931 accordance with this subsection, after hearing in the manner provided
932 for in sections 4-176e to 4-180a, inclusive, and 4-181a. Any vendor
933 convicted of vendor fraud under sections 53a-290 to 53a-296, inclusive,
934 shall have such license or franchise revoked. Nothing in this subsection
935 shall preclude any board or commission established under chapters
936 369 to 376, inclusive, 378 to 381, inclusive, and 383 to 388, inclusive,
937 and the Department of Public Health with respect to professions under
938 its jurisdiction which have no board or commission from taking any
939 action authorized in section 19a-17. Any vendor who is convicted in

940 any state or federal court of a crime involving fraud in the Medicare
941 program or Medicaid program or aid to families with dependent
942 children program or state-administered general assistance program or
943 temporary family assistance program or state supplement to the
944 federal Supplemental Security Income Program or any federal or state
945 energy assistance program or general assistance program or state-
946 funded child care program or the refugee program shall be terminated
947 from such programs, effective upon conviction, except that the
948 Commissioner of Social Services may delay termination for a period he
949 deems sufficient to protect the health and well-being of beneficiaries
950 receiving services from such vendor. A vendor who is ineligible for
951 federal financial participation shall be ineligible for participation in
952 such programs. No vendor shall be eligible for reimbursement for any
953 goods provided or services performed by a person convicted of a crime
954 involving fraud in such programs. The convicted person may request a
955 hearing concerning such ineligibility for reimbursement pursuant to
956 sections 4-176e to 4-180a, inclusive, and 4-181a provided such request
957 is filed in writing with the Commissioner of Social Services within ten
958 days of the date of written notice by the commissioner to the person of
959 such ineligibility. The commissioner shall give notice of such
960 ineligibility to such vendors by means of publication in the
961 Connecticut Law Journal following the expiration of said ten-day
962 hearing request period, if no timely request has been filed, or following
963 the decision on the hearing. The Commissioner of Social Services may
964 take such steps as [he considers] necessary to inform the public of the
965 conviction and ineligibility for reimbursement. No vendor or person so
966 terminated or denied reimbursement shall be readmitted to or be
967 eligible for reimbursement in such programs. Any sums paid as a
968 result of vendor fraud under sections 53a-290 to 53a-296, inclusive,
969 may be recovered in an action brought by the state against such
970 person.

971 (b) For the purpose of determining compliance with subsection (a),
972 all vendors shall notify the commissioner within thirty days after the
973 date of employment or conviction, whichever is later, of the identity,

974 interest and extent of services performed by any person convicted of a
975 crime involving fraud in the Medicare program or Medicaid program
976 or aid to families with dependent children program or state-
977 administered general assistance program or temporary family
978 assistance program or state supplement to the federal Supplemental
979 Security Income Program or any federal or state energy assistance
980 program or general assistance program or state-funded child care
981 program or the refugee program. Prior to the commissioner's
982 acceptance of a provider agreement or at any time upon written
983 request by the commissioner, the vendor shall furnish the
984 commissioner with the identity of any person convicted of a crime
985 involving fraud in such programs who has an ownership or control
986 interest in the vendor or who is an agent or managing employee. The
987 commissioner shall terminate, refuse to enter into or renew an
988 agreement with a vendor, except a vendor providing room and board
989 and services pursuant to section 17b-340, if such convicted person has
990 such interest or is such agent or employee. In the case of a vendor
991 providing room and board and services pursuant to said section 17b-
992 340, the commissioner may terminate, refuse to enter into or renew an
993 agreement after consideration of any adverse impact on beneficiaries
994 of such termination or refusal.

995 (c) The Department of Social Services shall distribute to all vendors
996 who are providers in the medical assistance program a copy of the
997 rules, regulations, standards and laws governing the program. The
998 Commissioner of Social Services shall adopt by regulation in the
999 manner provided for in sections 4-166 to 4-176, inclusive,
1000 administrative sanctions against providers in the Medicare program or
1001 Medicaid program or aid to families with dependent children program
1002 or state-funded child care program or state-administered general
1003 assistance program or temporary family assistance program or state
1004 supplement to the federal Supplemental Security Income Program
1005 including suspension from the program, for any violations of the rules,
1006 regulations, standards or law. The commissioner may adopt
1007 regulations in accordance with the provisions of chapter 54 to provide

1008 for the withholding of payments currently due in order to offset
1009 money previously obtained as the result of error or fraud. The
1010 department shall notify the proper professional society and licensing
1011 agency of any violations of this section.

1012 Sec. 23. Section 17b-737 of the general statutes is repealed and the
1013 following is substituted in lieu thereof:

1014 The Commissioner of Social Services shall establish a program,
1015 within available appropriations, to provide grants to municipalities,
1016 boards of education and child care providers to encourage the use of
1017 school facilities for the provision of child day care services before and
1018 after school. In order to qualify for a grant, a municipality, board of
1019 education or child care provider shall guarantee the availability of a
1020 school site which meets the standards set by the Department of Public
1021 Health in regulations adopted under sections 19a-77, 19a-79, 19a-80
1022 and 19a-82 to 19a-87a, inclusive, and shall agree to provide liability
1023 insurance coverage for the program. Grant funds shall be used by the
1024 municipality, board of education or child care provider for the
1025 maintenance and utility costs directly attributable to the use of the
1026 school facility for the day care program, for related transportation costs
1027 and for the portion of the municipality, board of education or child
1028 care provider liability insurance cost and other operational costs
1029 directly attributable to the day care program. The municipality or
1030 board of education may contract with a child day care provider for the
1031 program. [The contract shall limit the amount the provider may charge
1032 under the program to the provider's base cost per capita plus a
1033 percentage of the base cost.] The Commissioner of Social Services may
1034 adopt regulations, in accordance with the provisions of chapter 54 for
1035 purposes of this section. The commissioner may utilize available child
1036 care subsidies to implement the provisions of this section and
1037 encourage association and cooperation with the Head Start program
1038 established pursuant to section 10-16n.

1039 Sec. 24. Section 17b-802 of the general statutes is repealed and the
1040 following is substituted in lieu thereof:

1041 (a) The Commissioner of Social Services shall establish, within
1042 available appropriations, and administer a security deposit guarantee
1043 program [of grants to] for persons residing in emergency shelters or
1044 other emergency housing who are recipients of [public assistance]
1045 temporary family assistance, aid under the state supplement program,
1046 state-administered general assistance or general assistance and to
1047 persons who have a documented showing of financial need and are
1048 residing in emergency shelters or other emergency housing, for use by
1049 such persons [as] in lieu of a security deposit on a rental dwelling unit.
1050 Eligible persons may receive a [grant] security deposit guarantee in an
1051 amount not to exceed the equivalent of one month's rent on such rental
1052 unit, except that upon a documented showing of financial need, the
1053 commissioner may approve a [grant] security deposit guarantee in an
1054 amount not to exceed the equivalent of two month's rent. No person
1055 may apply for and receive a [grant for use as a] security deposit
1056 guarantee more than once without the express authorization of the
1057 Commissioner of Social Services, except as provided in subsection (b)
1058 of this section.

