



General Assembly

June Special Session, 2000

Bill No. 6002

LCO No. 5582

Referred to Committee on No Committee

Introduced by:

REP. LYONS, 146th Dist.

SEN. SULLIVAN, 5th Dist.

An Act Concerning Programs And Modifications Necessary To Implement The Budget Relative To The Department Of Social Services.

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

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

16 individual who physically lifts such person or utilizes a hoier lift,
17 transfer board or other device in order to move such person between
18 surfaces or to or from a bed, chair or wheelchair within such person's
19 residence.

20 (b) The Commissioner of Social Services shall adopt regulations, in
21 accordance with the provisions of chapter 54 of the general statutes, to
22 administer the program established under subsection (a) of this
23 section. Said commissioner may implement the program until January
24 1, 2002, while in the process of adopting such regulations, provided
25 notice of intent to adopt the regulations is published in the Connecticut
26 Law Journal within twenty days after implementation.

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

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

47 (b) Not later than October 1, 2000, said commissioners shall enter

48 into a memorandum of understanding for the purpose of the joint
49 administration of an integrated behavioral health service delivery
50 system. Such memorandum of understanding shall establish
51 mechanisms to administer combined funding, establish standards for,
52 and monitor implementation of, the integrated behavioral health
53 service delivery system and specify that (1) the Department of Social
54 Services, which is the agency designated as the single state agency for
55 the administration of the Medicaid program pursuant to Title XIX of
56 the Social Security Act, manage all Medicaid and HUSKY Plan
57 modifications, waiver amendments, federal reporting and claims
58 processing and provide financial management, and (2) the Department
59 of Children and Families, which is the state agency responsible for
60 administering and evaluating a comprehensive and integrated state-
61 wide program of services for children and youth who are seriously
62 emotionally disturbed, define the services to be included in the
63 continuum of care and develop state-wide training programs on the
64 systems of care approach for providers, families and other persons.

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

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

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

80 the life span of children, youth and adults with behavioral health
81 needs.

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

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

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

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

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

146 within the Department of Children and Families.

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

149 As used in sections 17a-1 to 17a-26, inclusive, as amended, 17a-28 to
150 17a-49, inclusive, as amended, 17a-127, as amended by this act, and
151 46b-120:

152 (1) "Commissioner" means the Commissioner of Children and
153 Families;

154 (2) "Council" means the State Advisory Council on Children and
155 Families;

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

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

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

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

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

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

172 (9) "Individual system of care plan" means a written plan developed

173 by the Commissioner of Children and Families for a child or youth
174 who is mentally ill, [or] emotionally disturbed or seriously emotionally
175 disturbed or who is at placement risk which shall be developed when
176 such child or youth needs services from at least two public agencies
177 and which shall be designed to meet the needs of the child or youth
178 and his family;

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

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

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

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

204 (14) "Serious emotional disturbance" and "seriously emotionally
205 disturbed" means, with regard to a child or youth, that the child or
206 youth (A) has a range of diagnosable mental, behavioral or emotional
207 disorders of sufficient duration to meet diagnostic criteria specified in
208 the most recent edition of the American Psychiatric Association's
209 "Diagnostic and Statistical Manual of Mental Disorders" and (B)
210 exhibits behaviors that substantially interfere with or limit the child's
211 or youth's ability to function in the family, school or community and
212 are not a temporary response to a stressful situation.

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

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

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

232 (2) Within available appropriations, case review committees may be
233 developed by each regional office of the Department of Children and
234 Families and shall be comprised of at least three parents of children or
235 adolescents with mental illness, emotional disturbance or serious

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

267 (3) A coordinated care committee shall be developed by the
268 Commissioner of Children and Families and shall be comprised of a
269 parent of a child or adolescent with [serious] mental illness, emotional

270 disturbance or serious emotional disturbance who is currently serving
271 or has served on a case review committee, a person who is now or has
272 been a recipient of services for a child or adolescent at placement risk,
273 representatives of the Departments of Children and Families,
274 Education, Mental Health and Addiction Services, Social Services and
275 Mental Retardation who are knowledgeable of the needs of a child or
276 adolescent at placement risk, and a representative of the Office of
277 Protection and Advocacy for Persons with Disabilities who is
278 knowledgeable of the needs of a child or adolescent at placement risk.

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

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

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

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

300 (b) In order to facilitate the development of assisted living services

301 in state-funded congregate housing facilities, the Commissioner of
302 Public Health may waive any provision of the regulations for assisted
303 living services agencies, as defined in section 19a-490 of the general
304 statutes, which provide services in state-funded congregate housing
305 facilities. No waiver of such regulations shall be made if the
306 commissioner determines that the waiver would: (1) Endanger the life,
307 safety or health of any resident receiving assisted living services in a
308 state-funded congregate housing facility; (2) impact the quality or
309 provision of services provided to a resident in a state-funded
310 congregate housing facility; (3) revise or eliminate the requirements for
311 an assisted living services agency's quality assurance program; (4)
312 revise or eliminate the requirements for an assisted living services
313 agency's grievance and appeals process; or (5) revise or eliminate the
314 assisted living services agency's requirements relative to a client's bill
315 of rights and responsibilities. The commissioner, upon the granting of
316 a waiver of any provision of such regulations, may impose conditions
317 which assure the health, safety and welfare of residents receiving
318 assisted living services in a state-funded congregate housing facility.
319 The commissioner may revoke such a waiver upon a finding (A) that
320 the health, safety or welfare of any such resident is jeopardized, or (B)
321 that such facility has failed to comply with such conditions as the
322 commissioner may impose pursuant to this subsection.

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 until January 1, 2002, while in the process of adopting
328 criteria for the waiver process in regulation form, provided notice of
329 intent to adopt the regulations is published in the Connecticut Law
330 Journal within twenty days after implementation.

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

334 (a) The Commissioner of Economic and Community Development
335 shall, within available appropriations, establish a demonstration
336 housing assistance and counseling program to offer advice on matters
337 concerning landlord and tenant relations and the financing of owner-
338 occupied and rental housing purchases, improvements and
339 renovations. The program shall provide: (1) Educational services
340 designed to inform landlords and tenants of their respective rights and
341 responsibilities; (2) dispute mediation services for landlords and
342 tenants; (3) information on securing housing-related financing,
343 including mortgage loans, home improvement loans, energy assistance
344 and weatherization assistance; and (4) such other housing-related
345 counseling and assistance as the commissioner shall provide by
346 regulations.

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

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

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

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

366 (e) The Commissioner of Economic and Community Development
367 shall establish criteria for making disbursements under the provisions
368 of subsection (d) of this section which shall include, but are not limited
369 to: (1) Size of the United States Department of Housing and Urban
370 Development, Section 202 and Section 236, elderly housing
371 developments; (2) geographic locations in which the developments are
372 located; (3) anticipated social and health value to the resident
373 population; (4) each Section 202 and Section 236 housing
374 development's designation as a managed residential community, as
375 defined in section 19-13-D105 of the regulations of Connecticut state
376 agencies; and (5) the potential community development benefit to the
377 relevant municipality. Such criteria may specify who may apply for
378 grants, the geographic locations determined to be eligible for grants,
379 and the eligible costs for which a grant may be made.

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

384 Sec. 10. Section 17b-342 of the general statutes, as amended by
385 section 12 of public act 99-279 and section 4 of public act 00-83, is
386 repealed and the following is substituted in lieu thereof:

387 (a) The Commissioner of Social Services shall administer the
388 Connecticut home-care program for the elderly state-wide in order to
389 prevent the institutionalization of elderly persons (1) who are
390 recipients of medical assistance, (2) who are eligible for such
391 assistance, [or] (3) who would be eligible for medical assistance if
392 residing in a nursing facility, or (4) who meet the criteria for the state-
393 funded portion of the program under subsection (i) of this section. For
394 purposes of this section, a long-term care facility is a facility which has
395 been federally certified as a skilled nursing facility or intermediate care
396 facility. The commissioner shall make any revisions in the state
397 Medicaid plan required by Title XIX of the Social Security Act prior to

398 implementing the program. The annualized cost of the community-
399 based services provided to such persons under the program shall not
400 exceed sixty per cent of the weighted average cost of care in skilled
401 nursing facilities and intermediate care facilities. The program shall be
402 structured so that the net cost to the state for long-term facility care in
403 combination with the community-based services under the program
404 shall not exceed the net cost the state would have incurred without the
405 program. The commissioner shall investigate the possibility of
406 receiving federal funds for the program and shall apply for any
407 necessary federal waivers. A recipient of services under the program,
408 and the estate and legally liable relatives of the recipient, shall be
409 responsible for reimbursement to the state for such services to the
410 same extent required of a recipient of assistance under the state
411 supplement program, medical assistance program, temporary family
412 assistance program or food stamps program. Only a United States
413 citizen or a noncitizen who meets the citizenship requirements for
414 eligibility under the Medicaid program shall be eligible for home-care
415 services under this section, except a qualified alien, as defined in
416 Section 431 of Public Law 104-193, admitted into the United States on
417 or after August 22, 1996, or other lawfully residing immigrant alien
418 determined eligible for services under this section prior to July 1, 1997,
419 shall remain eligible for such services until July 1, 2001. Qualified
420 aliens or other lawfully residing immigrant aliens not determined
421 eligible prior to July 1, 1997, shall be eligible for services under this
422 section subsequent to six months from establishing residency until July
423 1, 2001. Notwithstanding the provisions of this subsection, any
424 qualified alien or other lawfully residing immigrant alien or alien who
425 formerly held the status of permanently residing under color of law
426 who is a victim of domestic violence or who has mental retardation
427 shall be eligible for assistance pursuant to this section. Qualified aliens,
428 as defined in Section 431 of Public Law 104-193, or other lawfully
429 residing immigrant aliens or aliens who formerly held the status of
430 permanently residing under color of law shall be eligible for services
431 under this section provided other conditions of eligibility are met.

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

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

457 (d) Physicians, hospitals, long-term care facilities and other licensed
458 health care facilities may disclose, and, as a condition of eligibility for
459 the program, elderly persons, their guardians, and relatives shall
460 disclose, upon request from the Department of Social Services, such
461 financial, social and medical information as may be necessary to enable
462 the department or any agency administering the program on behalf of
463 the department to provide services under the program. Long-term care
464 facilities shall supply the Department of Social Services with the names

465 and addresses of all applicants for admission. Any information
466 provided pursuant to this subsection shall be confidential and shall not
467 be disclosed by the department or administering agency.

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

473 (f) The commissioner may require long-term care facilities to inform
474 applicants for admission of the program established under this section
475 and to distribute such forms as [he] the commissioner prescribes for
476 the program. Such forms shall be supplied by and be returnable to the
477 department.

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

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

493 (i) (1) On and after July 1, 1992, the Commissioner of Social Services
494 shall, within available appropriations, administer a state-funded
495 portion of the program for persons (A) who are sixty-five years of age

496 and older; (B) who are inappropriately institutionalized or at risk of
497 inappropriate institutionalization; (C) whose income is less than or
498 equal to the amount allowed under [the federally funded portion of
499 the program established pursuant to] subdivision (3) of subsection (a)
500 of this section; and (D) whose assets, if single, do not exceed the
501 minimum community spouse protected amount pursuant to Section
502 4022.05 of the department's uniform policy manual or, if married, the
503 couple's assets do not exceed one hundred fifty per cent of said
504 community spouse protected amount.

