



General Assembly

**Bill No. 2001**

June 30 Special Session,  
2003

LCO No. 8017

Referred to Committee on No Committee

Introduced by:

SEN. SULLIVAN, 5<sup>th</sup> Dist.

REP. LYONS, 146<sup>th</sup> Dist.

**AN ACT CONCERNING PUBLIC HEALTH, HUMAN SERVICES AND  
OTHER MISCELLANEOUS IMPLEMENTER PROVISIONS.**

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

1 Section 1. Section 19a-202 of the general statutes is repealed and the  
2 following is substituted in lieu thereof (*Effective from passage*):

3 Upon application to the Department of Public Health any municipal  
4 health department shall annually receive from the state an amount  
5 equal to [one dollar and thirteen] ninety-four cents per capita,  
6 provided such municipality (1) employs a full-time director of health,  
7 except that if a vacancy exists in the office of director of health or the  
8 office is filled by an acting director for more than three months, such  
9 municipality shall not be eligible for funding unless the Commissioner  
10 of Public Health waives this requirement; (2) submits a public health  
11 program and budget which is approved by the Commissioner of  
12 Public Health; and (3) appropriates not less than one dollar per capita,  
13 from the annual tax receipts, for health department services. Such  
14 municipal department of health is authorized to use additional funds,

15 which the Department of Public Health may secure from federal  
16 agencies or any other source and which it may allot to such municipal  
17 department of health. The money so received shall be disbursed upon  
18 warrants approved by the chief executive officer of such municipality.  
19 The Comptroller shall annually in July and upon a voucher of the  
20 Commissioner of Public Health, draw the Comptroller's order on the  
21 State Treasurer in favor of such municipal department of health for the  
22 amount due in accordance with the provisions of this section and  
23 under rules prescribed by the commissioner. Any moneys remaining  
24 unexpended at the end of a fiscal year shall be included in the budget  
25 of such municipal department of health for the ensuing year. This aid  
26 shall be rendered from appropriations made from time to time by the  
27 General Assembly to the Department of Public Health for this purpose.

28 Sec. 2. Section 19a-202a of the general statutes is repealed and the  
29 following is substituted in lieu thereof (*Effective from passage*):

30 (a) Upon application to the Department of Public Health, each part-  
31 time health department shall annually receive from the state an  
32 amount equal to ~~[fifty-nine]~~ forty-nine cents per capita.

33 (b) Any municipality may designate itself as having a part-time  
34 health department if: (1) The municipality has not had a full-time  
35 health department or been in a full-time health district prior to January  
36 1, 1998; (2) the municipality has the equivalent of at least one full-time  
37 employee, as determined by the Commissioner of Public Health; (3)  
38 the municipality annually submits a public health program plan and  
39 budget to the commissioner; and (4) the commissioner approves the  
40 program plan and budget.

41 (c) The Commissioner of Public Health shall adopt regulations, in  
42 accordance with the provisions of chapter 54, for the development and  
43 approval of the program plan and budget required by subdivision (3)  
44 of subsection (b) of this section.

45 Sec. 3. Section 19a-245 of the general statutes is repealed and the

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

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

74       Sec. 4. (NEW) (*Effective from passage*) (a) There is established a  
75 newborn screening account that shall be a separate nonlapsing account  
76 within the General Fund. The account shall contain any moneys  
77 required by law to be deposited into the account. Any balance  
78 remaining in said account at the end of any fiscal year shall be carried

79 forward in the account for the next fiscal year.

80 (b) Three hundred forty-five thousand dollars of the amount  
81 collected pursuant to section 19a-55 of the general statutes, in each  
82 fiscal year, shall be credited to the newborn screening account, and be  
83 available for expenditure by the Department of Public Health for the  
84 expenses of the testing required by sections 19a-55, as amended by this  
85 act, and 19a-59 of the general statutes.