1059 (b) In the case of any person who qualifies for a [grant] guarantee,
1060 the Commissioner of Social Services, or any emergency shelter under
1061 contract with the Department of Social Services to assist in the
1062 administration of the security deposit guarantee program established
1063 pursuant to subsection (a) of this section, may [, in accordance with the
1064 landlord's preference, either pay the security deposit directly to the
1065 landlord or] execute a written agreement to pay the landlord for any
1066 damages suffered by the landlord due to the tenant's failure to comply
1067 with such tenant's obligations as defined in section 47a-21, provided
1068 the amount of any such payment shall not exceed the amount of the
1069 requested security deposit. [Payment of a security deposit directly to
1070 the landlord shall be conditional upon the execution by the landlord of
1071 a written agreement providing that if the tenant for whom such
1072 payment is made vacates the housing unit, any return of the security
1073 deposit and of accrued interest to which the tenant would be entitled,
1074 shall be paid directly to the Department of Social Services. Such refund

1075 shall be made in accordance with the requirements of section 47a-21,
1076 and, if the landlord claims the right to withhold all or most of the
1077 security deposit, he shall comply with all of the applicable provisions
1078 of said section except that any notices required shall also be sent to the
1079 Department of Social Services. The rights of such a tenant to the return
1080 of a security deposit shall be subrogated to the state of Connecticut
1081 and if suit is necessary to collect the deposit, the defendant shall pay
1082 all costs and shall be subject to double damages as provided in section
1083 47a-21.] If a person who has previously received a grant for a security
1084 deposit or a security deposit guarantee becomes eligible for a
1085 subsequent [grant] security deposit guarantee, the amount of the
1086 subsequent [grant] security deposit guarantee for which such person
1087 would otherwise have been eligible shall be reduced by (1) any
1088 amount of [the] a previous grant which has not been returned to the
1089 department pursuant to section 47a-21 or (2) the amount of any
1090 payment made to the landlord for damages pursuant to this
1091 subsection. [In any fiscal year, the total amount of security deposits
1092 granted and written agreements executed for the payment of damages
1093 pursuant to this section shall not exceed the amount available for the
1094 program for that fiscal year.]

1095 (c) Any payment made pursuant to this section to any person
1096 receiving temporary family assistance, aid under the state supplement
1097 program, general assistance or state-administered general assistance
1098 shall not be deducted from the amount of assistance to which the
1099 recipient would otherwise be entitled.

1100 (d) On and after July 1, 2000, no special need or special benefit
1101 payments shall be made by the commissioner for security deposits
1102 from the temporary family assistance, state supplement, state-
1103 administered general assistance or general assistance programs.

1104 (e) The Commissioner of Social Services may, within available
1105 appropriations, from funds appropriated to the safety net account, on a
1106 case-by-case basis, provide a security deposit grant to a person
1107 residing in an emergency shelter or other emergency housing in an

1108 amount not to exceed the equivalent of one month's rent on such rental
1109 unit provided the commissioner determines that emergency
1110 circumstances exist which threaten the health, safety or welfare of a
1111 child who resides with such person. Such person shall not be eligible
1112 for more than one such grant without the authorization of said
1113 commissioner.

1114 [(d)] (f) The Commissioner of Social Services shall adopt regulations
1115 in accordance with the provisions of chapter 54 to administer the
1116 program established pursuant to this section and to set eligibility
1117 criteria for [grants under] the program, but may implement the
1118 program while in the process of adopting such regulations provided
1119 notice of intent to adopt the regulations is published in the Connecticut
1120 Law Journal within twenty days after implementation.

1121 Sec. 25. Section 53a-290 of the general statutes is repealed and the
1122 following is substituted in lieu thereof:

1123 A person commits vendor fraud when, with intent to defraud and
1124 acting on [his own] such person's own behalf or on behalf of an entity,
1125 [he] such person provides goods or services to a beneficiary under
1126 sections 17b-22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-103,
1127 inclusive, [17b-114,] 17b-180a, 17b-183, 17b-260 to 17b-262, inclusive,
1128 17b-264 to 17b-285, inclusive, 17b-357 to 17b-362, inclusive, 17b-600 to
1129 17b-604, inclusive, 17b-749, as amended, 17b-807 and 17b-808 or
1130 provides services to a recipient under Title XIX of the Social Security
1131 Act, as amended, and, (1) presents for payment any false claim for
1132 goods or services performed; (2) accepts payment for goods or services
1133 performed, which exceeds either the amounts due for goods or
1134 services performed, or the amounts authorized by law for the cost of
1135 such goods or services; (3) solicits to perform services for or sell goods
1136 to any such beneficiary, knowing that such beneficiary is not in need of
1137 such goods or services; (4) sells goods to or performs services for any
1138 such beneficiary without prior authorization by the Department of
1139 Social Services, when prior authorization is required by said
1140 department for the buying of such goods or the performance of any

1141 service; or (5) accepts from any person or source other than the state an
1142 additional compensation in excess of the amount authorized by law.

1143 Sec. 26. Section 19a-671 of the general statutes is repealed and the
1144 following is substituted in lieu thereof:

1145 The Commissioner of Social Services is authorized to determine the
1146 amount of payments pursuant to sections 19a-670 to 19a-672, inclusive,
1147 as amended, for each hospital. The commissioner's determination shall
1148 be based on the advice of the office and the application of the
1149 calculation in this section. For each hospital the Office of Health Care
1150 Access shall calculate the amount of payments to be made pursuant to
1151 sections 19a-670 to 19a-672, inclusive, as amended, as follows:

1152 (1) For the period April 1, 1994, to June 30, 1994, inclusive, and for
1153 the period July 1, 1994, to September 30, 1994, inclusive, the office shall
1154 calculate and advise the Commissioner of Social Services of the
1155 amount of payments to be made to each hospital as follows:

1156 (A) Determine the amount of pool payments for the hospital,
1157 including grants approved pursuant to section 19a-168k, in the
1158 previously authorized budget authorization for the fiscal year
1159 commencing October 1, 1993.

1160 (B) Calculate the sum of the result of subparagraph (A) of this
1161 subdivision for all hospitals.

1162 (C) Divide the result of subparagraph (A) of this subdivision by the
1163 result of subparagraph (B) of this subdivision.

1164 (D) From the anticipated appropriation to the medical assistance
1165 disproportionate share-emergency assistance account made pursuant
1166 to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2)
1167 and (29) of section 12-407, subsection (1) of section 12-408, section 12-
1168 408a, subdivision (5) of section 12-412, subsection (1) of section 12-414
1169 and sections 19a-646, 19a-659 to 19a-662, inclusive, and 19a-666 to 19a-
1170 680, inclusive, for the quarter subtract the amount of any additional

1171 medical assistance payments made to hospitals pursuant to any
1172 resolution of or court order entered in any civil action pending on
1173 April 1, 1994, in the United States District Court for the district of
1174 Connecticut, and also subtract the amount of any emergency assistance
1175 to families payments projected by the office to be made to hospitals in
1176 the quarter.

1177 (E) The disproportionate share payment shall be the result of
1178 subparagraph (D) of this subdivision multiplied by the result of
1179 subparagraph (C) of this subdivision.

1180 (2) For the fiscal year commencing October 1, 1994, and subsequent
1181 fiscal years, the interim payment shall be calculated as follows for each
1182 hospital:

1183 (A) For each hospital determine the amount of the medical
1184 assistance underpayment determined pursuant to section 19a-659, plus
1185 the [authorized] actual amount of uncompensated care including
1186 emergency assistance to families determined pursuant to section 19a-
1187 659, less any amount of uncompensated care determined by the
1188 Department of Social Services to be due to a failure of the hospital to
1189 enroll patients for emergency assistance to families, plus the amount of
1190 any grants authorized pursuant to the authority of section 19a-168k.