505 [(2) The commissioner shall establish a sliding fee scale for required
506 contributions to the cost of services provided under the program for
507 program participants whose income is equal to or greater than one
508 hundred fifty per cent of the federal poverty level. The sliding fee scale
509 shall be based on a formula which establishes the midpoint of each
510 twenty-five per cent income increase over the poverty level and
511 assesses a fee based on a percentage of the midpoint for all eligible
512 persons whose income is within that range. The percentage of the
513 midpoint shall start at eleven per cent and shall increase by one per
514 cent for each income range.]

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

520 (3) On and after June 30, 1992, the program shall serve persons
521 receiving state-funded home and community-based services from the
522 department, persons receiving services under the promotion of
523 independent living for the elderly program operated by the
524 Department of Social Services, regardless of age, and persons receiving
525 services on June 19, 1992, under the home care demonstration project
526 operated by the Department of Social Services. Such persons receiving
527 state-funded services whose income and assets exceed the limits

528 established pursuant to subdivision (1) of this subsection may continue
529 to participate in the program, but shall be required to pay the total cost
530 of care, including case management costs.

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

536 (5) The annualized cost of services provided to an individual under
537 the state-funded portion of the program shall not exceed fifty per cent
538 of the weighted average cost of care in nursing homes in the state,
539 except an individual who received services costing in excess of such
540 amount under the Department of Social Services in the fiscal year
541 ending June 30, 1992, may continue to receive such services, provided
542 the annualized cost of such services does not exceed eighty per cent of
543 the weighted average cost of such nursing home care. The
544 commissioner may allow the cost of services provided to an individual
545 to exceed the maximum cost established pursuant to this subdivision
546 in a case of extreme hardship, as determined by the commissioner,
547 provided in no case shall such cost exceed that of the weighted cost of
548 such nursing home care.

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

555 Sec. 11. Subsection (a) of section 37 of public act 99-279 is amended
556 to read as follows:

557 (a) On and after the effective date of [this section] section 37 of
558 public act 99-279, the Commissioner of Social Services shall establish a

559 state-funded pilot program to allow not more than ten persons to
560 receive services under the Connecticut home-care program for the
561 elderly established under section 17b-342 of the general statutes (1)
562 provided such persons would be eligible for the Medicaid-funded
563 portion of the Connecticut home-care program for the elderly except
564 that their monthly income exceeds the amount allowed under said
565 program by not more than one hundred dollars and formerly received
566 services under said program, and (2) only after an evaluation and a
567 determination by said commissioner that such persons would require
568 care in a long-term care facility if such persons did not receive services
569 under said program. Services provided and contributions required
570 under the pilot program shall be equivalent to those under the
571 Medicaid-funded portion of the Connecticut home-care program for
572 the elderly. Said pilot program shall terminate on [June 30, 2000] the
573 date on which such services are covered under the Medicaid-funded
574 portion of the Connecticut home-care program for the elderly or July 1,
575 2001, whichever is sooner. Such persons who participate in the pilot
576 program may continue to receive services under said program
577 provided all other conditions of eligibility are met.

578 Sec. 12. Section 38 of public act 99-279 is amended to read as
579 follows:

580 On and after the effective date of [this section] section 38 of public
581 act 99-279, [and until June 30, 2000,] the Commissioner of Social
582 Services shall provide medical services other than the services
583 provided under the Connecticut home-care program for the elderly
584 equivalent to the services provided under the Medicaid program to
585 persons who participate in the pilot program established under section
586 37 of [this act] public act 99-279, as amended by this act.

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

589 (a) The Commissioner of Social Services shall submit an application
590 for a federal waiver of any assistance program requirements, except

591 such application pertaining to routine operational issues, to the joint
592 standing committee of the General Assembly having cognizance of
593 matters relating to appropriations and the budgets of state agencies
594 and to the joint standing committee of the General Assembly having
595 cognizance of matters relating to human services prior to the
596 submission of such application to the federal government. Within
597 [fifteen] thirty days of their receipt of such application, the joint
598 standing committees may advise the commissioner of their approval,
599 denial or modifications, if any, of his application.

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

602 (h) No manufacturer or wholesaler shall sell any drugs except to the
603 state or any political subdivision thereof, to another manufacturer or
604 wholesaler, to any hospital recognized by the state as a general or
605 specialty hospital, to any institution having a full-time pharmacist who
606 is actively engaged in the practice of pharmacy in such institution not
607 less than thirty-five hours a week, to a chronic and convalescent
608 nursing home having a pharmacist actively engaged in the practice of
609 pharmacy based upon the ratio of one-tenth of one hour per patient
610 per week but not less than twelve hours per week, to a practicing
611 physician, podiatrist, dentist, optometrist or veterinarian or to a
612 licensed pharmacy or a store to which a permit to sell nonlegend drugs
613 has been issued as provided in section 20-624, as amended. The
614 commissioner may adopt such regulations as are necessary to
615 administer and enforce the provisions of this section.

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

618 (a) The rate to be paid by the state to hospitals receiving
619 appropriations granted by the General Assembly and to freestanding
620 chronic disease hospitals, providing services to persons aided or cared
621 for by the state for routine services furnished to state patients, shall be
622 based upon reasonable cost to such hospital, or the charge to the

623 general public for ward services or the lowest charge for semiprivate
624 services if the hospital has no ward facilities, imposed by such
625 hospital, whichever is lowest, except to the extent, if any, that the
626 commissioner in his discretion determines that a greater amount is
627 appropriate in the case of hospitals serving a disproportionate share of
628 indigent patients. Such rate shall be promulgated annually by the
629 Commissioner of Social Services. Nothing contained herein shall
630 authorize a payment by the state for such services to any such hospital
631 in excess of the charges made by such hospital for comparable services
632 to the general public. [Notwithstanding the provisions of this section,
633 on and after July 1, 1995, rates paid to freestanding chronic disease
634 hospitals shall not exceed rates paid in rate periods ending in 1995 plus
635 the inflation factor annually applied in determining acute care
636 inpatient hospital rates under the Medicaid program. A freestanding
637 chronic disease hospital having more than an average of fifty per cent
638 of its inpatient days paid for by the department may request that the
639 commissioner use the actual charge based on utilized service for the
640 rate period ending in 1995 in lieu of the rate paid for the period when
641 determining the rates to be paid on and after July 1, 1995.]
642 Notwithstanding the provisions of this section, for the rate period
643 beginning July 1, 2000, rates paid to freestanding chronic disease
644 hospitals and freestanding psychiatric hospitals shall be increased by
645 three per cent. For the rate period beginning July 1, 2001, and each
646 succeeding rate period, rates paid to freestanding chronic disease
647 hospitals and freestanding psychiatric hospitals shall be equal to but
648 not exceed rates for the preceding rate period, plus an inflation factor
649 equal to the Medicare market basket inflation rate as published in the
650 previous September federal register of each year with the wage portion
651 of such market basket adjusted for the Hartford metropolitan statistical
652 area.

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

656 (a) The Department of Social Services shall determine the rates to be
657 paid to home health care agencies and homemaker-home health aide
658 agencies by the state or any town in the state for persons aided or
659 cared for by the state or any such town. For the period from February
660 1, 1991, to January 31, 1992, inclusive, payment for each service to the
661 state shall be based upon the rate for such service as determined by the
662 Office of Health Care Access, except that for those providers whose
663 Medicaid rates for the year ending January 31, 1991, exceed the median
664 rate, no increase shall be allowed. For those providers whose rates for
665 the year ending January 31, 1991, are below the median rate, increases
666 shall not exceed the lower of the prior rate increased by the most
667 recent annual increase in the consumer price index for urban
668 consumers or the median rate. In no case shall any such rate exceed the
669 eightieth percentile of rates in effect January 31, 1991, nor shall any rate
670 exceed the charge to the general public for similar services. Rates
671 effective February 1, 1992, shall be based upon rates as determined by
672 the Office of Health Care Access, except that increases shall not exceed
673 the prior year's rate increased by the most recent annual increase in the
674 consumer price index for urban consumers and rates effective
675 February 1, 1992, shall remain in effect through June 30, 1993. Rates
676 effective July 1, 1993, shall be based upon rates as determined by the
677 Office of Health Care Access pursuant to the provisions of subsection
678 (b) of section 19a-635, except if the Medicaid rates for any service for
679 the period ending June 30, 1993, exceed the median rate for such
680 service, the increase effective July 1, 1993, shall not exceed one per
681 cent. If the Medicaid rate for any service for the period ending June 30,
682 1993, is below the median rate, the increase effective July 1, 1993, shall
683 not exceed the lower of the prior rate increased by one and one-half
684 times the most recent annual increase in the consumer price index for
685 urban consumers or the median rate plus one per cent. The
686 Commissioner of Social Services shall establish a fee schedule for home
687 health services to be effective on and after July 1, 1994. The
688 commissioner may annually increase any fee in the fee schedule based
689 on an increase in the cost of services. [The fee schedule may be phased

690 in over a two-year period during which no agency shall be paid for a
691 service in an amount which varies by more than ten per cent from the
692 payment made for the service in the preceding fiscal year.] The
693 commissioner shall increase the fee schedule for home health services
694 provided under the Connecticut home-care program for the elderly
695 established under section 17b-342, as amended, effective July 1, 2000,
696 by two per cent over the fee schedule for home health services for the
697 previous year. The commissioner may increase any fee payable to a
698 home health care agency or homemaker-home health aide agency
699 upon the application of such an agency evidencing extraordinary costs
700 related to (1) serving persons with AIDS; (2) high-risk maternal and
701 child health care; (3) escort services; or (4) extended hour services. In
702 no case shall any rate or fee exceed the charge to the general public for
703 similar services. A home health care agency or homemaker-home
704 health aide agency which, due to any material change in
705 circumstances, is aggrieved by a rate determined pursuant to this
706 subsection may, within ten days of receipt of written notice of such
707 rate from the Commissioner of Social Services, request in writing a
708 hearing on all items of aggrievement. The commissioner shall, upon
709 the receipt of all documentation necessary to evaluate the request,
710 determine whether there has been such a change in circumstances and
711 shall conduct a hearing if appropriate. The Commissioner of Social
712 Services shall adopt regulations, in accordance with chapter 54, to
713 implement the provisions of this subsection. The commissioner may
714 implement policies and procedures to carry out the provisions of this
715 subsection while in the process of adopting regulations, provided
716 notice of intent to adopt the regulations is published in the Connecticut
717 Law Journal within twenty days of implementing the policies and
718 procedures. Such policies and procedures shall be valid for not longer
719 than nine months.

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

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

726 The Commissioner of Social Services shall establish annually the
727 maximum allowable rate to be paid by said agencies for homemaker
728 services, chore person services, companion services, respite care, meals
729 on wheels, adult day care services, case management and assessment
730 services, transportation, mental health counseling and elderly foster
731 care, except that the maximum allowable rates in effect July 1, 1990,
732 shall remain in effect during the fiscal years ending June 30, 1992, and
733 June 30, 1993. The Commissioner of Social Services shall prescribe
734 uniform forms on which agencies providing such services shall report
735 their costs for such services. Such rates shall be determined on the
736 basis of a reasonable payment for necessary services rendered. The
737 maximum allowable rates established by the Commissioner of Social
738 Services for the Connecticut home-care program for the elderly
739 established under section 17b-342, as amended, shall constitute the
740 rates required under this section until revised in accordance with this
741 section. The Commissioner of Social Services shall establish a fee
742 schedule, to be effective on and after July 1, 1994, for homemaker
743 services, chore person services, companion services, respite care, meals
744 on wheels, adult day care services, case management and assessment
745 services, transportation, mental health counseling and elderly foster
746 care. The commissioner may annually increase any fee in the fee
747 schedule based on an increase in the cost of services. The
748 commissioner shall increase the fee schedule effective July 1, 2000, by
749 not less than five per cent, for adult day care services. Nothing
750 contained in this section shall authorize a payment by the state to any
751 agency for such services in excess of the amount charged by such
752 agency for such services to the general public.