86 Sec. 5. Section 19a-55 of the general statutes is repealed and the  
87 following is substituted in lieu thereof (*Effective from passage*):

88 (a) The administrative officer or other person in charge of each  
89 institution caring for newborn infants shall cause to have administered  
90 to every such infant in its care an HIV-related test, as defined in section  
91 19a-581, a test for phenylketonuria and other metabolic diseases,  
92 hypothyroidism, galactosemia, sickle cell disease, maple syrup urine  
93 disease, homocystinuria, biotinidase deficiency, congenital adrenal  
94 hyperplasia and such other tests for inborn errors of metabolism as  
95 shall be prescribed by the Department of Public Health. The tests shall  
96 be administered as soon after birth as is medically appropriate. If the  
97 mother has had an HIV-related test pursuant to section 19a-90 or 19a-  
98 593, the person responsible for testing under this section may omit an  
99 HIV-related test. The Commissioner of Public Health shall (1)  
100 administer the newborn screening program, (2) direct persons  
101 identified through the screening program to appropriate specialty  
102 centers for treatments, consistent with any applicable confidentiality  
103 requirements, and (3) set the fees to be charged to institutions to cover  
104 all expenses of the comprehensive screening program including  
105 testing, tracking and treatment. The fees to be charged pursuant to  
106 subdivision (3) of this section shall be set at a minimum of twenty-  
107 eight dollars. The commissioner shall adopt regulations, in accordance  
108 with chapter 54, specifying the abnormal conditions to be tested for  
109 and the manner of recording and reporting results. On or before  
110 January 1, [2003] 2004, such regulations shall include requirements for

111 testing for amino acid disorders, organic acid disorders and fatty acid  
112 oxidation disorders, including, but not limited to, long-chain 3-  
113 hydroxyacyl CoA dehydrogenase (L-CHAD) and medium-chain acyl-  
114 CoA dehydrogenase (MCAD).

115 (b) The provisions of this section shall not apply to any infant whose  
116 parents object to the test or treatment as being in conflict with their  
117 religious tenets and practice.

118 Sec. 6. (NEW) (*Effective from passage*) (a) Not later than September 1,  
119 2003, and annually thereafter, the Secretary of the Office of Policy and  
120 Management, in consultation with the Commissioner of Public Health,  
121 shall (1) determine the amount appropriated for the following  
122 purposes: (A) To purchase, store and distribute vaccines for routine  
123 immunizations included in the schedule for active immunization  
124 required by section 19a-7f of the general statutes; (B) to purchase, store  
125 and distribute (i) vaccines to prevent hepatitis A and B in persons of all  
126 ages, as recommended by the schedule for immunizations published  
127 by the National Advisory Committee for Immunization Practices, (ii)  
128 antibiotics necessary for the treatment of tuberculosis and biologics  
129 and antibiotics necessary for the detection and treatment of  
130 tuberculosis infections, and (iii) antibiotics to support treatment of  
131 patients in communicable disease control clinics, as defined in section  
132 19a-216a of the general statutes; and (C) to provide services needed to  
133 collect up-to-date information on childhood immunizations for all  
134 children enrolled in Medicaid who reach two years of age during the  
135 year preceding the current fiscal year, to incorporate such information  
136 into the childhood immunization registry, as defined in section 19a-7h  
137 of the general statutes, and (2) inform the Insurance Commissioner of  
138 such amount.

139 (b) Each domestic insurer or health care center doing life insurance  
140 or health insurance business in this state shall annually pay to the  
141 Insurance Commissioner, for deposit in the General Fund, a health and  
142 welfare fee assessed by the Insurance Commissioner pursuant to this

143 section. Not later than October 1, 2003, the Insurance Commissioner  
144 shall determine the fee to be assessed against each such domestic  
145 insurer or health care center for the fiscal year ending June 30, 2004.  
146 Not later than October 1, 2003, and annually thereafter, the Insurance  
147 Commissioner shall determine the fee to be assessed against each such  
148 domestic insurer or health care center for the next fiscal year. Such fee  
149 shall be a percentage of the total amount appropriated, as identified in  
150 subsection (a) of this section, and shall be calculated on the basis of life  
151 insurance premiums and health insurance premiums and subscriber  
152 charges in the same manner as calculations under section 38a-48 of the  
153 general statutes. Not later than November 1, 2003, and annually  
154 thereafter, the Insurance Commissioner shall submit a statement to  
155 each such insurer and health care center that includes the proposed fee  
156 for the insurer or health care center calculated in accordance with this  
157 section. As used in this section, "health insurance" means health  
158 insurance, as defined in subdivisions (1) to (13), inclusive, of section  
159 38a-469 of the general statutes.