1191 (B) Calculate the sum of the result of subparagraph (A) of this
1192 subdivision for all hospitals.

1193 (C) Divide the result of subparagraph (A) of this subdivision by the
1194 result of subparagraph (B) of this subdivision.

1195 (D) From the anticipated appropriation made to the medical
1196 assistance disproportionate share-emergency assistance account
1197 pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, as
1198 amended, subdivisions (2) and (29) of section 12-407, as amended,
1199 subsection (1) of section 12-408, as amended, section 12-408a,
1200 subdivision (5) of section 12-412, subsection (1) of section 12-414 and
1201 sections 19a-646, 19a-659 to 19a-662, inclusive, and 19a-666 to 19a-680,

1202 inclusive, as amended, for the fiscal year, subtract the amount of any
1203 additional medical assistance payments made to hospitals pursuant to
1204 any resolution of or court order entered in any civil action pending on
1205 April 1, 1994, in the United States District Court for the district of
1206 Connecticut, and also subtract any emergency assistance to families
1207 payments projected by the office to be made to the hospitals for the
1208 year.

1209 (E) The disproportionate share payment shall be the result of
1210 subparagraph (D) of this subdivision multiplied by the result of
1211 subparagraph (C) of this subdivision.

1212 Sec. 27. Section 31-261 of the general statutes is repealed and the
1213 following is substituted in lieu thereof:

1214 (a) There is created in the State Treasury a special segregated fund
1215 to be known as the Unemployment Compensation Fund. Said fund
1216 shall consist of all contributions and moneys paid into or received by it
1217 for the payment of unemployment compensation benefits, of any
1218 property or securities acquired from the use of moneys belonging to
1219 the fund, all interest earned thereon, all money credited to this state's
1220 account in the Unemployment Trust Fund established by Section 904
1221 of the Social Security Act pursuant to Section 903 of the Social Security
1222 Act, as amended, and all money received for the fund from any other
1223 source. All moneys in said fund shall be expended solely for the
1224 payment of benefits and refunds provided for by this chapter,
1225 exclusive of the expenses of administration, except that money
1226 credited to the account of this state in the Unemployment Trust Fund
1227 by the Secretary of the Treasury of the United States pursuant to
1228 Section 903 of the Social Security Act, as amended, may be
1229 requisitioned and used for the payment of expenses incurred for the
1230 administration of this chapter pursuant to a specific appropriation by
1231 the General Assembly, provided the expenses are incurred and the
1232 money is requisitioned after the enactment of an appropriation act
1233 which [(a)] (1) specifies the purposes for which such money is
1234 appropriated and the amounts appropriated therefor, [(b)] (2) limits

1235 the period within which such money may be obligated to a period
1236 ending not more than two years after the date of the enactment of such
1237 act, and [(c)] (3) limits the amount which may be used during a twelve-
1238 month period beginning on July first and ending on the next June
1239 thirtieth to an amount which does not exceed the amount by which
1240 [(1)] (A) the aggregate of the amounts credited to the account of this
1241 state pursuant to Section 903 of the Social Security Act, as amended,
1242 during the same twelve-month period and the twenty-four preceding
1243 twelve-month periods exceeds [(2)] (B) the aggregate of the amounts
1244 used pursuant to this [subsection] subdivision and charged against the
1245 amounts credited to the account of this state during any of such
1246 twenty-five twelve-month periods. For the purposes of this
1247 [subsection] subdivision, amounts used during any such twelve-month
1248 period shall be charged against equivalent amounts which were first
1249 credited and which are not already so charged, except that no amount
1250 used for administration during any such twelve-month period may be
1251 charged against any amount credited during such a twelve-month
1252 period earlier than the twenty-fourth preceding such period. Money
1253 credited to the account of this state pursuant to Section 903 of the
1254 Social Security Act, as amended, may not be withdrawn or used except
1255 for the payment of benefits and for the payment of expenses for the
1256 administration of this chapter and of public employment offices
1257 pursuant to this [section] subsection. Money requisitioned for the
1258 payment of expense of administration pursuant to this [section]
1259 subsection shall be deposited in the Employment Security
1260 Administration Fund, but, until expended, shall remain a part of the
1261 Unemployment Compensation Fund. The administrator shall maintain
1262 a separate record of the deposit, obligation, expenditure and return of
1263 funds so deposited. If any money so deposited is, for any reason, not to
1264 be obligated for the purpose for which it was appropriated, or if it
1265 remains unobligated at the end of the period specified by the law
1266 appropriating such money, or if any money which has been obligated
1267 within the period will not be expended, it shall be withdrawn and
1268 returned to the Secretary of the Treasury of the United States for credit
1269 to this state's account in the Unemployment Trust Fund. The State

1270 Treasurer shall be liable on his official bond for the faithful
1271 performance of his duties in connection with the Unemployment
1272 Compensation Fund. All sums recovered on any surety bond for losses
1273 sustained by the Unemployment Compensation Fund shall be
1274 deposited in said fund.

1275 (b) Notwithstanding the provisions of subsection (a) of this section,
1276 money credited to the account of this state pursuant to Section 903 of
1277 the Social Security Act, as amended, with respect to the federal fiscal
1278 years 1999, 2000 and 2001, shall be used solely for the payment of
1279 expenses incurred for the administration of this chapter, and such
1280 money shall not otherwise be subject to the provisions of subsection (a)
1281 of this section.

1282 Sec. 28. Section 40 of public act 99-2 of the June special session is
1283 repealed and the following is substituted in lieu thereof:

1284 (a) The Office of Health Care Access, in consultation with the Office
1285 of Policy and Management, may provide [loans to] grants, technical
1286 assistance or consultation services, or any combination thereof, to one
1287 or more nongovernmental acute care general hospitals as permitted by
1288 this section. Such grants, technical assistance or consultation services
1289 shall be consistent with applicable federal disproportionate share
1290 regulations, as from time to time amended.

1291 (b) [Loans] Grants, technical assistance or consultation services, or
1292 any combination thereof, provided under [the provisions of] this
1293 section may be made to assist [an] a nongovernmental acute care
1294 general hospital to develop and implement a plan to achieve financial
1295 stability and assure the delivery of appropriate health care services in
1296 the service area of [the hospital seeking a loan under this program. The
1297 maximum term of any loan authorized pursuant to this section shall
1298 not exceed five years] such hospital, or to assist a nongovernmental
1299 acute care general hospital in determining strategies, goals and plans
1300 to ensure its financial viability or stability. Any such hospital seeking
1301 such [loan] grants, technical assistance or consultation services shall

1302 prepare and submit to the Office of Health Care Access a plan that
1303 includes at least the following: (1) A statement of the [facility's]
1304 hospital's current projections of its finances for the [term of the
1305 proposed loan] current and the next three fiscal years; (2) identification
1306 of the major financial issues which effect the financial stability of the
1307 hospital; (3) the steps proposed to study or improve the financial status
1308 of the hospital and eliminate ongoing operating losses; (4) plans to
1309 study or change the mix of services provided by the hospital, which
1310 may include transition to an alternative licensure category; and (5)
1311 other related elements as determined by the Office of Health Care
1312 Access. Such plan shall clearly identify the amount, value or type of
1313 the [loan] grant, technical assistance or consultation services, or
1314 combination thereof, requested. Any [loans originated by the state
1315 pursuant to this act shall bear interest at a rate agreed to] grants,
1316 technical assistance or consultation services, or any combination
1317 thereof, provided under this section shall be determined by the
1318 Secretary of the Office of Policy and Management [and which will] not
1319 to jeopardize the federal matching payments under the medical
1320 assistance program and the emergency assistance to families program
1321 as determined by the Office of Health Care Access or the Department
1322 of Social Services in consultation with the Office of Policy and
1323 Management. [The hospital's proposed financial plan must include a
1324 plan to repay the loan with interest within five years of initiation.]