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

756 (a) Medical assistance shall be provided for any otherwise eligible
757 person whose income, including any available support from legally
758 liable relatives and the income of the person's spouse or dependent
759 child, is not more than one hundred forty-three per cent, pending
760 approval of a federal waiver applied for pursuant to subsection (d) of
761 this section, of the benefit amount paid to a person with no income
762 under the temporary family assistance program in the appropriate
763 region of residence and if such person is an institutionalized
764 individual as defined in Section 1917(c) of the Social Security Act, 42
765 USC 1396p(c), and has not made an assignment or transfer or other
766 disposition of property for less than fair market value for the purpose
767 of establishing eligibility for benefits or assistance under this section.
768 Any such disposition shall be treated in accordance with Section
769 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
770 property made on behalf of an applicant or recipient or the spouse of
771 an applicant or recipient by a guardian, conservator, person
772 authorized to make such disposition pursuant to a power of attorney
773 or other person so authorized by law shall be attributed to such
774 applicant, recipient or spouse. A disposition of property ordered by a
775 court shall be evaluated in accordance with the standards applied to
776 any other such disposition for the purpose of determining eligibility.
777 The commissioner shall establish the standards for eligibility for
778 medical assistance at one hundred forty-three per cent of the benefit
779 amount paid to a family unit of equal size with no income under the
780 temporary family assistance program in the appropriate region of
781 residence, pending federal approval, except that the medical assistance
782 program shall provide coverage to persons under the age of nineteen
783 [born after September 30, 1981,] up to one hundred eighty-five per cent
784 of the federal poverty level without an asset limit. On and after [July 1,
785 2000] January 1, 2001, said medical assistance program shall also
786 provide coverage to persons under the age of nineteen and their
787 parents and needy caretaker relatives who qualify for coverage under
788 Section 1931 of the Social Security Act with family income up to one
789 hundred [eighty-five] fifty per cent of the federal poverty level without

790 an asset limit, upon the request of such a person or upon a
791 redetermination of eligibility. Such levels shall be based on the
792 regional differences in such benefit amount, if applicable, unless such
793 levels based on regional differences are not in conformance with
794 federal law. Any income in excess of the applicable amounts shall be
795 applied as may be required by said federal law, and assistance shall be
796 granted for the balance of the cost of authorized medical assistance. All
797 contracts entered into on and after July 1, 1997, pursuant to this section
798 shall include provisions for collaboration of managed care
799 organizations with the Healthy Families Connecticut Program
800 established pursuant to section 17a-56. The Commissioner of Social
801 Services shall provide applicants for assistance under this section, at
802 the time of application, with a written statement advising them of the
803 effect of an assignment or transfer or other disposition of property on
804 eligibility for benefits or assistance.

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

807 (NEW) (e) On or after May 1, 2000, the payment to the
808 Commissioner of Social Services of (1) any monetary sanction imposed
809 by the commissioner on a managed care organization under the
810 provisions of a contract between the commissioner and such
811 organization entered into pursuant to this section or sections 17b-289
812 to 17b-304, inclusive, or (2) any sum agreed upon by the commissioner
813 and such an organization as settlement of a claim brought by the
814 commissioner or the state against such an organization for failure to
815 comply with the terms of a contract with the commissioner or fraud
816 affecting the Department of Social Services shall be deposited in an
817 account designated for use by the department for expenditures for
818 children's health programs and services.

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

821 The commissioner shall submit a state children's health insurance

822 plan to implement the provisions of sections 17b-289 to 17b-303,
823 inclusive, and section 16 of public act 97-1 of the October 29 special
824 session* to the Health Care Financing Administration in accordance
825 with the provisions of Subtitle J of Public Law 105-33. Such plan and
826 any revisions thereto shall be submitted to the joint standing
827 committees of the General Assembly having cognizance of matters
828 relating to human services, public health, insurance and
829 appropriations and the budgets of state agencies. Within [fifteen] thirty
830 days of receipt of such plan or revisions thereto, said joint standing
831 committees of the General Assembly may advise the commissioner of
832 their approval, denial or modifications, if any, of the plan or any
833 revisions thereto. If the joint standing committees do not concur, the
834 committee chairmen shall appoint a committee on conference which
835 shall be comprised of three members from each joint standing
836 committee. At least one member appointed from each committee shall
837 be a member of the minority party. The report of the committee on
838 conference shall be made to each committee, which shall vote to accept
839 or reject the report. The report of the committee on conference may not
840 be amended. If a joint standing committee rejects the report of the
841 committee on conference, the plan or revisions thereto shall be deemed
842 approved. If the joint standing committees accept the report, the
843 committee having cognizance of matters relating to appropriations and
844 the budgets of state agencies shall advise the commissioner of their
845 approval or modifications, if any, of the plan or revisions thereto,
846 provided if the committees do not act within [fifteen] thirty days, the
847 plan or revisions thereto shall be deemed approved.

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

851 (h) For the fiscal year ending June 30, 1993, any residential care
852 home with an operating cost component of its rate in excess of one
853 hundred thirty per cent of the median of operating cost components of
854 rates in effect January 1, 1992, shall not receive an operating cost

855 component increase. For the fiscal year ending June 30, 1993, any
856 residential care home with an operating cost component of its rate that
857 is less than one hundred thirty per cent of the median of operating cost
858 components of rates in effect January 1, 1992, shall have an allowance
859 for real wage growth equal to sixty-five per cent of the increase
860 determined in accordance with subsection (q) of section 17-311-52 of
861 the regulations of Connecticut state agencies, provided such operating
862 cost component shall not exceed one hundred thirty per cent of the
863 median of operating cost components in effect January 1, 1992.
864 Beginning with the fiscal year ending June 30, 1993, for the purpose of
865 determining allowable fair rent, a residential care home with allowable
866 fair rent less than the twenty-fifth percentile of the state-wide
867 allowable fair rent shall be reimbursed as having allowable fair rent
868 equal to the twenty-fifth percentile of the state-wide allowable fair
869 rent. Beginning with the fiscal year ending June 30, 1997, a residential
870 care home with allowable fair rent less than three dollars and ten cents
871 per day shall be reimbursed as having allowable fair rent equal to
872 three dollars and ten cents per day. Property additions placed in
873 service during the cost year ending September 30, 1996, or any
874 succeeding cost year shall receive a fair rent allowance for such
875 additions as an addition to three dollars and ten cents per day if the
876 fair rent for the facility for property placed in service prior to
877 September 30, 1995, is less than or equal to three dollars and ten cents
878 per day. For the fiscal year ending June 30, 1996, and any succeeding
879 fiscal year, the allowance for real wage growth, as determined in
880 accordance with subsection (q) of section 17-311-52 of the regulations
881 of Connecticut state agencies shall not be applied. For the fiscal year
882 ending June 30, 1996, and any succeeding fiscal year, the inflation
883 adjustment made in accordance with subsection (p) of section
884 17-311-52 of the regulations of Connecticut state agencies shall not be
885 applied to real property costs. Beginning with the fiscal year ending
886 June 30, 1997, minimum allowable patient days for rate computation
887 purposes for a residential care home with twenty-five beds or less shall
888 be eighty-five per cent of licensed capacity. Beginning with the fiscal

889 year ending June 30, 1998, for the purposes of determining the
890 allowable salary of an administrator of a residential care home with
891 sixty beds or less the department shall revise the allowable base salary
892 to thirty thousand dollars to be annually inflated thereafter in
893 accordance with section 17-311-52 of the regulations of Connecticut
894 state agencies and, beginning with the fiscal year ending June 30, 2000,
895 the inflation adjustment for rates made in accordance with subsection
896 (p) of section 17-311-52 of the regulations of state agencies shall be
897 increased by two per cent. Beginning with the fiscal year ending June
898 30, 1999, for the purpose of determining the allowable salary of a
899 related party, the department shall revise the maximum salary to
900 twenty seven thousand eight hundred fifty-six dollars to be annually
901 inflated thereafter in accordance with section 17-311-52 of the
902 regulations of Connecticut state agencies and beginning with the fiscal
903 year ending June 30, 2001, such allowable salary shall be computed on
904 an hourly basis and the maximum number of hours allowed for a
905 related party other than the proprietor shall be increased from forty
906 hours to forty-eight hours per work week.

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

909 (a) Any vendor found guilty of vendor fraud under sections 53a-290
910 to 53a-296, inclusive, shall be subject to forfeiture or suspension of any
911 franchise or license held by [him] such vendor from the state in
912 accordance with this subsection, after hearing in the manner provided
913 for in sections 4-176e to 4-180a, inclusive, and 4-181a. Any vendor
914 convicted of vendor fraud under sections 53a-290 to 53a-296, inclusive,
915 shall have such license or franchise revoked. Nothing in this subsection
916 shall preclude any board or commission established under chapters
917 369 to 376, inclusive, 378 to 381, inclusive, and 383 to 388, inclusive,
918 and the Department of Public Health with respect to professions under
919 its jurisdiction which have no board or commission from taking any
920 action authorized in section 19a-17. Any vendor who is convicted in
921 any state or federal court of a crime involving fraud in the Medicare

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

952 (b) For the purpose of determining compliance with subsection (a),
953 all vendors shall notify the commissioner within thirty days after the
954 date of employment or conviction, whichever is later, of the identity,
955 interest and extent of services performed by any person convicted of a

956 crime involving fraud in the Medicare program or Medicaid program
957 or aid to families with dependent children program or state-
958 administered general assistance program or temporary family
959 assistance program or state supplement to the federal Supplemental
960 Security Income Program or any federal or state energy assistance
961 program or general assistance program or state-funded child care
962 program or the refugee program. Prior to the commissioner's
963 acceptance of a provider agreement or at any time upon written
964 request by the commissioner, the vendor shall furnish the
965 commissioner with the identity of any person convicted of a crime
966 involving fraud in such programs who has an ownership or control
967 interest in the vendor or who is an agent or managing employee. The
968 commissioner shall terminate, refuse to enter into or renew an
969 agreement with a vendor, except a vendor providing room and board
970 and services pursuant to section 17b-340, if such convicted person has
971 such interest or is such agent or employee. In the case of a vendor
972 providing room and board and services pursuant to said section 17b-
973 340, the commissioner may terminate, refuse to enter into or renew an
974 agreement after consideration of any adverse impact on beneficiaries
975 of such termination or refusal.

976 (c) The Department of Social Services shall distribute to all vendors
977 who are providers in the medical assistance program a copy of the
978 rules, regulations, standards and laws governing the program. The
979 Commissioner of Social Services shall adopt by regulation in the
980 manner provided for in sections 4-166 to 4-176, inclusive,
981 administrative sanctions against providers in the Medicare program or
982 Medicaid program or aid to families with dependent children program
983 or state-funded child care program or state-administered general
984 assistance program or temporary family assistance program or state
985 supplement to the federal Supplemental Security Income Program
986 including suspension from the program, for any violations of the rules,
987 regulations, standards or law. The commissioner may adopt
988 regulations in accordance with the provisions of chapter 54 to provide
989 for the withholding of payments currently due in order to offset

990 money previously obtained as the result of error or fraud. The
991 department shall notify the proper professional society and licensing
992 agency of any violations of this section.