160 (c) Any domestic insurer or health care center aggrieved by an  
161 assessment levied under this section may appeal therefrom in the same  
162 manner as provided for appeals under section 38a-52 of the general  
163 statutes.

164 (d) For the fiscal year ending June 30, 2004, the aggregate  
165 assessment under this section shall not exceed seven million one  
166 hundred thousand dollars. For the fiscal year ending June 30, 2005, the  
167 aggregate assessment under this section shall not exceed seven million  
168 one hundred thousand dollars.

169 Sec. 7. Section 38a-490a of the general statutes is repealed and the  
170 following is substituted in lieu thereof (*Effective from passage*):

171 [Every] Each individual health insurance policy providing coverage  
172 of the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
173 38a-469 delivered, issued for delivery or renewed in this state on or

174 after July 1, 1996, shall provide coverage [for at least five thousand  
175 dollars annually] for medically necessary early intervention services  
176 provided as part of an individualized family service plan pursuant to  
177 section 17a-248e. Such policy shall provide (1) coverage for such  
178 services provided by qualified personnel, as defined in section 17a-248,  
179 for a child from birth until the child's third birthday, and (2) a  
180 maximum benefit of three thousand two hundred dollars per child per  
181 year and an aggregate benefit of nine thousand six hundred dollars per  
182 child over the total three-year period. No payment made under this  
183 [subsection] section shall be applied by the insurer, health care center  
184 or plan administrator against any maximum lifetime or annual limits  
185 specified in the policy or health benefits plan.

186 Sec. 8. Section 38a-516a of the general statutes is repealed and the  
187 following is substituted in lieu thereof (*Effective from passage*):

188 [Every] Each group health insurance policy providing coverage of  
189 the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
190 38a-469 delivered, issued for delivery or renewed in this state on or  
191 after July 1, 1996, shall provide coverage [for at least five thousand  
192 dollars annually] for medically necessary early intervention services  
193 provided as part of an individualized family service plan pursuant to  
194 section 17a-248e. Such policy shall provide (1) coverage for such  
195 services provided by qualified personnel, as defined in section 17a-248,  
196 for a child from birth until the child's third birthday, and (2) a  
197 maximum benefit of three thousand two hundred dollars per child per  
198 year and an aggregate benefit of nine thousand six hundred dollars per  
199 child over the total three-year period. No payment made under this  
200 [subsection] section shall be applied by the insurer, health care center  
201 or plan administrator against any maximum lifetime or annual limits  
202 specified in the policy or health benefits plan.

203 Sec. 9. Subsection (e) of section 17a-248g of the general statutes is  
204 repealed and the following is substituted in lieu thereof (*Effective from*  
205 *passage*):

206 (e) The commissioner shall establish a schedule of fees based on a  
207 sliding scale for early intervention services. The schedule of fees shall  
208 consider the cost of such services relative to the financial resources of  
209 the parents or legal guardians of eligible children. Fees may be charged  
210 to any such parent or guardian, regardless of income, and shall be  
211 charged to any such parent or guardian with a gross annual family  
212 income of forty-five thousand dollars or more, except that no fee may  
213 be charged to the parent or guardian of a child who is eligible for  
214 Medicaid. The Department of Mental Retardation may assign its right  
215 to collect fees to a designee or provider participating in the early  
216 intervention program and providing services to a recipient in order to  
217 assist the provider in obtaining payment for such services. The  
218 commissioner may implement procedures for the collection of the  
219 schedule of fees while in the process of adopting or amending such  
220 criteria in regulation, provided the commissioner prints notice of  
221 intention to adopt or amend the regulations in the Connecticut Law  
222 Journal within twenty days of implementing the policy. Such collection  
223 procedures and schedule of fees shall be valid until the time the final  
224 regulations or amendments are effective.