1325 (c) There is established a [non-lapsing] nonlapsing account, from
1326 which [loans] grants, purchases of services of any type or
1327 reimbursement of state costs for agency services deemed necessary by
1328 the Office of Health Care Access to assist one or more
1329 nongovernmental acute care general hospitals under this section shall
1330 be made. [Upon receipt of repayment of some or all of said loans, such
1331 funds shall be deposited in the General Fund.]

1332 (d) The submission of [the] a proposed plan by the hospital under
1333 subsection (b) of this section may be considered a letter of intent for the
1334 purposes of any certificate of need which may be required to change
1335 the [facility's] hospital's service offering.

1336 (e) Upon review and approval of the [financial viability] probable
1337 significant benefit of a hospital's submitted plan, the Office of Health
1338 Care Access may recommend that a [loan] grant be awarded and issue
1339 such [loan] grant, or may provide or contract with one or more
1340 consultants to provide technical or other assistance or consultation
1341 services, or may provide any combination of such grant and assistance
1342 that the office deems necessary or advisable.

1343 Sec. 29. (a) The Commissioner of Social Services may develop a plan
1344 to modify the Connecticut Pharmaceutical Assistance Contract to the
1345 Elderly and Disabled program, otherwise known as "ConnPACE", by
1346 establishing a component to be known as "ConnPACE Part B", to meet
1347 the prescription drug assistance needs of elderly and disabled
1348 residents who are ineligible for ConnPACE due to income exceeding
1349 ConnPACE income standards and who have no means of paying the
1350 full or partial cost of their prescription drug needs through private
1351 insurance or other means.

1352 (b) (1) Any plan developed by the Commissioner of Social Services
1353 under subsection (a) of this section may include, but shall not be
1354 limited to, the following: (A) A reasonable application fee for
1355 applicants of the program; (B) a prescription drug benefit where
1356 recipients may receive prescription drugs at a reduced cost which to
1357 the extent possible is at or below the current Medicaid rate; (C) a
1358 manufacturers' drug rebate agreement which equals the rebates
1359 established under the Medicaid program and which may require a
1360 manufacturer participating in the ConnPACE program to participate
1361 in the ConnPACE Part B program; (D) a provision establishing a
1362 dispensing fee and additional subsidies paid to a pharmacist
1363 participating in the program; (E) an eligibility income limitation based
1364 on a percentage of the federal poverty level; and (F) an eligibility
1365 provision whereby income spent on catastrophic costs of prescription
1366 drugs would not be counted in a determination of eligibility.

1367 (2) Such plan shall include a fiscal impact analysis which specifies
1368 (A) the overall program and administrative costs, including projections

1369 of costs associated with any fees or subsidies provided to a pharmacist
1370 participating in the program, any costs associated with the eligibility
1371 determination and claims processing requirements of a ConnPACE
1372 part B program and any potential program start-up costs, and (B)
1373 projections of revenues, including anticipated manufacturer
1374 participation and rebates and revenues associated with an application
1375 fee. Program expenditures and administrative costs under such plan
1376 shall not exceed estimated revenues from such program.

1377 (c) Not later than January 1, 2001, the Commissioner of Social
1378 Services shall submit any such plan to the joint standing committees of
1379 the General Assembly having cognizance of matters relating to human
1380 services and appropriations and the budgets of state agencies. Within
1381 thirty days of the receipt of the plan, said committees shall make a
1382 finding to the speaker of the House of Representatives, the president
1383 pro tempore of the Senate, the majority leader of the House of
1384 Representatives, the majority leader of the Senate, the minority leader
1385 of the House of Representatives, the minority leader of the Senate and
1386 the Commissioner of Social Services, that such plan meets, or fails to
1387 meet, the requirements that program expenditures and administrative
1388 costs do not exceed estimated revenues. If said committees find that
1389 projected program expenditures and administrative costs exceed
1390 estimated revenues, said committees may recommend, in addition to
1391 their finding, a modification to achieve cost neutrality. In the event that
1392 the committees find that program expenditures and administrative
1393 costs do not exceed estimated revenues or modify the plan to do so,
1394 such plan or modified plan shall be implemented by the commissioner
1395 as soon as is practicable, but no later than July 1, 2001.

1396 (d) There shall be established a separate, nonlapsing ConnPACE
1397 Part B account, into which ConnPACE Part B manufacturers' rebates
1398 and other revenues may be deposited and from which payments for
1399 program expenditures and administrative costs may be made.

1400 (e) The Commissioner of Social Services may negotiate the
1401 contractual terms of participation of any pharmaceutical manufacturer,

1402 pharmacists and eligibility and claims processing agent participating
1403 in the ConnPACE Part B program.

1404 Sec. 30. Not later than February 1, 2001, the Commissioner of Social
1405 Services shall study the impact of the security deposit guarantee
1406 program on access to affordable housing for recipients of benefits
1407 under such program and report any findings and recommendations to
1408 the joint standing committees of the General Assembly having
1409 cognizance of matters relating to human services and appropriations
1410 and the budgets of state agencies, in accordance with the provisions of
1411 section 11-4a of the general statutes.

1412 Sec. 31. (a) The Commissioner of Social Services shall study methods
1413 of operating the Medicaid managed care program including primary
1414 care case management, fee for service and the current system. The
1415 study shall compare probable costs and quality under each system,
1416 including provider participation, client participation, client access to
1417 care parameters, ease of access, preventive care, treatment referrals,
1418 outreach, any disincentives to providing care, public ownership of
1419 program information and data and the administrative burden on
1420 providers, clients and the state. The commissioner shall rely on the
1421 experiences of other states and input from current and potential
1422 providers and clients of such program.

1423 (b) Not later than March 1, 2001, the Commissioner of Social
1424 Services shall submit a report of any findings and recommendations to
1425 the joint standing committees of the General Assembly having
1426 cognizance of matters relating to public health, human services and
1427 appropriations and the budgets of state agencies, in accordance with
1428 the provisions of section 11-4a of the general statutes.

1429 Sec. 32. (a) There is established a Dental Advisory Council
1430 consisting of the following members: (1) The Commissioner of Social
1431 Services, or the commissioner's designee; (2) the Commissioner of
1432 Public Health, or the commissioner's designee; (3) the dean of The
1433 University of Connecticut School of Dentistry, or the dean's designee;

1434 and (4) six persons appointed by the Commissioner of Social Services,
1435 one of whom shall be a representative of the Connecticut State Dental
1436 Association, one of whom shall be a representative of a managed care
1437 organization, one of whom shall be a representative of the Connecticut
1438 Dental Hygiene Association, one of whom shall be a representative of
1439 the Connecticut Children's Health Council, one of whom shall be a
1440 representative of a community health center or a school-based health
1441 center, and one of whom shall be a faculty member or an administrator
1442 of a dental hygiene school located in the state.