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

995 The Commissioner of Social Services shall establish a program,
996 within available appropriations, to provide grants to municipalities,
997 boards of education and child care providers to encourage the use of
998 school facilities for the provision of child day care services before and
999 after school. In order to qualify for a grant, a municipality, board of
1000 education or child care provider shall guarantee the availability of a
1001 school site which meets the standards set by the Department of Public
1002 Health in regulations adopted under sections 19a-77, 19a-79, 19a-80
1003 and 19a-82 to 19a-87a, inclusive, and shall agree to provide liability
1004 insurance coverage for the program. Grant funds shall be used by the
1005 municipality, board of education or child care provider for the
1006 maintenance and utility costs directly attributable to the use of the
1007 school facility for the day care program, for related transportation costs
1008 and for the portion of the municipality, board of education or child
1009 care provider liability insurance cost and other operational costs
1010 directly attributable to the day care program. The municipality or
1011 board of education may contract with a child day care provider for the
1012 program. [The contract shall limit the amount the provider may charge
1013 under the program to the provider's base cost per capita plus a
1014 percentage of the base cost.] The Commissioner of Social Services may
1015 adopt regulations, in accordance with the provisions of chapter 54, for
1016 purposes of this section. The commissioner may utilize available child
1017 care subsidies to implement the provisions of this section and
1018 encourage association and cooperation with the Head Start program
1019 established pursuant to section 10-16n.

1020 Sec. 24. Section 17b-802 of the general statutes is repealed and the
1021 following is substituted in lieu thereof:

1022 (a) The Commissioner of Social Services shall establish, within
1023 available appropriations, and administer a security deposit guarantee
1024 program [of grants to] for persons [residing in emergency shelters or
1025 other emergency housing] who are recipients of [public assistance]
1026 temporary family assistance, aid under the state supplement program,
1027 state-administered general assistance or general assistance and to
1028 persons who have a documented showing of financial need and are
1029 residing in emergency shelters or other emergency housing or who
1030 cannot remain in permanent housing due to any reason specified in
1031 subsection (a) of section 17b-808, for use by such persons [as] in lieu of
1032 a security deposit on a rental dwelling unit. Eligible persons may
1033 receive a [grant] security deposit guarantee in an amount not to exceed
1034 the equivalent of one month's rent on such rental unit, except that
1035 upon a documented showing of financial need, the commissioner may
1036 approve a [grant] security deposit guarantee in an amount not to
1037 exceed the equivalent of two month's rent. No person may apply for
1038 and receive a [grant for use as a] security deposit guarantee more than
1039 once without the express authorization of the Commissioner of Social
1040 Services, except as provided in subsection (b) of this section.

1041 (b) In the case of any person who qualifies for a [grant] guarantee,
1042 the Commissioner of Social Services, or any emergency shelter under
1043 contract with the Department of Social Services to assist in the
1044 administration of the security deposit guarantee program established
1045 pursuant to subsection (a) of this section, may [, in accordance with the
1046 landlord's preference, either pay the security deposit directly to the
1047 landlord or] execute a written agreement to pay the landlord for any
1048 damages suffered by the landlord due to the tenant's failure to comply
1049 with such tenant's obligations as defined in section 47a-21, provided
1050 the amount of any such payment shall not exceed the amount of the
1051 requested security deposit. [Payment of a security deposit directly to
1052 the landlord shall be conditional upon the execution by the landlord of
1053 a written agreement providing that if the tenant for whom such
1054 payment is made vacates the housing unit, any return of the security
1055 deposit and of accrued interest to which the tenant would be entitled,

1056 shall be paid directly to the Department of Social Services. Such refund
1057 shall be made in accordance with the requirements of section 47a-21,
1058 and, if the landlord claims the right to withhold all or most of the
1059 security deposit, he shall comply with all of the applicable provisions
1060 of said section except that any notices required shall also be sent to the
1061 Department of Social Services. The rights of such a tenant to the return
1062 of a security deposit shall be subrogated to the state of Connecticut
1063 and if suit is necessary to collect the deposit, the defendant shall pay
1064 all costs and shall be subject to double damages as provided in section
1065 47a-21.] If a person who has previously received a grant for a security
1066 deposit or a security deposit guarantee becomes eligible for a
1067 subsequent [grant] security deposit guarantee, the amount of the
1068 subsequent [grant] security deposit guarantee for which such person
1069 would otherwise have been eligible shall be reduced by (1) any
1070 amount of [the] a previous grant which has not been returned to the
1071 department pursuant to section 47a-21 or (2) the amount of any
1072 payment made to the landlord for damages pursuant to this
1073 subsection. [In any fiscal year, the total amount of security deposits
1074 granted and written agreements executed for the payment of damages
1075 pursuant to this section shall not exceed the amount available for the
1076 program for that fiscal year.]

1077 (c) Any payment made pursuant to this section to any person
1078 receiving temporary family assistance, aid under the state supplement
1079 program, general assistance or state-administered general assistance
1080 shall not be deducted from the amount of assistance to which the
1081 recipient would otherwise be entitled.

1082 (d) On and after July 1, 2000, no special need or special benefit
1083 payments shall be made by the commissioner for security deposits
1084 from the temporary family assistance, state supplement, state-
1085 administered general assistance or general assistance programs.

1086 (e) The Commissioner of Social Services may, within available
1087 appropriations, from funds appropriated to the safety net account, on a

1088 case-by-case basis, provide a security deposit grant to a person
1089 residing in an emergency shelter or other emergency housing or to a
1090 person who cannot remain in permanent housing due to any reason
1091 specified in subsection (a) of section 17b-808, in an amount not to
1092 exceed the equivalent of one month's rent on such rental unit provided
1093 the commissioner determines that emergency circumstances exist
1094 which threaten the health, safety or welfare of a child who resides with
1095 such person. Such person shall not be eligible for more than one such
1096 grant without the authorization of said commissioner.

1097 (f) The Commissioner of Social Services may provide a security
1098 deposit grant to a person receiving such grant through any emergency
1099 shelter under an existing contract with the Department of Social
1100 Services to assist in the administration of the security deposit program,
1101 but in no event shall a payment be authorized after October 1, 2000.

1102 [(d)] (g) The Commissioner of Social Services shall adopt
1103 regulations, in accordance with the provisions of chapter 54, to
1104 administer the program established pursuant to this section and to set
1105 eligibility criteria for [grants under] the program, but may implement
1106 the program until January 1, 2002, while in the process of adopting
1107 such regulations provided notice of intent to adopt the regulations is
1108 published in the Connecticut Law Journal within twenty days after
1109 implementation.

1110 Sec. 25. Section 53a-290 of the general statutes is repealed and the
1111 following is substituted in lieu thereof:

1112 A person commits vendor fraud when, with intent to defraud and
1113 acting on [his own] such person's own behalf or on behalf of an entity,
1114 [he] such person provides goods or services to a beneficiary under
1115 sections 17b-22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-103,
1116 inclusive, [17b-114,] 17b-180a, 17b-183, 17b-260 to 17b-262, inclusive,
1117 17b-264 to 17b-285, inclusive, 17b-357 to 17b-362, inclusive, 17b-600 to
1118 17b-604, inclusive, 17b-749, as amended, 17b-807 and 17b-808 or
1119 provides services to a recipient under Title XIX of the Social Security

1120 Act, as amended, and, (1) presents for payment any false claim for
1121 goods or services performed; (2) accepts payment for goods or services
1122 performed, which exceeds either the amounts due for goods or
1123 services performed, or the amounts authorized by law for the cost of
1124 such goods or services; (3) solicits to perform services for or sell goods
1125 to any such beneficiary, knowing that such beneficiary is not in need of
1126 such goods or services; (4) sells goods to or performs services for any
1127 such beneficiary without prior authorization by the Department of
1128 Social Services, when prior authorization is required by said
1129 department for the buying of such goods or the performance of any
1130 service; or (5) accepts from any person or source other than the state an
1131 additional compensation in excess of the amount authorized by law.

1132 Sec. 26. Section 19a-671 of the general statutes is repealed and the
1133 following is substituted in lieu thereof:

1134 The Commissioner of Social Services is authorized to determine the
1135 amount of payments pursuant to sections 19a-670 to 19a-672, inclusive,
1136 as amended, for each hospital. The commissioner's determination shall
1137 be based on the advice of the office and the application of the
1138 calculation in this section. For each hospital the Office of Health Care
1139 Access shall calculate the amount of payments to be made pursuant to
1140 sections 19a-670 to 19a-672, inclusive, as amended, as follows:

1141 (1) For the period April 1, 1994, to June 30, 1994, inclusive, and for
1142 the period July 1, 1994, to September 30, 1994, inclusive, the office shall
1143 calculate and advise the Commissioner of Social Services of the
1144 amount of payments to be made to each hospital as follows:

1145 (A) Determine the amount of pool payments for the hospital,
1146 including grants approved pursuant to section 19a-168k, in the
1147 previously authorized budget authorization for the fiscal year
1148 commencing October 1, 1993.

1149 (B) Calculate the sum of the result of subparagraph (A) of this
1150 subdivision for all hospitals.

1151 (C) Divide the result of subparagraph (A) of this subdivision by the
1152 result of subparagraph (B) of this subdivision.

1153 (D) From the anticipated appropriation to the medical assistance
1154 disproportionate share-emergency assistance account made pursuant
1155 to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2)
1156 and (29) of section 12-407, subsection (1) of section 12-408, section 12-
1157 408a, subdivision (5) of section 12-412, subsection (1) of section 12-414
1158 and sections 19a-646, 19a-659 to 19a-662, inclusive, and 19a-666 to 19a-
1159 680, inclusive, for the quarter subtract the amount of any additional
1160 medical assistance payments made to hospitals pursuant to any
1161 resolution of or court order entered in any civil action pending on
1162 April 1, 1994, in the United States District Court for the district of
1163 Connecticut, and also subtract the amount of any emergency assistance
1164 to families payments projected by the office to be made to hospitals in
1165 the quarter.

1166 (E) The disproportionate share payment shall be the result of
1167 subparagraph (D) of this subdivision multiplied by the result of
1168 subparagraph (C) of this subdivision.

1169 (2) For the fiscal year commencing October 1, 1994, and subsequent
1170 fiscal years, the interim payment shall be calculated as follows for each
1171 hospital:

1172 (A) For each hospital determine the amount of the medical
1173 assistance underpayment determined pursuant to section 19a-659, plus
1174 the [authorized] actual amount of uncompensated care including
1175 emergency assistance to families determined pursuant to section 19a-
1176 659, less any amount of uncompensated care determined by the
1177 Department of Social Services to be due to a failure of the hospital to
1178 enroll patients for emergency assistance to families, plus the amount of
1179 any grants authorized pursuant to the authority of section 19a-168k.

1180 (B) Calculate the sum of the result of subparagraph (A) of this
1181 subdivision for all hospitals.

1182 (C) Divide the result of subparagraph (A) of this subdivision by the
1183 result of subparagraph (B) of this subdivision.

1184 (D) From the anticipated appropriation made to the medical
1185 assistance disproportionate share-emergency assistance account
1186 pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, as
1187 amended, subdivisions (2) and (29) of section 12-407, as amended,
1188 subsection (1) of section 12-408, as amended, section 12-408a,
1189 subdivision (5) of section 12-412, subsection (1) of section 12-414 and
1190 sections 19a-646, 19a-659 to 19a-662, inclusive, and 19a-666 to 19a-680,
1191 inclusive, as amended, for the fiscal year, subtract the amount of any
1192 additional medical assistance payments made to hospitals pursuant to
1193 any resolution of or court order entered in any civil action pending on
1194 April 1, 1994, in the United States District Court for the district of
1195 Connecticut, and also subtract any emergency assistance to families
1196 payments projected by the office to be made to the hospitals for the
1197 year.