225 Sec. 10. Section 4-28f of the general statutes, as amended by section 3  
226 of public act 03-19, is repealed and the following is substituted in lieu  
227 thereof (*Effective from passage*):

228 (a) There is created a Tobacco and Health Trust Fund which shall be  
229 a separate nonlapsing fund. The purpose of the trust fund shall be to  
230 create a continuing significant source of funds to (1) support and  
231 encourage development of programs to reduce tobacco abuse through  
232 prevention, education and cessation programs, (2) support and  
233 encourage development of programs to reduce substance abuse, and  
234 (3) develop and implement programs to meet the unmet physical and  
235 mental health needs in the state.

236 (b) The trust fund may accept transfers from the Tobacco Settlement  
237 Fund and may apply for and accept gifts, grants or donations from

238 public or private sources to enable the trust fund to carry out its  
239 objectives.

240 (c) The trust fund shall be administered by a board of trustees,  
241 [which] except that the board shall suspend its operations from July 1,  
242 2003, to June 30, 2005, inclusive. The board shall consist of seventeen  
243 trustees. The appointment of the initial trustees shall be as follows: (1)  
244 The Governor shall appoint four trustees, one of whom shall serve for  
245 a term of one year from July 1, 2000, two of whom shall serve for a  
246 term of two years from July 1, 2000, and one of whom shall serve for a  
247 term of three years from July 1, 2000; (2) the speaker of the House of  
248 Representatives and the president pro tempore of the Senate each shall  
249 appoint two trustees, one of whom shall serve for a term of two years  
250 from July 1, 2000, and one of whom shall serve for a term of three years  
251 from July 1, 2000; (3) the majority leader of the House of  
252 Representatives and the majority leader of the Senate each shall  
253 appoint two trustees, one of whom shall serve for a term of one year  
254 from July 1, 2000, and one of whom shall serve for a term of three years  
255 from July 1, 2000; (4) the minority leader of the House of  
256 Representatives and the minority leader of the Senate each shall  
257 appoint two trustees, one of whom shall serve for a term of one year  
258 from July 1, 2000, and one of whom shall serve for a term of two years  
259 from July 1, 2000; and (5) the Secretary of the Office of Policy and  
260 Management, or the secretary's designee, shall serve as an ex-officio  
261 voting member. Following the expiration of such initial terms,  
262 subsequent trustees shall serve for a term of three years. The period of  
263 suspension of the board's operations from July 1, 2003, to June 30, 2005,  
264 inclusive, shall not be included in the term of any trustee serving on  
265 July 1, 2003. The trustees shall serve without compensation except for  
266 reimbursement for necessary expenses incurred in performing their  
267 duties. The board of trustees shall establish rules of procedure for the  
268 conduct of its business which shall include, but not be limited to,  
269 criteria, processes and procedures to be used in selecting programs to  
270 receive money from the trust fund. The trust fund shall be within the

271 Office of Policy and Management for administrative purposes only.  
272 The board of trustees shall meet not less than bimonthly except during  
273 the fiscal years ending June 30, 2004, and June 30, 2005, and, not later  
274 than January first of each year, except during the fiscal years ending  
275 June 30, 2004, and June 30, 2005, shall submit a report of its activities  
276 and accomplishments to the joint standing committees of the General  
277 Assembly having cognizance of matters relating to public health and  
278 appropriations and the budgets of state agencies, in accordance with  
279 section 11-4a. Such report shall be approved by each trustee.

280 (d) (1) During the period commencing July 1, 2000, and ending June  
281 30, [2005] 2003, the board of trustees, by majority vote, may  
282 recommend authorization of disbursement from the trust fund for the  
283 purposes described in subsection (a) of this section and section 19a-6c,  
284 provided the board may not recommend authorization of  
285 disbursement of more than fifty per cent of net earnings from the  
286 principal of the trust fund for such purposes. For the fiscal year  
287 commencing July 1, 2005, and each fiscal year thereafter, the board  
288 may recommend authorization of the net earnings from the principal  
289 of the trust fund for such purposes. The board's recommendations  
290 shall give (A) priority to programs that address tobacco and substance  
291 abuse and serve minors, pregnant women and parents of young  
292 children, and (B) consideration to the availability of private matching  
293 funds. Recommended disbursements from the trust fund shall be in  
294 addition to any resources that would otherwise be appropriated by the  
295 state for such purposes and programs.