1443 (b) The Dental Advisory Council shall: (1) Review fees for dental
1444 services paid by the Department of Social Services under the Medicaid
1445 dental program to determine the adequacy of such fees and make
1446 recommendations for adjustments or modifications to such fees based
1447 on experience and access to dental services and dental utilization as
1448 reflected in annual Health Care Financing Administration utilization
1449 reports; (2) monitor the effects of fee increases under the Medicaid
1450 dental program on the number of persons eligible under the program
1451 who obtain dental services and the number of dental care providers
1452 who participate in the program; (3) make recommendations on dental
1453 services capacity assessment; (4) identify private foundation support
1454 for public or nonprofit health care entities providing dental services;
1455 (5) evaluate dental care pilot programs; (6) enhance public and medical
1456 community awareness of dental access issues; and (7) make
1457 recommendations concerning the expansion of access to dental care
1458 and the increase of dental services utilization in the state including, but
1459 not limited to, recommendations for state utilization goals.

1460 (c) Not later than April 15, 2001, the Dental Advisory Council shall
1461 submit an interim report of its analysis and recommendations under
1462 subsection (b) of this section to the joint standing committees of the
1463 General Assembly having cognizance of matters relating to public
1464 health and human services, in accordance with the provisions of
1465 section 11-4a of the general statutes. The Dental Advisory Council shall
1466 submit its final report under this subsection to said committees not
1467 later than January 1, 2002.

1468 Sec. 33. Not later than January 1, 2001, the Commissioner of
1469 Children and Families, in conjunction with the Office of Fiscal
1470 Analysis, shall submit a report to the joint standing committee of the
1471 General Assembly having cognizance of matters relating to human
1472 services which shall specify a methodology said commissioner will use
1473 to indicate in said agency's estimate of expenditure requirements
1474 transmitted pursuant to subsection (a) of section 4-77 of the general
1475 statutes, expenditure requirements classified to indicate expenditures
1476 estimated for the following: (1) Child protective services; (2) juvenile
1477 justice; (3) children's mental health and substance abuse services; (4)
1478 prevention; and (5) administration.

1479 Sec. 34. (NEW) The expenditure report relative to the temporary
1480 assistance for needy families block grant required to be submitted by
1481 the Commissioner of Social Services to the federal Department of
1482 Health and Human Services shall be transmitted to the joint standing
1483 committees of the General Assembly having cognizance of matters
1484 relating to human services and appropriations and the budgets of state
1485 agencies within forty-five days of the date of such submission. Such
1486 report for the last quarter of the fiscal year shall include the
1487 identification of unliquidated obligations either identified in previous
1488 quarterly reports for the same fiscal year and claimed before the prior
1489 quarterly report or those not yet claimed by the commissioner for the
1490 purposes of receiving federal reimbursement. In the event that such
1491 report identifies any unliquidated obligations, the commissioner shall
1492 notify said committees of the commissioner's intention concerning the
1493 disposition of such unliquidated obligations, which may include,
1494 establishing or contributing to a reserve account to meet future needs
1495 in the temporary family assistance program.

1496 Sec. 35. (NEW) (a) The Commissioner of Social Services may
1497 establish maximum allowable costs to be paid under the Medicaid,
1498 general assistance and ConnPACE programs for generic prescription
1499 drugs based on, but not limited to, the actual acquisition cost.
1500 Reimbursements to pharmacies for generic prescription drugs shall
1501 cover actual acquisition costs and a reasonable profit margin, as

1502 determined by the commissioner. Maximum allowable costs
1503 established pursuant to this section shall be reported to the joint
1504 standing committees of the General Assembly having cognizance of
1505 matters relating to human services and appropriations and the budgets
1506 of state agencies not later than January 1, 2001. Said committees shall
1507 review the impact of establishing such maximum allowable costs on
1508 pharmacies and on access to prescription drugs for which such
1509 maximums have been established and shall assess savings achieved.
1510 Not later than January 31, 2001, said committees shall jointly report
1511 their findings to the speaker of the House of Representatives, the
1512 president pro tempore of the Senate, the majority leader of the House
1513 of Representatives, the majority leader of the Senate, the minority
1514 leader of the House of Representatives and the minority leader of the
1515 Senate.

1516 (b) The maximum allowable cost paid for Factor VIII
1517 pharmaceuticals under said programs shall be the actual acquisition
1518 cost plus eight per cent. The commissioner may designate a specific
1519 supplier of Factor VIII pharmaceuticals from which a dispensing
1520 pharmacy shall order the prescription to be delivered to the pharmacy
1521 and billed by the supplier to the Department of Social Services. If the
1522 commissioner so designates a specific supplier of Factor VIII
1523 pharmaceuticals, the department shall pay the dispensing pharmacy a
1524 handling fee equal to eight per cent of the actual acquisition cost for
1525 such prescription.

1526 Sec. 36. (NEW) Notwithstanding the provisions of section 17b-262 of
1527 the general statutes and any regulation adopted thereunder, on or after
1528 July 1, 2000, the Commissioner of Social Services may establish a
1529 maximum quantity of oral dosage units permitted to be dispensed at
1530 one time for prescriptions covered under the Medicaid and general
1531 assistance programs based on a review of utilization patterns.

1532 Sec. 37. (NEW) (a) The Commissioner of Social Services shall
1533 establish a plan for the prior authorization of certain prescription
1534 drugs covered under the Medicaid, general assistance and ConnPACE

1535 programs.

1536 (b) The Commissioner of Social Services shall, to increase cost-
1537 efficiency or enhance access to a particular prescription drug, establish
1538 a plan under which the commissioner may designate a specific
1539 supplier of a prescription drug from which a dispensing pharmacy
1540 shall order the prescription to be delivered to the pharmacy and billed
1541 by the supplier to the department. For each prescription dispensed
1542 through a designated supplier, the department shall pay the
1543 dispensing pharmacy a handling fee not to exceed four hundred per
1544 cent of the dispensing fee established pursuant to section 17b-280 of
1545 the general statutes, as amended by this act.

1546 (c) A plan established pursuant to subsection (a) or (b) of this
1547 section and any revisions thereto shall be submitted to the joint
1548 standing committees of the General Assembly having cognizance of
1549 matters relating to human services and appropriations and the budgets
1550 of state agencies. Within thirty days of receipt of such a plan or
1551 revisions thereto, said joint standing committees of the General
1552 Assembly shall approve, deny or modify the plan or any revisions
1553 thereto and advise the commissioner of their approval, denial or
1554 modifications, if any, of the plan or any revisions thereto. If the joint
1555 standing committees do not concur, the committee chairpersons shall
1556 appoint a committee on conference which shall be comprised of three
1557 members from each said joint standing committee. At least one
1558 member appointed from each committee shall be a member of the
1559 minority party. The report of the committee on conference shall be
1560 made to each committee, which shall vote to accept or reject the report
1561 within sixty days from the date the plan or revisions thereto was
1562 submitted to said joint standing committees. The report of the
1563 committee on conference may not be amended. If a joint standing
1564 committee rejects the report of the committee on conference, the plan
1565 or revisions thereto shall be deemed approved. If the joint standing
1566 committees accept the report, the committee having cognizance of
1567 matters relating to appropriations and the budgets of state agencies
1568 shall advise the commissioner of their approval or modifications, if

1569 any, of the plan or revisions thereto, provided if the committees do not
1570 act within thirty days, the plan or revisions thereto shall be deemed
1571 approved.