1198 (E) The disproportionate share payment shall be the result of
1199 subparagraph (D) of this subdivision multiplied by the result of
1200 subparagraph (C) of this subdivision.

1201 Sec. 27. Section 31-261 of the general statutes is repealed and the
1202 following is substituted in lieu thereof:

1203 (a) There is created in the State Treasury a special segregated fund
1204 to be known as the Unemployment Compensation Fund. Said fund
1205 shall consist of all contributions and moneys paid into or received by it
1206 for the payment of unemployment compensation benefits, of any
1207 property or securities acquired from the use of moneys belonging to
1208 the fund, all interest earned thereon, all money credited to this state's
1209 account in the Unemployment Trust Fund established by Section 904
1210 of the Social Security Act pursuant to Section 903 of the Social Security
1211 Act, as amended, and all money received for the fund from any other
1212 source. All moneys in said fund shall be expended solely for the
1213 payment of benefits and refunds provided for by this chapter,

1214 exclusive of the expenses of administration, except that money
1215 credited to the account of this state in the Unemployment Trust Fund
1216 by the Secretary of the Treasury of the United States pursuant to
1217 Section 903 of the Social Security Act, as amended, may be
1218 requisitioned and used for the payment of expenses incurred for the
1219 administration of this chapter pursuant to a specific appropriation by
1220 the General Assembly, provided the expenses are incurred and the
1221 money is requisitioned after the enactment of an appropriation act
1222 which [(a)] (1) specifies the purposes for which such money is
1223 appropriated and the amounts appropriated therefor, [(b)] (2) limits
1224 the period within which such money may be obligated to a period
1225 ending not more than two years after the date of the enactment of such
1226 act, and [(c)] (3) limits the amount which may be used during a twelve-
1227 month period beginning on July first and ending on the next June
1228 thirtieth to an amount which does not exceed the amount by which
1229 [(1)] (A) the aggregate of the amounts credited to the account of this
1230 state pursuant to Section 903 of the Social Security Act, as amended,
1231 during the same twelve-month period and the twenty-four preceding
1232 twelve-month periods exceeds [(2)] (B) the aggregate of the amounts
1233 used pursuant to this [subsection] subdivision and charged against the
1234 amounts credited to the account of this state during any of such
1235 twenty-five twelve-month periods. For the purposes of this
1236 [subsection] subdivision, amounts used during any such twelve-month
1237 period shall be charged against equivalent amounts which were first
1238 credited and which are not already so charged, except that no amount
1239 used for administration during any such twelve-month period may be
1240 charged against any amount credited during such a twelve-month
1241 period earlier than the twenty-fourth preceding such period. Money
1242 credited to the account of this state pursuant to Section 903 of the
1243 Social Security Act, as amended, may not be withdrawn or used except
1244 for the payment of benefits and for the payment of expenses for the
1245 administration of this chapter and of public employment offices
1246 pursuant to this [section] subsection. Money requisitioned for the
1247 payment of expense of administration pursuant to this [section]

1248 subsection shall be deposited in the Employment Security
1249 Administration Fund, but, until expended, shall remain a part of the
1250 Unemployment Compensation Fund. The administrator shall maintain
1251 a separate record of the deposit, obligation, expenditure and return of
1252 funds so deposited. If any money so deposited is, for any reason, not to
1253 be obligated for the purpose for which it was appropriated, or if it
1254 remains unobligated at the end of the period specified by the law
1255 appropriating such money, or if any money which has been obligated
1256 within the period will not be expended, it shall be withdrawn and
1257 returned to the Secretary of the Treasury of the United States for credit
1258 to this state's account in the Unemployment Trust Fund. The State
1259 Treasurer shall be liable on his official bond for the faithful
1260 performance of his duties in connection with the Unemployment
1261 Compensation Fund. All sums recovered on any surety bond for losses
1262 sustained by the Unemployment Compensation Fund shall be
1263 deposited in said fund.

1264 (b) Notwithstanding the provisions of subsection (a) of this section,
1265 money credited to the account of this state pursuant to Section 903 of
1266 the Social Security Act, as amended, with respect to the federal fiscal
1267 years 1999, 2000 and 2001, shall be used solely for the payment of
1268 expenses incurred for the administration of this chapter, and such
1269 money shall not otherwise be subject to the provisions of subsection (a)
1270 of this section.

1271 Sec. 28. Section 40 of public act 99-2 of the June special session is
1272 repealed and the following is substituted in lieu thereof:

1273 (a) The [Office of Health Care Access, in consultation with the]
1274 Office of Policy and Management, may provide [loans to] grants,
1275 technical assistance or consultation services, or any combination
1276 thereof, to one or more nongovernmental acute care general hospitals
1277 as permitted by this section. Such grants, technical assistance or
1278 consultation services shall be consistent with applicable federal
1279 disproportionate share regulations, as from time to time amended.

1280 (b) [Loans] Grants, technical assistance or consultation services, or
1281 any combination thereof, provided under [the provisions of] this
1282 section may be made to assist [an] a nongovernmental acute care
1283 general hospital to develop and implement a plan to achieve financial
1284 stability and assure the delivery of appropriate health care services in
1285 the service area of [the hospital seeking a loan under this program. The
1286 maximum term of any loan authorized pursuant to this section shall
1287 not exceed five years] such hospital, or to assist a nongovernmental
1288 acute care general hospital in determining strategies, goals and plans
1289 to ensure its financial viability or stability. Any such hospital seeking
1290 such [loan] grants, technical assistance or consultation services shall
1291 prepare and submit to the Office of Policy and Management and the
1292 Office of Health Care Access a plan that includes at least the following:
1293 (1) A statement of the [facility's] hospital's current projections of its
1294 finances for the [term of the proposed loan] current and the next three
1295 fiscal years; (2) identification of the major financial issues which effect
1296 the financial stability of the hospital; (3) the steps proposed to study or
1297 improve the financial status of the hospital and eliminate ongoing
1298 operating losses; (4) plans to study or change the mix of services
1299 provided by the hospital, which may include transition to an
1300 alternative licensure category; and (5) other related elements as
1301 determined by the Office of [Health Care Access] Policy and
1302 Management. Such plan shall clearly identify the amount, value or
1303 type of the [loan] grant, technical assistance or consultation services, or
1304 combination thereof, requested. Any [loans originated by the state
1305 pursuant to this act shall bear interest at a rate agreed to] grants,
1306 technical assistance or consultation services, or any combination
1307 thereof, provided under this section shall be determined by the
1308 Secretary of the Office of Policy and Management [and which will] not
1309 to jeopardize the federal matching payments under the medical
1310 assistance program and the emergency assistance to families program
1311 as determined by the Office of Health Care Access or the Department
1312 of Social Services in consultation with the Office of Policy and
1313 Management. [The hospital's proposed financial plan must include a

1314 plan to repay the loan with interest within five years of initiation.]

1315 (c) There is established a [non-lapsing] nonlapsing account, from
1316 which [loans] grants, purchases of services of any type or
1317 reimbursement of state costs for services deemed necessary by the
1318 Office of Policy and Management to assist one or more
1319 nongovernmental acute care general hospitals under this section shall
1320 be made. [Upon receipt of repayment of some or all of said loans, such
1321 funds shall be deposited in the General Fund.]

1322 (d) The submission of [the] a proposed plan by the hospital under
1323 subsection (b) of this section may be considered a letter of intent for the
1324 purposes of any certificate of need which may be required to change
1325 the [facility's] hospital's service offering.

1326 (e) Upon review and approval of the [financial viability] probable
1327 significant benefit of a hospital's submitted plan, the Office of [Health
1328 Care Access] Policy and Management may recommend that a [loan]
1329 grant be awarded and issue such [loan] grant, or contract with one or
1330 more consultants to provide technical or other assistance or
1331 consultation services, or may provide any combination of such grant
1332 and assistance that the office deems necessary or advisable.

1333 Sec. 29. (a) The Commissioner of Social Services shall develop a plan
1334 to modify the Connecticut Pharmaceutical Assistance Contract to the
1335 Elderly and Disabled program, otherwise known as "ConnPACE", by
1336 establishing a component to be known as "ConnPACE Part B", to meet
1337 the prescription drug assistance needs of elderly and disabled
1338 residents who are ineligible for ConnPACE due to income exceeding
1339 ConnPACE income standards and who have no means of paying the
1340 full or partial cost of their prescription drug needs through private
1341 insurance or other means.

1342 (b) (1) The plan developed by the Commissioner of Social Services
1343 under subsection (a) of this section may include, but shall not be
1344 limited to, the following: (A) A reasonable application fee for

1345 applicants of the program; (B) a prescription drug benefit where
1346 recipients may receive prescription drugs at a reduced cost which to
1347 the extent possible is at or below the current Medicaid rate; (C) a
1348 manufacturers' drug rebate agreement which equals the rebates
1349 established under the Medicaid program and which may require a
1350 manufacturer participating in the ConnPACE program to participate
1351 in the ConnPACE Part B program; (D) a provision establishing a
1352 dispensing fee and additional subsidies paid to a pharmacist
1353 participating in the program; (E) an eligibility income limitation based
1354 on a percentage of the federal poverty level; and (F) an eligibility
1355 provision whereby income spent on catastrophic costs of prescription
1356 drugs would not be counted in a determination of eligibility.

1357 (2) Such plan shall include a fiscal impact analysis which specifies
1358 (A) the overall program and administrative costs, including projections
1359 of costs associated with any fees or subsidies provided to a pharmacist
1360 participating in the program, any costs associated with the eligibility
1361 determination and claims processing requirements of a ConnPACE
1362 part B program and any potential program start-up costs, and (B)
1363 projections of revenues, including anticipated manufacturer
1364 participation and rebates and revenues associated with an application
1365 fee. Program expenditures and administrative costs under such plan
1366 shall not exceed estimated revenues from such program.

1367 (c) Not later than January 1, 2001, the Commissioner of Social
1368 Services shall submit such plan to the joint standing committees of the
1369 General Assembly having cognizance of matters relating to public
1370 health, human services and appropriations and the budgets of state
1371 agencies. Within thirty days of the receipt of the plan, said committees
1372 shall make a finding to the speaker of the House of Representatives,
1373 the president pro tempore of the Senate, the majority leader of the
1374 House of Representatives, the majority leader of the Senate, the
1375 minority leader of the House of Representatives, the minority leader of
1376 the Senate and the Commissioner of Social Services, that such plan
1377 meets, or fails to meet, the requirements that program expenditures

1378 and administrative costs do not exceed estimated revenues. In the
1379 event that the committees find that program expenditures and
1380 administrative costs do not exceed estimated revenues, such plan shall
1381 be implemented by the commissioner as soon as is practicable, but not
1382 later than July 1, 2001.

1383 (d) There shall be established a separate, nonlapsing ConnPACE
1384 Part B account, into which ConnPACE Part B manufacturers' rebates
1385 and other revenues may be deposited and from which payments for
1386 program expenditures and administrative costs may be made.

1387 (e) The Commissioner of Social Services may negotiate the
1388 contractual terms of participation of any pharmaceutical manufacturer,
1389 pharmacist and eligibility and claims processing agent participating in
1390 the ConnPACE Part B program.