296 (2) [The] Except during the fiscal years ending June 30, 2004, and  
297 June 30, 2005, the board of trustees shall submit such  
298 recommendations for the authorization of disbursement from the trust  
299 fund to the joint standing committees of the General Assembly having  
300 cognizance of matters relating to public health and appropriations and  
301 the budgets of state agencies. Not later than thirty days after receipt of  
302 such recommendations, said committees shall advise the board of their  
303 approval, modifications, if any, or rejection of the board's

304 recommendations. If said joint standing committees do not concur, the  
305 speaker of the House of Representatives, the president pro tempore of  
306 the Senate, the majority leader of the House of Representatives, the  
307 majority leader of the Senate, the minority leader of the House of  
308 Representatives and the minority leader of the Senate each shall  
309 appoint one member from each of said joint standing committees to  
310 serve as a committee on conference. The committee on conference shall  
311 submit its report to both committees, which shall vote to accept or  
312 reject the report. The report of the committee on conference may not be  
313 amended. If a joint standing committee rejects the report of the  
314 committee on conference, the board's recommendations shall be  
315 deemed approved. If the joint standing committees accept the report of  
316 the committee on conference, the joint standing committee having  
317 cognizance of matters relating to appropriations and the budgets of  
318 state agencies shall advise the board of said joint standing committees'  
319 approval or modifications, if any, of the board's recommended  
320 disbursement. If said joint standing committees do not act within thirty  
321 days after receipt of the board's recommendations for the  
322 authorization of disbursement, such recommendations shall be  
323 deemed approved. Disbursement from the trust fund shall be in  
324 accordance with the board's recommendations as approved or  
325 modified by said joint standing committees.

326 (3) After such recommendations for the authorization of  
327 disbursement have been approved or modified pursuant to  
328 subdivision (2) of this subsection, any modification in the amount of an  
329 authorized disbursement in excess of fifty thousand dollars or ten per  
330 cent of the authorized amount, whichever is less, shall be submitted to  
331 said joint standing committees and approved, modified or rejected in  
332 accordance with the procedure set forth in subdivision (2) of this  
333 subsection. Notification of all disbursements from the trust fund made  
334 pursuant to this section shall be sent to the joint standing committees  
335 of the General Assembly having cognizance of matters relating to  
336 public health and appropriations and the budgets of state agencies,

337 through the Office of Fiscal Analysis.

338 (4) The board of trustees shall, not later than February first of each  
339 year, except during the fiscal years ending June 30, 2004, and June 30,  
340 2005, submit a report to the General Assembly, in accordance with the  
341 provisions of section 11-4a, that includes all disbursements and other  
342 expenditures from the trust fund and an evaluation of the performance  
343 and impact of each program receiving funds from the trust fund. Such  
344 report shall also include the criteria and application process used to  
345 select programs to receive such funds.

346 Sec. 11. (*Effective from passage*) The Connecticut Health and  
347 Educational Facilities Authority, in conjunction with the Departments  
348 of Public Safety, Social Services and Public Health, shall, within  
349 available appropriations, develop a strategy for planning and  
350 financing the installation of automatic fire sprinkler systems in nursing  
351 homes licensed under chapter 368v of the general statutes. On or  
352 before February 1, 2004, such strategy shall be submitted, in  
353 accordance with section 11-4a of the general statutes, to the Governor  
354 and to the joint standing committees of the General Assembly having  
355 cognizance of matters relating to public safety, human services and  
356 public health.