1572 Sec. 38. (NEW) (a) Each long-term care facility shall return to the
1573 vendor pharmacy which shall accept, for repackaging and
1574 reimbursement to the Department of Social Services, drug products
1575 that were dispensed to a patient and not used if such drug products
1576 are (1) prescription drug products that are not controlled substances,
1577 (2) sealed in individually packaged units, (3) returned to the vendor
1578 pharmacy within the recommended period of shelf life for the purpose
1579 of redispensing such drug products, and (4) oral and parenteral
1580 medication in single-dose sealed containers approved by the federal
1581 Food and Drug Administration, topical or inhalant drug products in
1582 units of use containers approved by the federal Food and Drug
1583 Administration or parenteral medications in multiple-dose sealed
1584 containers approved by the federal Food and Drug Administration
1585 from which no doses have been withdrawn.

1586 (b) Notwithstanding the provisions of subsection (a) of this section:

1587 (1) If such drug products are packaged in manufacturer's unit-dose
1588 packages, such drug products shall be returned to the vendor
1589 pharmacy for redispensing and reimbursement to the Department of
1590 Social Services if such drugs may be redispensed for use before the
1591 expiration date, if any, indicated on the package.

1592 (2) If such drug products are repackaged in manufacturer's unit-
1593 dose or multiple-dose blister packs, such drug products shall be
1594 returned to the vendor pharmacy for redispensing and reimbursement
1595 to the Department of Social Services if (A) the date on which such drug
1596 product was repackaged, such drug product's lot number and
1597 expiration date are indicated clearly on the package of such
1598 repackaged drug; (B) ninety days or fewer have elapsed from the date
1599 of repackaging of such drug product; and (C) a repackaging log is
1600 maintained by the pharmacy in the case of drug products repackaged

1601 in advance of immediate needs.

1602 (3) No drug products dispensed in a bulk dispensing container may
1603 be returned to the vendor pharmacy.

1604 (c) Each long-term care facility shall establish procedures for the
1605 return of unused drug products to the vendor pharmacy from which
1606 such drug products were purchased.

1607 (d) The Department of Social Services may (1) reimburse to the
1608 vendor pharmacy a restocking fee, as determined by the
1609 commissioner, for the return of unused drug products, or (2) establish
1610 procedures, if feasible, for reimbursement to nonMedicaid payors for
1611 drug products returned pursuant to this section.

1612 (e) The Department of Consumer Protection, in consultation with
1613 the Department of Social Services, shall adopt regulations, in
1614 accordance with the provisions of chapter 54 of the general statutes,
1615 which shall govern the repackaging and labeling of drug products
1616 returned pursuant to subsections (a) and (b) of this section. The
1617 Department of Consumer Protection shall implement the policies and
1618 procedures necessary to carry out the provisions of this section while
1619 in the process of adopting such policies and procedures in regulation
1620 form, provided notice of intent to adopt the regulations is published in
1621 the Connecticut Law Journal within twenty days after implementation.
1622 Such policies and procedures shall be valid until the time final
1623 regulations are effective.

1624 Sec. 39. Section 17b-245a of the general statutes is repealed and the
1625 following is substituted in lieu thereof:

1626 (a) On and after April 1, 1996, in the determination of rates for
1627 federally qualified health centers, the Commissioner of Social Services
1628 shall apply Medicare productivity standards and a maximum
1629 allowable per visit cost of one hundred fifteen per cent of the median
1630 cost per visit.

1631 (b) On and after October 1, 1999, the Commissioner of Social
1632 Services may modify the method by which rates are calculated for
1633 federally qualified health centers to apply the minimum percentage of
1634 allowable costs permitted under federal law. Such methodology shall
1635 apply both to direct payments to such centers and to supplemental
1636 payments to such centers for services provided as part of a Medicaid
1637 managed care program established in accordance with section 17b-266,
1638 as amended by this act.

1639 Sec. 40. Section 17b-274 of the general statutes is repealed and the
1640 following is substituted in lieu thereof:

1641 (a) The Commissioner of Social Services shall pay a pharmacist a
1642 professional dispensing fee of fifty cents per prescription, in addition
1643 to any other dispensing fee, for substituting a generically equivalent
1644 drug product, in accordance with section 20-619, as amended by this
1645 act, for the drug prescribed by the licensed practitioner for a Medicaid
1646 recipient, provided the substitution is not required by federal law or
1647 regulation.

1648 (b) The Division of Criminal Justice shall periodically investigate
1649 pharmacies to ensure that the state is not billed for a brand name drug
1650 product when a less expensive generic substitute drug product is
1651 dispensed to a Medicaid recipient. The Commissioner of Social
1652 Services shall cooperate and provide information as requested by such
1653 division.

1654 (c) A licensed medical practitioner may specify in writing or by a
1655 telephonic or electronic communication that there shall be no
1656 substitution for the specified brand name drug product in any
1657 prescription for a Medicaid, general assistance or ConnPACE recipient,
1658 provided (1) the practitioner specifies the basis on which the brand
1659 name drug product and dosage form is medically necessary in
1660 comparison to a chemically equivalent generic drug product
1661 substitution, and (2) the phrase "brand medically necessary" shall be in
1662 the practitioner's handwriting on the prescription form or, if the

1663 prohibition was communicated by telephonic or electronic
1664 communication, in the pharmacist's handwriting on such form, and
1665 shall not be preprinted or stamped or initialed on such form. If the
1666 practitioner specifies by telephonic or electronic communication that
1667 there shall be no substitution for the specified brand name drug
1668 product in any prescription for a Medicaid, general assistance or
1669 ConnPACE recipient, written certification in the practitioner's
1670 handwriting bearing the phrase "brand medically necessary" shall be
1671 sent to the dispensing pharmacy within ten days. A pharmacist shall
1672 dispense a generically equivalent drug product for any drug listed in
1673 accordance with the Code of Federal Regulations Title 42 Part 447.332
1674 for a drug prescribed for a Medicaid, general assistance or ConnPACE
1675 recipient unless the phrase "brand medically necessary" is ordered in
1676 accordance with this subsection and such pharmacist has received
1677 approval to dispense the brand name drug product in accordance with
1678 subsection (d) of this section.

1679 (d) The Commissioner of Social Services shall establish a procedure
1680 by which a pharmacist shall obtain approval from the Department of
1681 Social Services whenever the pharmacist dispenses a brand name drug
1682 product to a Medicaid, general assistance or ConnPACE recipient and
1683 a chemically equivalent generic drug product substitution is available.
1684 The pharmacist may appeal a denial of reimbursement to the
1685 department based on the failure of such pharmacist to substitute a
1686 generic drug product in accordance with this section.

1687 (e) A licensed medical practitioner shall disclose to the Department
1688 of Social Services, upon request, the basis on which the brand name
1689 drug product and dosage form is medically necessary in comparison to
1690 a chemically equivalent generic drug product substitution. The
1691 Commissioner of Social Services shall establish a procedure by which
1692 such a practitioner may appeal a determination that a chemically
1693 equivalent generic drug product substitution is required for a
1694 Medicaid, general assistance or ConnPACE recipient.