1391 Sec. 30. Not later than February 1, 2001, the Commissioner of Social
1392 Services shall study the impact of the security deposit guarantee
1393 program on access to affordable housing for recipients of benefits
1394 under such program and report any findings and recommendations to
1395 the joint standing committees of the General Assembly having
1396 cognizance of matters relating to human services and appropriations
1397 and the budgets of state agencies, in accordance with the provisions of
1398 section 11-4a of the general statutes.

1399 Sec. 31. (a) The Commissioner of Social Services shall study methods
1400 of operating the Medicaid managed care program including primary
1401 care case management, fee for service and the current system. The
1402 study shall compare probable costs and quality under each system,
1403 including provider participation, client participation, client access to
1404 care parameters, ease of access, preventive care, treatment referrals,
1405 outreach, any disincentives to providing care, public ownership of
1406 program information and data and the administrative burden on
1407 providers, clients and the state. The commissioner shall rely on the
1408 experiences of other states and input from current and potential
1409 providers and clients of such program.

1410 (b) Not later than March 1, 2001, the Commissioner of Social
1411 Services shall submit a report of any findings and recommendations to
1412 the joint standing committees of the General Assembly having
1413 cognizance of matters relating to public health, human services and
1414 appropriations and the budgets of state agencies, in accordance with
1415 the provisions of section 11-4a of the general statutes.

1416 Sec. 32. (a) There is established a Dental Advisory Council
1417 consisting of the following members: (1) The Commissioner of Social
1418 Services, or the commissioner's designee; (2) the Commissioner of
1419 Public Health, or the commissioner's designee; (3) the dean of The
1420 University of Connecticut School of Dentistry, or the dean's designee;
1421 and (4) seven persons, one of whom shall be a representative of a
1422 mobile dental clinic appointed by the Governor, one of whom shall be
1423 a representative of the Connecticut State Dental Association appointed
1424 by the speaker of the House of Representatives, one of whom shall be a
1425 representative of a managed care organization appointed by the
1426 president pro tempore of the Senate, one of whom shall be a
1427 representative of a community health center or a school-based health
1428 center appointed by the majority leader of the House of
1429 Representatives, one of whom shall be a representative of the
1430 Connecticut Dental Hygiene Association appointed by the majority
1431 leader of the Senate, one of whom shall be a representative of the
1432 Connecticut Children's Health Council appointed by the minority
1433 leader of the House Of Representatives, and one of whom shall be a
1434 faculty member or an administrator of a dental hygiene school located
1435 in the state appointed by the minority leader of the Senate.

1436 (b) The Dental Advisory Council shall: (1) Review fees for dental
1437 services paid by the Department of Social Services under the Medicaid
1438 dental program to determine the adequacy of such fees and make
1439 recommendations for adjustments or modifications to such fees based
1440 on experience and access to dental services and dental utilization as
1441 reflected in annual Health Care Financing Administration utilization
1442 reports; (2) monitor the effects of fee increases under the Medicaid

1443 dental program on the number of persons eligible under the program
1444 who obtain dental services and the number of dental care providers
1445 who participate in the program; (3) make recommendations on dental
1446 services capacity assessment; (4) identify private foundation support
1447 for public or nonprofit health care entities providing dental services;
1448 (5) evaluate dental care pilot programs; (6) enhance public and medical
1449 community awareness of dental access issues; and (7) make
1450 recommendations concerning the expansion of access to dental care
1451 and the increase of dental services utilization in the state including, but
1452 not limited to, recommendations for state utilization goals.

1453 (c) Not later than April 15, 2001, the Dental Advisory Council shall
1454 submit an interim report of its analysis and recommendations under
1455 subsection (b) of this section to the joint standing committees of the
1456 General Assembly having cognizance of matters relating to public
1457 health and human services, in accordance with the provisions of
1458 section 11-4a of the general statutes. The Dental Advisory Council shall
1459 submit its final report under this subsection to said committees not
1460 later than January 1, 2002.

1461 Sec. 33. Not later than January 1, 2001, the Commissioner of
1462 Children and Families shall submit a report to the joint standing
1463 committees of the General Assembly having cognizance of matters
1464 relating to human services and appropriations and the budgets of state
1465 agencies which shall specify a methodology said commissioner will
1466 use to indicate in said agency's estimate of expenditure requirements
1467 transmitted pursuant to subsection (a) of section 4-77 of the general
1468 statutes, expenditure requirements classified to indicate expenditures
1469 estimated for the following: (1) Child protective services; (2) juvenile
1470 justice; (3) children's mental health and substance abuse services; (4)
1471 prevention; and (5) administration.

1472 Sec. 34. (NEW) The expenditure report relative to the temporary
1473 assistance for needy families block grant required to be submitted by
1474 the Commissioner of Social Services to the federal Department of

1475 Health and Human Services shall be transmitted to the joint standing
1476 committees of the General Assembly having cognizance of matters
1477 relating to human services and appropriations and the budgets of state
1478 agencies within forty-five days of the date of such submission. Such
1479 report for the last quarter of the fiscal year shall include the
1480 identification of unliquidated obligations either identified in previous
1481 quarterly reports for the same fiscal year and claimed before the prior
1482 quarterly report or those not yet claimed by the commissioner for the
1483 purposes of receiving federal reimbursement. In the event that such
1484 report identifies any unliquidated obligations, the commissioner shall
1485 notify said committees of the commissioner's intention concerning the
1486 disposition of such unliquidated obligations, which may include,
1487 establishing or contributing to a reserve account to meet future needs
1488 in the temporary family assistance program.

1489 Sec. 35. (NEW) The maximum allowable cost paid for Factor VIII
1490 pharmaceuticals under the Medicaid, state-administered general
1491 assistance, general assistance and ConnPACE programs shall be the
1492 actual acquisition cost plus eight per cent. The Commissioner of Social
1493 Services may designate specific suppliers of Factor VIII
1494 pharmaceuticals from which a dispensing pharmacy shall order the
1495 prescription to be delivered to the pharmacy and billed by the supplier
1496 to the Department of Social Services. If the commissioner so designates
1497 specific suppliers of Factor VIII pharmaceuticals, the department shall
1498 pay the dispensing pharmacy a handling fee equal to eight per cent of
1499 the actual acquisition cost for such prescription.

1500 Sec. 36. (NEW) (a) The Commissioner of Social Services may
1501 establish a plan for the prior authorization of (1) any initial
1502 prescription for a drug covered under the Medicaid, state-
1503 administered general assistance, general assistance or ConnPACE
1504 program that costs five hundred dollars or more for a thirty-day
1505 supply or (2) any early refill of a prescription drug covered under any
1506 of said programs. The Commissioner of Social Services shall establish a
1507 procedure by which prior authorization under this subsection shall be

1508 obtained from an independent pharmacy consultant acting on behalf
1509 of the Department of Social Services, under an administrative services
1510 only contract. If prior authorization is not granted or denied within
1511 twenty-four hours of receipt by the commissioner of the request for
1512 prior authorization, it shall be deemed granted.

1513 (b) The Commissioner of Social Services shall, to increase cost-
1514 efficiency or enhance access to a particular prescription drug, establish
1515 a plan under which the commissioner may designate specific suppliers
1516 of a prescription drug from which a dispensing pharmacy shall order
1517 the prescription to be delivered to the pharmacy and billed by the
1518 supplier to the department. For each prescription dispensed through
1519 designated suppliers, the department shall pay the dispensing
1520 pharmacy a handling fee not to exceed four hundred per cent of the
1521 dispensing fee established pursuant to section 17b-280 of the general
1522 statutes, as amended by this act. In no event shall the provisions of this
1523 subsection be construed to allow the commissioner to purchase all
1524 prescription drugs covered under the Medicaid, state-administered
1525 general assistance, general assistance and ConnPACE programs under
1526 one contract.

1527 (c) Notwithstanding the provisions of section 17b-262 of the general
1528 statutes and any regulation adopted thereunder, on or after July 1,
1529 2000, the Commissioner of Social Services may establish a schedule of
1530 maximum quantities of oral dosage units permitted to be dispensed at
1531 one time for prescriptions covered under the Medicaid, state-
1532 administered general assistance and general assistance programs
1533 based on a review of utilization patterns.

1534 (d) A plan or schedule established pursuant to subsection (a), (b) or
1535 (c) of this section and any revisions thereto shall be submitted to the
1536 joint standing committees of the General Assembly having cognizance
1537 of matters relating to public health, human services and appropriations
1538 and the budgets of state agencies. Within sixty days of receipt of such a
1539 plan or schedule or revisions thereto, said joint standing committees of

1540 the General Assembly shall approve or deny the plan or schedule or
1541 any revisions thereto and advise the commissioner of their approval or
1542 denial of the plan or schedule or any revisions thereto. The plan or
1543 schedule or any revisions thereto shall be deemed approved unless all
1544 committees vote to reject such plan or schedule or revisions thereto
1545 within sixty days of receipt of such plan or schedule or revisions
1546 thereto.

1547 Sec. 37. (NEW) (a) Each long-term care facility shall return to the
1548 vendor pharmacy which shall accept, for repackaging and
1549 reimbursement to the Department of Social Services, drug products
1550 that were dispensed to a patient and not used if such drug products
1551 are (1) prescription drug products that are not controlled substances,
1552 (2) sealed in individually packaged units, (3) returned to the vendor
1553 pharmacy within the recommended period of shelf life for the purpose
1554 of redispensing such drug products, and (4) oral and parenteral
1555 medication in single-dose sealed containers approved by the federal
1556 Food and Drug Administration, topical or inhalant drug products in
1557 units of use containers approved by the federal Food and Drug
1558 Administration or parenteral medications in multiple-dose sealed
1559 containers approved by the federal Food and Drug Administration
1560 from which no doses have been withdrawn.

1561 (b) Notwithstanding the provisions of subsection (a) of this section:

1562 (1) If such drug products are packaged in manufacturer's unit-dose
1563 packages, such drug products shall be returned to the vendor
1564 pharmacy for redispensing and reimbursement to the Department of
1565 Social Services if such drugs may be redispensed for use before the
1566 expiration date, if any, indicated on the package.

1567 (2) If such drug products are repackaged in manufacturer's unit-
1568 dose or multiple-dose blister packs, such drug products shall be
1569 returned to the vendor pharmacy for redispensing and reimbursement
1570 to the Department of Social Services if (A) the date on which such drug
1571 product was repackaged, such drug product's lot number and

1572 expiration date are indicated clearly on the package of such
1573 repackaged drug; (B) ninety days or fewer have elapsed from the date
1574 of repackaging of such drug product; and (C) a repackaging log is
1575 maintained by the pharmacy in the case of drug products repackaged
1576 in advance of immediate needs.

1577 (3) No drug products dispensed in a bulk dispensing container may
1578 be returned to the vendor pharmacy.

1579 (c) Each long-term care facility shall establish procedures for the
1580 return of unused drug products to the vendor pharmacy from which
1581 such drug products were purchased.

1582 (d) The Department of Social Services (1) shall reimburse to the
1583 vendor pharmacy the reasonable cost of services incurred in the
1584 operation of this section, as determined by the commissioner, and (2)
1585 may establish procedures, if feasible, for reimbursement to
1586 nonMedicaid payors for drug products returned pursuant to this
1587 section.

1588 (e) The Department of Consumer Protection, in consultation with
1589 the Department of Social Services, shall adopt regulations, in
1590 accordance with the provisions of chapter 54 of the general statutes,
1591 which shall govern the repackaging and labeling of drug products
1592 returned pursuant to subsections (a) and (b) of this section. The
1593 Department of Consumer Protection shall implement the policies and
1594 procedures necessary to carry out the provisions of this section until
1595 January 1, 2002, while in the process of adopting such policies and
1596 procedures in regulation form, provided notice of intent to adopt the
1597 regulations is published in the Connecticut Law Journal within twenty
1598 days after implementation.