357 Sec. 12. (NEW) (*Effective from passage*) (a) For the purposes of this  
358 section, "residence for adult persons with acquired brain injuries"  
359 means a community-based residence (1) exclusively serving adult  
360 persons with acquired brain injuries, (2) funded or operated by the  
361 Department of Mental Health and Addiction Services, and (3) that  
362 provides rehabilitation and other support services for persons with  
363 acquired brain injuries requiring assistance to live in the community.

364 (b) Notwithstanding the provisions of chapters 368v and 368z of the  
365 general statutes, community-based organizations may operate  
366 residences for adult persons with acquired brain injuries on a pilot  
367 basis until October 1, 2005. Notwithstanding the provisions of chapter

368 378 of the general statutes, medication may be administered to persons  
369 residing in such residences by trained persons pursuant to the written  
370 order of a physician licensed under chapter 370 of the general statutes,  
371 a dentist licensed under chapter 379 of the general statutes, an  
372 advanced practice registered nurse licensed to prescribe in accordance  
373 with section 20-94a of the general statutes, or a physician assistant  
374 licensed to prescribe in accordance with section 20-12d of the general  
375 statutes. The Commissioner of Public Health, in consultation with the  
376 Commissioner of Mental Health and Addiction Services, shall develop  
377 standards for the operation of such residences and the training  
378 required of persons authorized under this section to administer  
379 medications in such residences.

380 Sec. 13. Subsection (d) of section 54-56d of the general statutes is  
381 repealed and the following is substituted in lieu thereof (*Effective from*  
382 *passage*):

383 (d) If the court finds that the request for an examination is justified  
384 and that, in accordance with procedures established by the judges of  
385 the Superior Court, there is probable cause to believe that the  
386 defendant has committed the crime for which he is charged, the court  
387 shall order an examination of the defendant as to his competency. The  
388 court [either] may (1) appoint one or more physicians specializing in  
389 psychiatry to examine the defendant, or [it may] (2) order the  
390 Commissioner of Mental Health and Addiction Services to conduct the  
391 examination either (A) by a clinical team consisting of a physician  
392 specializing in psychiatry, a clinical psychologist and one of the  
393 following: A clinical social worker licensed pursuant to chapter 383b or  
394 a psychiatric nurse clinical specialist holding a master's degree in  
395 nursing, or (B) by one or more physicians specializing in psychiatry,  
396 except that no employee of the Department of Mental Health and  
397 Addiction Services who has served as a member of a clinical team in  
398 the course of such employment for at least five years prior to October  
399 1, 1995, shall be precluded from being appointed as a member of a  
400 clinical team. If the Commissioner of Mental Health and Addiction

401 Services is ordered to conduct the examination, [he] the commissioner  
402 shall select the members of the clinical team or the physician or  
403 physicians. If the examiners determine that the defendant is not  
404 competent, they shall then determine whether there is substantial  
405 probability that the defendant, if provided with a course of treatment,  
406 will regain competency within the maximum period of any placement  
407 order under this section, or whether the defendant appears to be  
408 eligible for civil commitment, with monitoring by the Court Support  
409 Services Division, pursuant to subdivision (2) of subsection (h) of this  
410 section, as amended by this act. The court may authorize a physician  
411 specializing in psychiatry, a clinical psychologist, a clinical social  
412 worker licensed pursuant to chapter 383b or a psychiatric nurse  
413 clinical specialist holding a master's degree in nursing selected by the  
414 defendant to observe the examination. Counsel for the defendant may  
415 observe the examination. The examination shall be completed within  
416 fifteen days from the date it was ordered and the examiner or  
417 examiners shall prepare and sign, without notarization, a written  
418 report and file [it] such report with the court within twenty-one  
419 business days of the date of the order. On receipt of the written report,  
420 the clerk of the court shall cause copies to be delivered immediately to  
421 the state's attorney and to counsel for the defendant.

422 Sec. 14. Subsection (h) of section 54-56d of the general statutes is  
423 repealed and the following is substituted in lieu thereof (*Effective from*  
424 *passage*):

425 (h) (1) If, at the hearing, the court finds that there is a substantial  
426 probability that the defendant, if provided with a course of treatment,  
427 will regain competency within the period of any placement order  
428 under this section, the court shall either (A) order placement of the  
429 defendant for treatment for the purpose of rendering him competent,  
430 or (B) order placement of the defendant at a treatment facility pending  
431 civil commitment proceedings pursuant to subdivision (2) of this  
432 subsection.