1695 Sec. 41. Section 17b-280 of the general statutes is repealed and the

1696 following is substituted in lieu thereof:

1697 Notwithstanding any provision of the regulations of Connecticut
1698 state agencies concerning payment for drugs provided to Medicaid
1699 recipients [(1)] effective July 1, 1989, the state shall reimburse for all
1700 legend drugs provided to such recipients at the rate established by the
1701 Health Care Finance Administration as the federal acquisition cost, or,
1702 if no such rate is established, the commissioner shall establish and
1703 periodically revise the estimated acquisition cost in accordance with
1704 federal regulations. [The] Effective July 1, 2000, the commissioner shall
1705 [also] establish a professional fee to be paid to licensed pharmacies for
1706 dispensing drugs to general assistance, ConnPACE and Medicaid
1707 recipients in accordance with federal regulations [; and (2) on] which
1708 shall be three dollars and sixty cents for each prescription. On and after
1709 September 4, 1991, payment for legend and nonlegend drugs provided
1710 to Medicaid recipients shall be based upon the actual package size
1711 dispensed. Effective October 1, 1991, reimbursement for over-the-
1712 counter drugs for such recipients shall be limited to those over-the-
1713 counter drugs and products published in the Connecticut Formulary,
1714 or the cross reference list, issued by the commissioner. The cost of all
1715 over-the-counter drugs and products provided to residents of nursing
1716 facilities, chronic disease hospitals, and intermediate care facilities for
1717 the mentally retarded shall be included in the facilities' per diem rate.

1718 Sec. 42. Section 17b-362a of the general statutes is repealed and the
1719 following is substituted in lieu thereof:

1720 The Commissioner of Social Services shall establish a pharmacy
1721 review panel to serve as advisors in the operation of pharmacy benefit
1722 programs administered by the Department of Social Services,
1723 including the implementation of any cost-saving initiatives undertaken
1724 pursuant to section 17b-362 [,] and subsection (e) of section 17b-491,
1725 [and section 17b-363.] The panel shall be appointed by the
1726 commissioner to a three-year term and shall be composed of two
1727 representatives of independent pharmacies, two representatives of
1728 chain pharmacies, two representatives of pharmaceutical

1729 manufacturers, one physician specializing in family practice and one
1730 physician specializing in internal medicine or geriatrics. The panel
1731 shall meet at least quarterly with the commissioner or [his] said
1732 commissioner's designee.

1733 Sec. 43. Subsection (e) of section 17b-491 of the general statutes is
1734 repealed and the following is substituted in lieu thereof:

1735 (e) All prescription drugs of a pharmaceutical manufacturer that
1736 participates in the program pursuant to subsection (d) of this section
1737 shall be subject to prospective drug utilization review, [but not prior
1738 authorization.] Any prescription drug of a manufacturer that does not
1739 participate in the program shall not be reimbursable, unless the
1740 department determines the prescription drug is essential to program
1741 participants.

1742 Sec. 44. Section 17b-493 of the general statutes is repealed and the
1743 following is substituted in lieu thereof:

1744 A pharmacist shall, except as limited by subsection (c) of section 20-
1745 619, as amended by this act, and section 17b-274, as amended by this
1746 act, substitute a therapeutically and chemically equivalent generic
1747 drug product for a prescribed drug product when filling a prescription
1748 for an eligible person under the program.

1749 Sec. 45 Subsection (c) of section 20-619 of the general statutes, as
1750 amended by section 39 of public act 99-175, is repealed and the
1751 following is substituted in lieu thereof:

1752 (c) A prescribing practitioner may specify in writing or by a
1753 telephonic or other electronic communication that there shall be no
1754 substitution for the specified brand name drug product in any
1755 prescription, provided (1) in any prescription for a Medicaid, general
1756 assistance or ConnPACE recipient, such practitioner specifies the basis
1757 on which the brand name drug product and dosage form is medically
1758 necessary in comparison to a chemically equivalent generic drug
1759 product substitution, and (2) the phrase "NO SUBSTITUTION" or, for

1760 prescriptions covered by medical assistance in accordance with the
1761 Code of Federal Regulations, Title 42, Part 447.332, the phrase
1762 "BRAND MEDICALLY NECESSARY", shall be in the practitioner's
1763 handwriting on the prescription form or on an electronically-produced
1764 copy of the prescription form or, if the prohibition was communicated
1765 by telephonic or other electronic communication that did not
1766 reproduce the practitioner's handwriting, a statement to that effect
1767 appears on the form. The phrase "NO SUBSTITUTION" or "BRAND
1768 MEDICALLY NECESSARY" shall not be preprinted or stamped or
1769 initialed on the form. If the practitioner specifies by telephonic or other
1770 electronic communication that did not reproduce the practitioner's
1771 handwriting that there shall be no substitution for the specified brand
1772 name drug product in any prescription for a Medicaid, general
1773 assistance or ConnPACE recipient, written certification in the
1774 practitioner's handwriting bearing the phrase "BRAND MEDICALLY
1775 NECESSARY" shall be sent to the dispensing pharmacy within ten
1776 days.

1777 Sec. 46. Subsection (b) of section 17b-134 of the general statutes is
1778 repealed and the following is substituted in lieu thereof:

1779 (b) At the end of each quarter, one of the selectmen or the public
1780 official charged with the administration of general assistance in each
1781 town shall send to the Commissioner of Social Services, in the form
1782 prescribed by said commissioner, a statement of the cost to such town
1783 of general assistance during such quarter, which report shall be signed
1784 and sworn to by such selectman or public official. Such report form
1785 shall be uniform throughout the state and shall include, but not be
1786 limited to, the following information: (1) The approved budget of each
1787 town for general assistance, (2) the number of applications received, (3)
1788 compilation of data required under section 17b-123, (4) the extent to
1789 which recipients participated in work relief programs, if any, (5) the
1790 amount of the support and medical aid furnished, (6) the amount of
1791 the town's share of the cost for inpatient hospital and other medical
1792 services paid by the Department of Social Services pursuant to section
1793 17b-220, and (7) such other information the commissioner deems

1794 necessary for the proper administration and oversight of the general
1795 assistance program. "Cost", as used herein, means the actual relief
1796 expenditure made by such town for persons therein or sent from such
1797 town to such licensed institutions, including expenses, except
1798 attorneys' fees, incurred in an appeal of a denial of Supplemental
1799 Security Income Assistance as provided in section 17b-119, but not
1800 including administrative costs, provided the expenditures for medical
1801 care shall not exceed the amounts set forth in the various fee schedules
1802 promulgated by the Commissioner of Social Services for medical,
1803 dental and allied services and supplies or the charges made for
1804 comparable services and supplies to the general public, whichever is
1805 less. Upon state processing and payment of medical claims pursuant to
1806 this chapter, pharmaceutical manufacturers shall be liable for rebates
1807 on pharmaceutical products. Rebate amounts shall be [equal to]
1808 established by the commissioner, provided such amounts may not be
1809 less than those under the Medicaid program. The process for
1810 computing and collecting such rebates shall parallel such process in
1811 the Medicaid program. Failure or refusal of a manufacturer to pay
1812 rebate amounts billed may result in elimination of coverage under
1813 general assistance for all or some products of the manufacturer. Any
1814 hospital receiving state aid shall charge a uniform rate for paupers
1815 receiving medical treatment or being supported or cared for in such
1816 hospital under the provisions of this section, not in excess of the rate
1817 established under the provisions of section 17b-238 for room, board,
1818 ordinary nursing care and routine medications and not in excess of the
1819 daily average cost rate for special professional services as established
1820 under the provisions of subsection (b) of section 17b-239. The
1821 commissioner, if satisfied that the statements are substantially true and
1822 if the town has complied with the reporting requirements of this
1823 section, shall certify them to the Comptroller, who shall pay within
1824 sixty days of receipt of such certification, subject to subsequent audits,
1825 to the town for general assistance expenditures, subject to section 17b-
1826 220, ninety per cent for expenditures made prior to July 1, 1992, and
1827 notwithstanding the provisions of section 2-32a, eighty-five per cent
1828 for expenditures made on and after July 1, 1992, eighty per cent for