1599 Sec. 38. Section 17b-274 of the general statutes is repealed and the
1600 following is substituted in lieu thereof:

1601 (a) The Commissioner of Social Services shall pay a pharmacist a

1602 professional dispensing fee of fifty cents per prescription, in addition
1603 to any other dispensing fee, for substituting a generically equivalent
1604 drug product, in accordance with section 20-619, as amended by this
1605 act, for the drug prescribed by the licensed practitioner for a Medicaid
1606 recipient, provided the substitution is not required by federal law or
1607 regulation.

1608 (b) The Division of Criminal Justice shall periodically investigate
1609 pharmacies to ensure that the state is not billed for a brand name drug
1610 product when a less expensive generic substitute drug product is
1611 dispensed to a Medicaid recipient. The Commissioner of Social
1612 Services shall cooperate and provide information as requested by such
1613 division.

1614 (c) A licensed medical practitioner may specify in writing or by a
1615 telephonic or electronic communication that there shall be no
1616 substitution for the specified brand name drug product in any
1617 prescription for a Medicaid, state-administered general assistance,
1618 general assistance or ConnPACE recipient, provided (1) the
1619 practitioner specifies the basis on which the brand name drug product
1620 and dosage form is medically necessary in comparison to a chemically
1621 equivalent generic drug product substitution, and (2) the phrase
1622 "brand medically necessary" shall be in the practitioner's handwriting
1623 on the prescription form or, if the prohibition was communicated by
1624 telephonic communication, in the pharmacist's handwriting on such
1625 form, and shall not be preprinted or stamped or initialed on such form.
1626 If the practitioner specifies by telephonic communication that there
1627 shall be no substitution for the specified brand name drug product in
1628 any prescription for a Medicaid, state-administered general assistance,
1629 general assistance or ConnPACE recipient, written certification in the
1630 practitioner's handwriting bearing the phrase "brand medically
1631 necessary" shall be sent to the dispensing pharmacy within ten days. A
1632 pharmacist shall dispense a generically equivalent drug product for
1633 any drug listed in accordance with the Code of Federal Regulations
1634 Title 42 Part 447.332 for a drug prescribed for a Medicaid, state-

1635 administered general assistance, general assistance or ConnPACE
1636 recipient unless the phrase "brand medically necessary" is ordered in
1637 accordance with this subsection and such pharmacist has received
1638 approval to dispense the brand name drug product in accordance with
1639 subsection (d) of this section.

1640 (d) The Commissioner of Social Services shall establish a procedure
1641 by which a pharmacist shall obtain approval from an independent
1642 pharmacy consultant acting on behalf of the Department of Social
1643 Services, under an administrative services only contract, whenever the
1644 pharmacist dispenses a brand name drug product to a Medicaid, state-
1645 administered general assistance, general assistance or ConnPACE
1646 recipient and a chemically equivalent generic drug product
1647 substitution is available, provided such procedure shall not require
1648 approval for other than initial prescriptions for such drug product. If
1649 such approval is not granted or denied within twenty-four hours of
1650 receipt by the commissioner of the request for approval, it shall be
1651 deemed granted. The pharmacist may appeal a denial of
1652 reimbursement to the department based on the failure of such
1653 pharmacist to substitute a generic drug product in accordance with
1654 this section.

1655 (e) A licensed medical practitioner shall disclose to the Department
1656 of Social Services or such consultant, upon request, the basis on which
1657 the brand name drug product and dosage form is medically necessary
1658 in comparison to a chemically equivalent generic drug product
1659 substitution. The Commissioner of Social Services shall establish a
1660 procedure by which such a practitioner may appeal a determination
1661 that a chemically equivalent generic drug product substitution is
1662 required for a Medicaid, state-administered general assistance, general
1663 assistance or ConnPACE recipient.

1664 Sec. 39. Section 17b-280 of the general statutes is repealed and the
1665 following is substituted in lieu thereof:

1666 Notwithstanding any provision of the regulations of Connecticut

1667 state agencies concerning payment for drugs provided to Medicaid
1668 recipients [(1)] effective July 1, 1989, the state shall reimburse for all
1669 legend drugs provided to such recipients at the rate established by the
1670 Health Care Finance Administration as the federal acquisition cost, or,
1671 if no such rate is established, the commissioner shall establish and
1672 periodically revise the estimated acquisition cost in accordance with
1673 federal regulations. [The] Effective July 1, 2000, the commissioner shall
1674 [also] establish a professional fee to be paid to licensed pharmacies for
1675 dispensing drugs to Medicaid, state-administered general assistance,
1676 general assistance and ConnPACE recipients in accordance with
1677 federal regulations [; and (2) on] which shall be three dollars and sixty
1678 cents for each prescription. On and after September 4, 1991, payment
1679 for legend and nonlegend drugs provided to Medicaid recipients shall
1680 be based upon the actual package size dispensed. Effective October 1,
1681 1991, reimbursement for over-the-counter drugs for such recipients
1682 shall be limited to those over-the-counter drugs and products
1683 published in the Connecticut Formulary, or the cross reference list,
1684 issued by the commissioner. The cost of all over-the-counter drugs and
1685 products provided to residents of nursing facilities, chronic disease
1686 hospitals, and intermediate care facilities for the mentally retarded
1687 shall be included in the facilities' per diem rate.

1688 Sec. 40. Section 17b-362a of the general statutes is repealed and the
1689 following is substituted in lieu thereof:

1690 The Commissioner of Social Services shall establish a pharmacy
1691 review panel to serve as advisors in the operation of pharmacy benefit
1692 programs administered by the Department of Social Services,
1693 including the implementation of any cost-saving initiatives undertaken
1694 pursuant to section 17b-362, subsection (e) of section 17b-491 and
1695 section 17b-363. The panel shall be appointed by the commissioner to a
1696 three-year term and shall be composed of two representatives of
1697 independent pharmacies, two representatives of chain pharmacies,
1698 two representatives of institutional pharmacies, two representatives of
1699 pharmaceutical manufacturers, one physician specializing in family

1700 practice and one physician specializing in internal medicine or
1701 geriatrics. The panel shall meet at least quarterly with the
1702 commissioner or [his] said commissioner's designee.

1703 Sec. 41. Subsection (e) of section 17b-491 of the general statutes is
1704 repealed and the following is substituted in lieu thereof:

1705 (e) All prescription drugs of a pharmaceutical manufacturer that
1706 participates in the program pursuant to subsection (d) of this section
1707 shall be subject to prospective drug utilization review, [but not prior
1708 authorization.] Any prescription drug of a manufacturer that does not
1709 participate in the program shall not be reimbursable, unless the
1710 department determines the prescription drug is essential to program
1711 participants.

1712 Sec. 42. Section 17b-493 of the general statutes is repealed and the
1713 following is substituted in lieu thereof:

1714 A pharmacist shall, except as limited by subsection (c) of section 20-
1715 619, as amended by this act, and section 17b-274, as amended by this
1716 act, substitute a therapeutically and chemically equivalent generic
1717 drug product for a prescribed drug product when filling a prescription
1718 for an eligible person under the program.

1719 Sec. 43. Subsection (c) of section 20-619 of the general statutes, as
1720 amended by section 39 of public act 99-175, is repealed and the
1721 following is substituted in lieu thereof:

1722 (c) A prescribing practitioner may specify in writing or by a
1723 telephonic or other electronic communication that there shall be no
1724 substitution for the specified brand name drug product in any
1725 prescription, provided (1) in any prescription for a Medicaid, state-
1726 administered general assistance, general assistance or ConnPACE
1727 recipient, such practitioner specifies the basis on which the brand
1728 name drug product and dosage form is medically necessary in
1729 comparison to a chemically equivalent generic drug product

1730 substitution, and (2) the phrase ["NO SUBSTITUTION" or, for
1731 prescriptions covered by medical assistance in accordance with the
1732 Code of Federal Regulations, Title 42, Part 447.332, the phrase]
1733 "BRAND MEDICALLY NECESSARY", shall be in the practitioner's
1734 handwriting on the prescription form or on an electronically-produced
1735 copy of the prescription form or, if the prohibition was communicated
1736 by telephonic or other electronic communication that did not
1737 reproduce the practitioner's handwriting, a statement to that effect
1738 appears on the form. The phrase ["NO SUBSTITUTION" or] "BRAND
1739 MEDICALLY NECESSARY" shall not be preprinted or stamped or
1740 initialed on the form. If the practitioner specifies by telephonic or other
1741 electronic communication that did not reproduce the practitioner's
1742 handwriting that there shall be no substitution for the specified brand
1743 name drug product in any prescription for a Medicaid, state-
1744 administered general assistance, general assistance or ConnPACE
1745 recipient, written certification in the practitioner's handwriting bearing
1746 the phrase "BRAND MEDICALLY NECESSARY" shall be sent to the
1747 dispensing pharmacy within ten days.

1748 Sec. 44. Subsection (b) of section 17b-134 of the general statutes is
1749 repealed and the following is substituted in lieu thereof:

1750 (b) At the end of each quarter, one of the selectmen or the public
1751 official charged with the administration of general assistance in each
1752 town shall send to the Commissioner of Social Services, in the form
1753 prescribed by said commissioner, a statement of the cost to such town
1754 of general assistance during such quarter, which report shall be signed
1755 and sworn to by such selectman or public official. Such report form
1756 shall be uniform throughout the state and shall include, but not be
1757 limited to, the following information: (1) The approved budget of each
1758 town for general assistance, (2) the number of applications received, (3)
1759 compilation of data required under section 17b-123, (4) the extent to
1760 which recipients participated in work relief programs, if any, (5) the
1761 amount of the support and medical aid furnished, (6) the amount of
1762 the town's share of the cost for inpatient hospital and other medical

1763 services paid by the Department of Social Services pursuant to section
1764 17b-220, and (7) such other information the commissioner deems
1765 necessary for the proper administration and oversight of the general
1766 assistance program. "Cost", as used herein, means the actual relief
1767 expenditure made by such town for persons therein or sent from such
1768 town to such licensed institutions, including expenses, except
1769 attorneys' fees, incurred in an appeal of a denial of Supplemental
1770 Security Income Assistance as provided in section 17b-119, but not
1771 including administrative costs, provided the expenditures for medical
1772 care shall not exceed the amounts set forth in the various fee schedules
1773 promulgated by the Commissioner of Social Services for medical,
1774 dental and allied services and supplies or the charges made for
1775 comparable services and supplies to the general public, whichever is
1776 less. Upon state processing and payment of medical claims pursuant to
1777 this chapter, pharmaceutical manufacturers shall be liable for rebates
1778 on pharmaceutical products. Rebate amounts for brand name
1779 pharmaceutical products shall be equal to those under the Medicaid
1780 program. Rebate amounts for generic pharmaceutical products shall be
1781 [equal to] established by the commissioner, provided such amounts
1782 may not be less than those under the Medicaid program. The process
1783 for computing and collecting such rebates shall parallel such process in
1784 the Medicaid program. Failure or refusal of a manufacturer to pay
1785 rebate amounts billed may result in elimination of coverage under
1786 general assistance for all or some products of the manufacturer. Any
1787 hospital receiving state aid shall charge a uniform rate for paupers
1788 receiving medical treatment or being supported or cared for in such
1789 hospital under the provisions of this section, not in excess of the rate
1790 established under the provisions of section 17b-238 for room, board,
1791 ordinary nursing care and routine medications and not in excess of the
1792 daily average cost rate for special professional services as established
1793 under the provisions of subsection (b) of section 17b-239. The
1794 commissioner, if satisfied that the statements are substantially true and
1795 if the town has complied with the reporting requirements of this
1796 section, shall certify them to the Comptroller, who shall pay within