433       (2) (A) Except as provided in subparagraph (B) of this subdivision, if  
434 the court makes a finding pursuant to subdivision (1) of this subsection  
435 and does not order placement pursuant to subparagraph (A) of said  
436 subdivision, the court shall, on its own motion or on motion of the  
437 state or the defendant, order placement of the defendant in the custody  
438 of the Commissioner of Mental Health and Addiction Services at a  
439 treatment facility pending civil commitment proceedings. The  
440 treatment facility shall be determined by the Commissioner of Mental  
441 Health and Addiction Services. Such order shall: (i) Include an  
442 authorization for the Commissioner of Mental Health and Addiction  
443 Services to apply for civil commitment of such defendant pursuant to  
444 sections 17a-495 to 17a-528, inclusive; (ii) permit the defendant to agree  
445 to participate voluntarily in a treatment plan prepared by the  
446 Commissioner of Mental Health and Addiction Services and require  
447 that the defendant comply with such treatment plan; and (iii) provide  
448 that if the application for civil commitment is denied or not pursued  
449 by the Commissioner of Mental Health and Addiction Services, or if, in  
450 the case of a defendant who is participating voluntarily in a treatment  
451 plan, such defendant ceases to so participate voluntarily, the person in  
452 charge of the treatment facility, or such person's designee, shall submit  
453 a written progress report to the court pursuant to subsection (j) of this  
454 section, as amended by this act, and the defendant shall be returned to  
455 the court for a hearing pursuant to subsection (k) of this section. The  
456 Court Support Services Division shall monitor the defendant's  
457 compliance with any applicable provisions of such order. The period  
458 of placement and monitoring under such order shall not exceed the  
459 period of the maximum sentence which the defendant could receive on  
460 conviction of the charges against such defendant, or eighteen months,  
461 whichever is less. If the defendant has complied with such treatment  
462 plan and any applicable provisions of such order, at the end of the  
463 period of placement and monitoring, the court shall approve the entry  
464 of a nolle prosequi to the charges against the defendant or shall  
465 dismiss such charges.

466        (B) This subdivision shall not apply: (i) To any person charged with  
467 a class A felony, a class B felony, except a violation of section 53a-122  
468 that does not involve the use, attempted use or threatened use of  
469 physical force against another person, or a violation of section 14-227a,  
470 subdivision (2) of subsection (a) of section 53-21 or section 53a-56b,  
471 53a-60d, 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a or 53a-72b; (ii) to any  
472 person charged with a crime or motor vehicle violation who, as a result  
473 of the commission of such crime or motor vehicle violation, causes the  
474 death of another person; or (iii) unless good cause is shown, to any  
475 person charged with a class C felony.

476        Sec. 15. Subsection (j) of section 54-56d of the general statutes is  
477 repealed and the following is substituted in lieu thereof (*Effective from*  
478 *passage*):

479        (j) The person in charge of the treatment facility, or [his] such  
480 person's designee, shall submit a written progress report to the court  
481 (1) at least seven days prior to the date of any hearing on the issue of  
482 the defendant's competency; (2) whenever he believes that the  
483 defendant has attained competency; [or] (3) whenever he believes that  
484 there is not a substantial probability that the defendant will attain  
485 competency within the period covered by the placement order; or (4)  
486 whenever the defendant has been placed for treatment pending civil  
487 commitment proceedings pursuant to subdivision (2) of subsection (h)  
488 of this section, as amended by this act, and the application for civil  
489 commitment of the defendant is denied or not pursued. The progress  
490 report shall contain: (A) [the] The clinical findings of the person  
491 submitting the report and the facts on which the findings are based; (B)  
492 the opinion of the person submitting the report as to whether the  
493 defendant has attained competency or as to whether the defendant is  
494 making progress, under treatment, toward attaining competency  
495 within the period covered by the placement order; and (C) any other  
496 information concerning the defendant requested by the court, [such as]  
497 including, but not limited to, the method of treatment or the type,  
498 dosage and effect of any medication the defendant is receiving.