1829 expenditures made on and after July 1, 1993, ninety per cent for
1830 expenditures made on and after April 1, 1996, and one hundred per
1831 cent for expenditures made on and after April 1, 1997. The
1832 commissioner may reduce by twenty-five per cent the amount
1833 otherwise payable to the town in accordance with this section for any
1834 statement which is submitted more than three months after the close of
1835 the quarter for which the statement was prepared. Effective August 31,
1836 1997, towns shall not be reimbursed for assistance paid to employable
1837 persons. If not satisfied, the commissioner may reject such claim and
1838 shall notify the selectmen or other public official submitting the report
1839 of his decision. Notwithstanding any other provision of this section,
1840 the state shall charge the town for ten per cent of the inpatient hospital
1841 expenses paid prior to July 1, 1992, of a person who is hospitalized and
1842 is eligible for or is receiving general assistance benefits in the form of
1843 an adjustment to the quarterly statement submitted by the town
1844 pursuant to this section. Notwithstanding the provisions of section 2-
1845 32a, (A) the state shall charge the town for fifteen per cent of the
1846 inpatient hospital and other medical expenses paid on and after July 1,
1847 1992, on behalf of any such person in such form and (B) the state shall
1848 charge the town for twenty per cent of the inpatient hospital and other
1849 medical expenses paid on or after July 1, 1993, ten per cent for such
1850 expenses paid on or after April 1, 1996, and the state shall not charge
1851 for such expenses on or after April 1, 1997, on behalf of any person in
1852 such form. Any town aggrieved by the action of the commissioner
1853 may, within thirty days after receipt of such notice, request a hearing
1854 before the commissioner. The commissioner shall fix a time and place
1855 for the hearing, which shall be not more than thirty days after the
1856 receipt of such request and notify the town of the time and place not
1857 later than fifteen days before the date of the hearing. The hearing shall
1858 be conducted in accordance with the procedures established under
1859 sections 4-176e, 4-177, 4-177c and 4-180 for contested cases. The
1860 commissioner or the person authorized by him to conduct the hearing
1861 shall render a decision within thirty days after the hearing and notify
1862 the town by mailing a copy of the decision to the selectmen or the
1863 public official charged with the administration of general assistance. If

1864 the town is aggrieved by the decision, it may appeal to the Superior
1865 Court in accordance with the provisions of section 4-183.

1866 Sec. 47. Subsection (d) of section 17b-491 of the general statutes is
1867 repealed and the following is substituted in lieu thereof:

1868 (d) The commissioner shall establish an application form whereby a
1869 pharmaceutical manufacturer may apply to participate in the program.
1870 Upon receipt of a completed application, the department shall issue a
1871 certificate of participation to the manufacturer. Participation by a
1872 pharmaceutical manufacturer shall require that the department shall
1873 receive a rebate from the pharmaceutical manufacturer [equal to]
1874 established by the commissioner, provided such rebate may not be less
1875 than the rebate supplied by the manufacturer under Section 1927 of
1876 Title XIX of the Social Security Act for every prescription drug
1877 dispensed under the program. A participating pharmaceutical
1878 manufacturer shall make quarterly rebate payments to the department
1879 [equal to the rebate supplied by the manufacturer under Section 1927
1880 of Title XIX of the Social Security Act] for the total number of dosage
1881 units of each form and strength of a prescription drug which the
1882 department reports as reimbursed to providers of prescription drugs,
1883 provided such payments shall not be due until thirty days following
1884 the manufacturer's receipt of utilization data from the department
1885 including the number of dosage units reimbursed to providers of
1886 prescription drugs during the quarter for which payment is due.

1887 Sec. 48. (a) The Commissioner of Social Services, in consultation
1888 with the pharmacy review panel established pursuant to section 17b-
1889 362a of the general statutes shall study the feasibility of
1890 implementation of additional pharmacy efficiencies in the Medicaid,
1891 ConnPACE and general assistance programs, including, but not
1892 limited to, (1) enhanced use of cognitive services by pharmacists in the
1893 use of medicines for chronic disease; (2) enhancement of services to
1894 address adverse drug reactions experienced by recipients of such
1895 programs; and (3) pursuit of fraudulent use or other misuse of
1896 prescriptive authority by licensed medical practitioners.

1897 (b) Not later than May 1, 2000, the Commissioner of Social Services
1898 shall submit a report of any findings and recommendations to the joint
1899 standing committees of the General Assembly having cognizance of
1900 matters relating to human services and appropriations and the budgets
1901 of state agencies, in accordance with the provisions of section 11-4a of
1902 the general statutes.

1903 Sec. 49. In the event that prescription drug and pharmacy savings
1904 initiatives undertaken by the Department of Social Services, pursuant
1905 to sections 35 to 48, inclusive, of this act, for the fiscal year ending June
1906 30, 2001, result in greater savings than anticipated, the Commissioner
1907 of Social Services shall develop a plan for the disbursement to
1908 participating pharmacies of any such excess savings and shall report
1909 such savings and such plan to the joint standing committees of the
1910 General Assembly having cognizance of matters relating to human
1911 services and appropriations and the budgets of state agencies not later
1912 than May 15, 2001.

1913 Sec. 50. (a) The Commissioner of Social Services shall conduct a
1914 comprehensive needs assessment detailing the continuum of care
1915 needs of children or young adults with specific chronic medical
1916 conditions.

1917 (b) Not later than February 1, 2001, the commissioner shall submit a
1918 report of any findings and recommendations to the joint standing
1919 committees of the General Assembly having cognizance of matters
1920 relating to human services, public health, insurance and
1921 appropriations and the budgets of state agencies, in accordance with
1922 the provisions of section 11-4a of the general statutes.

1923 Sec. 51. The unexpended balance of funds appropriated to the Office
1924 of Health Care Access under special act 99-10 for the purposes of a
1925 distressed hospitals loan program shall be transferred to the hospital
1926 grant and assistance program established pursuant to section 40 of
1927 public act 99-2 of the June special session, as amended by this act.

1928 Sec. 52. Section 17b-114 of the general statutes is repealed.

1929 Sec. 53. This act shall take from its passage, except that sections 1 to
1930 7, inclusive, 11 to 17, inclusive, and 20 to 52, inclusive, shall take effect
1931 July 1, 2000, sections 8 to 10, inclusive, shall take effect October 1, 2000,
1932 and section 18 shall take effect January 1, 2001."