1797 sixty days of receipt of such certification, subject to subsequent audits,
1798 to the town for general assistance expenditures, subject to section 17b-
1799 220, ninety per cent for expenditures made prior to July 1, 1992, and
1800 notwithstanding the provisions of section 2-32a, eighty-five per cent
1801 for expenditures made on and after July 1, 1992, eighty per cent for
1802 expenditures made on and after July 1, 1993, ninety per cent for
1803 expenditures made on and after April 1, 1996, and one hundred per
1804 cent for expenditures made on and after April 1, 1997. The
1805 commissioner may reduce by twenty-five per cent the amount
1806 otherwise payable to the town in accordance with this section for any
1807 statement which is submitted more than three months after the close of
1808 the quarter for which the statement was prepared. Effective August 31,
1809 1997, towns shall not be reimbursed for assistance paid to employable
1810 persons. If not satisfied, the commissioner may reject such claim and
1811 shall notify the selectmen or other public official submitting the report
1812 of his decision. Notwithstanding any other provision of this section,
1813 the state shall charge the town for ten per cent of the inpatient hospital
1814 expenses paid prior to July 1, 1992, of a person who is hospitalized and
1815 is eligible for or is receiving general assistance benefits in the form of
1816 an adjustment to the quarterly statement submitted by the town
1817 pursuant to this section. Notwithstanding the provisions of section 2-
1818 32a, (A) the state shall charge the town for fifteen per cent of the
1819 inpatient hospital and other medical expenses paid on and after July 1,
1820 1992, on behalf of any such person in such form and (B) the state shall
1821 charge the town for twenty per cent of the inpatient hospital and other
1822 medical expenses paid on or after July 1, 1993, ten per cent for such
1823 expenses paid on or after April 1, 1996, and the state shall not charge
1824 for such expenses on or after April 1, 1997, on behalf of any person in
1825 such form. Any town aggrieved by the action of the commissioner
1826 may, within thirty days after receipt of such notice, request a hearing
1827 before the commissioner. The commissioner shall fix a time and place
1828 for the hearing, which shall be not more than thirty days after the
1829 receipt of such request and notify the town of the time and place not
1830 later than fifteen days before the date of the hearing. The hearing shall

1831 be conducted in accordance with the procedures established under
1832 sections 4-176e, 4-177, 4-177c and 4-180 for contested cases. The
1833 commissioner or the person authorized by him to conduct the hearing
1834 shall render a decision within thirty days after the hearing and notify
1835 the town by mailing a copy of the decision to the selectmen or the
1836 public official charged with the administration of general assistance. If
1837 the town is aggrieved by the decision, it may appeal to the Superior
1838 Court in accordance with the provisions of section 4-183.

1839 Sec. 45. Subsection (d) of section 17b-491 of the general statutes is
1840 repealed and the following is substituted in lieu thereof:

1841 (d) The commissioner shall establish an application form whereby a
1842 pharmaceutical manufacturer may apply to participate in the program.
1843 Upon receipt of a completed application, the department shall issue a
1844 certificate of participation to the manufacturer. Participation by a
1845 pharmaceutical manufacturer shall require that the department shall
1846 receive a rebate from the pharmaceutical manufacturer, [equal to the
1847 rebate supplied by the manufacturer under Section 1927 of Title XIX of
1848 the Social Security Act for every prescription drug dispensed under the
1849 program.] Rebate amounts for brand name prescription drugs shall be
1850 equal to those under the Medicaid program. Rebate amounts for
1851 generic prescription drugs shall be established by the commissioner,
1852 provided such amounts may not be less than those under the Medicaid
1853 program. A participating pharmaceutical manufacturer shall make
1854 quarterly rebate payments to the department [equal to the rebate
1855 supplied by the manufacturer under Section 1927 of Title XIX of the
1856 Social Security Act] for the total number of dosage units of each form
1857 and strength of a prescription drug which the department reports as
1858 reimbursed to providers of prescription drugs, provided such
1859 payments shall not be due until thirty days following the
1860 manufacturer's receipt of utilization data from the department
1861 including the number of dosage units reimbursed to providers of
1862 prescription drugs during the quarter for which payment is due.

1863 Sec. 46. (a) The Commissioner of Social Services, in consultation
1864 with the pharmacy review panel established pursuant to section 17b-
1865 362a of the general statutes, as amended by this act, shall study the
1866 feasibility of implementation of additional pharmacy efficiencies in the
1867 Medicaid, state-administered general assistance, general assistance and
1868 ConnPACE programs, including, but not limited to, (1) enhanced use
1869 of cognitive services by pharmacists in the use of medicines for chronic
1870 disease, including pharmacy-based disease management programs; (2)
1871 enhancement of services to address adverse drug reactions
1872 experienced by recipients of such programs; and (3) pursuit of
1873 fraudulent use or other misuse of prescriptive authority by licensed
1874 medical practitioners.

1875 (b) Not later than May 1, 2001, the Commissioner of Social Services
1876 shall submit a report of any findings and recommendations to the joint
1877 standing committees of the General Assembly having cognizance of
1878 matters relating to public health, human services and appropriations
1879 and the budgets of state agencies, in accordance with the provisions of
1880 section 11-4a of the general statutes.

1881 Sec. 47. In the event that prescription drug and pharmacy savings
1882 initiatives undertaken by the Department of Social Services pursuant
1883 to sections 35 to 37, inclusive of this act, sections 17b-274 and 17b-280
1884 of the general statutes, as amended by this act, section 17b-362a of the
1885 general statutes, as amended by this act, subsections (d) and (e) of
1886 section 17b-491 of the general statutes, as amended by this act, section
1887 17b-493 of the general statutes, as amended by this act, subsection (c)
1888 of section 20-619 of the general statutes, as amended by this act,
1889 subsection (b) of section 17b-134 of the general statutes, as amended by
1890 this act, and section 46 of this act, for the fiscal year ending June 30,
1891 2001, result in greater savings than anticipated, the Commissioner of
1892 Social Services shall develop a plan for the disbursement to
1893 participating pharmacies of any such excess savings and shall report
1894 such savings and such plan to the joint standing committees of the
1895 General Assembly having cognizance of matters relating to public

1896 health, human services and appropriations and the budgets of state
1897 agencies not later than May 15, 2001.

1898 Sec. 48. During the fiscal year ending June 30, 2001, the
1899 Commissioner of Social Services may, within available appropriations
1900 and in consultation with the Connecticut State Medical Society,
1901 establish and operate a pharmacy-based disease management pilot
1902 program for persons with asthma, diabetes or hypertension.

1903 Sec. 49. (a) The Commissioner of Social Services shall, within
1904 available appropriations, establish and operate a state-funded pilot
1905 program to allow not more than fifty persons who are sixty-five years
1906 of age or older and (1) who had received services under the personal
1907 care assistance program established under section 17b-605a of the
1908 general statutes, as amended, at any time within the twelve-month
1909 period preceding such person's sixty-fifth birthday, or (2) who are
1910 eligible for services under the Connecticut home-care program for the
1911 elderly established under section 17b-342 of the general statutes, as
1912 amended by this act, provided the commissioner determines that such
1913 persons are unable to access adequate home care services, to receive
1914 personal care assistance in order to avoid institutionalization.

1915 (b) The Commissioner of Social Services shall evaluate the cost
1916 effectiveness of providing personal care assistance under the
1917 provisions of subsection (a) of this section.

1918 (c) The Commissioner of Social Services may, within available
1919 appropriations, increase the number of persons participating in the
1920 pilot program to no more than one hundred provided such personal
1921 care assistance has been demonstrated to be cost-effective.

1922 (d) Not later than January 1, 2002, the Commissioner of Social
1923 Services shall submit a report to the joint standing committees of the
1924 General Assembly having cognizance of matters relating to public
1925 health, human services and appropriations and the budgets of state
1926 agencies on the pilot program established under subsection (a) of this

1927 section.

1928 Sec. 50. (NEW) No person shall, except for purposes directly
1929 connected with the administration of programs of the social service
1930 department of a municipality, solicit, disclose, receive or make use of,
1931 knowingly permit, participate in or acquiesce in the use of, any list of
1932 the names of, or any personally identifiable social, financial,
1933 employment, medical health, mental health, substance abuse treatment
1934 or case history information pertaining to individuals receiving
1935 assistance from or participating in any program administered by the
1936 social services department of a municipality, directly or indirectly
1937 derived from the records, papers, files or communications of such
1938 municipal department, or acquired in the course of the performance of
1939 official duties.

1940 Sec. 51. (NEW) (a) As used in this section, "registered nurse's aide"
1941 shall have the same meaning as provided in section 20-102aa of the
1942 general statutes.

1943 (b) The Commissioner of Public Health shall adopt regulations, in
1944 accordance with chapter 54 of the general statutes, to authorize the
1945 administration of nonprescription medications in nursing homes by
1946 registered nurse's aides. Such regulations shall include, but not be
1947 limited to, education and training requirements, provisions concerning
1948 supervision, restrictions on medications to be administered and
1949 provisions for disciplinary procedures.

1950 Sec. 52. (a) The Commissioner of Social Services shall conduct a
1951 comprehensive needs assessment detailing the continuum of care
1952 needs of children and young adults with specific chronic medical
1953 conditions.

1954 (b) Not later than February 1, 2001, the commissioner shall submit a
1955 report of any findings and recommendations to the joint standing
1956 committees of the General Assembly having cognizance of matters
1957 relating to human services, public health, insurance and

1958 appropriations and the budgets of state agencies, in accordance with
1959 the provisions of section 11-4a of the general statutes.

1960 Sec. 53. Section 17b-283 of the general statutes is repealed and the
1961 following is substituted in lieu thereof:

1962 [(a)] The Commissioner of Social Services shall amend the state's
1963 model 2176 Medicaid waiver to allow one hundred twenty-five
1964 disabled persons to participate under the waiver. The commissioner
1965 may, within available appropriations, amend such waiver to increase
1966 the number of persons eligible to participate under the waiver to not
1967 more than two hundred disabled persons.

1968 [(b) The Commissioner of Social Services may study the feasibility
1969 of and costs associated with providing Medicaid coverage for
1970 outpatient substance abuse treatment services. The commissioner shall
1971 report his findings and recommendations to the joint standing
1972 committees of the General Assembly having cognizance of matters
1973 relating to human services and appropriations and the budgets of state
1974 agencies by January 1, 1991.]

1975 Sec. 54. The unexpended balance of funds appropriated to the Office
1976 of Health Care Access under special act 99-10 for the purposes of a
1977 distressed hospitals loan program shall be transferred to the hospital
1978 grant and assistance program in the Office of Policy and Management
1979 established pursuant to section 40 of public act 99-2 of the June special
1980 session, as amended by this act.

1981 Sec. 55. Section 3 of public act 99-279 and section 27 of public act 00-
1982 216 are repealed.

1983 Sec. 56. This act shall take effect from its passage, except that
1984 sections 1 to 7, inclusive, 13 to 18, inclusive, 20 to 49, inclusive, and 51
1985 to 55, inclusive, shall take effect July 1, 2000, and sections 8 to 10,
1986 inclusive, shall take effect October 1, 2000.