499 Sec. 16. Subsection (m) of section 54-56d of the general statutes is  
500 repealed and the following is substituted in lieu thereof (*Effective from*  
501 *passage*):

502 (m) If at any time the court determines that there is not a substantial  
503 probability that the defendant will attain competency within the  
504 period of treatment allowed by this section, or if at the end of [that]  
505 such period the court finds that the defendant is still not competent,  
506 the court shall either release the defendant from custody or order the  
507 defendant placed in the custody of the Commissioner of Mental Health  
508 and Addiction Services, the Commissioner of Children and Families or  
509 the Commissioner of Mental Retardation. The commissioner given  
510 custody, or [his] the commissioner's designee, shall then apply for civil  
511 commitment according to sections 17a-75 to 17a-83, inclusive, 17a-270  
512 to 17a-283, inclusive, and 17a-495 to 17a-528, inclusive. The court shall  
513 hear arguments as to whether the defendant should be released or  
514 should be placed in the custody of the Commissioner of Mental Health  
515 and Addiction Services, the Commissioner of Children and Families or  
516 the Commissioner of Mental Retardation. If the court orders the release  
517 of a defendant charged with the commission of a crime that resulted in  
518 the death or serious physical injury, as defined in section 53a-3, of  
519 another person, [it] or orders the placement of such defendant in the  
520 custody of the Commissioner of Mental Health and Addiction  
521 Services, the court may, on its own motion or on motion of the  
522 prosecuting authority, order, as a condition of such release or  
523 placement, periodic examinations of the defendant as to his  
524 competency. Such an examination shall be conducted in accordance  
525 with subsection (d) of this section, as amended by this act. Upon  
526 receipt of the written report as provided in [said] subsection (d) of this  
527 section, as amended by this act, the court shall, upon the request of  
528 either party filed not later than thirty days after the court receives such  
529 report, conduct a hearing as provided in subsection (e) of this section.  
530 Such hearing shall be held not later than ninety days after the court  
531 receives such report. If the court finds that the defendant has attained

532 competency, he shall be returned to the custody of the Commissioner  
533 of Correction or released, if he has met the conditions for release, and  
534 the court shall continue with the criminal proceedings. Periodic  
535 examinations ordered by the court under this subsection shall continue  
536 until the court finds that the defendant has attained competency or  
537 until the time within which the defendant may be prosecuted for the  
538 crime with which he is charged, as provided in section 54-193 or 54-  
539 193a, has expired, whichever occurs first. The court shall dismiss, with  
540 or without prejudice, any charges for which a nolle prosequi is not  
541 entered when the time within which the defendant may be prosecuted  
542 for the crime with which he is charged, as provided in section 54-193  
543 or 54-193a, has expired. Notwithstanding the erasure provisions of  
544 section 54-142a, police and court records and records of any state's  
545 attorney pertaining to a charge which is nolle or dismissed without  
546 prejudice while the defendant is not competent shall not be erased  
547 until the time for the prosecution of the defendant expires under  
548 section 54-193 or 54-193a. A defendant who is not civilly committed as  
549 a result of an application made by the Commissioner of Mental Health  
550 and Addiction Services, the Commissioner of Children and Families or  
551 the Commissioner of Mental Retardation pursuant to this section shall  
552 be released. A defendant who is civilly committed pursuant to such an  
553 application shall be treated in the same manner as any other civilly  
554 committed person.

555 Sec. 17. Subsection (n) of section 54-56d of the general statutes is  
556 repealed and the following is substituted in lieu thereof (*Effective from*  
557 *passage*):

558 (n) The cost of the examination effected by the Commissioner of  
559 Mental Health and Addiction Services and of testimony of persons  
560 conducting the examination effected by the commissioner shall be paid  
561 by the Department of Mental Health and Addiction Services. The cost  
562 of the examination and testimony by physicians appointed by the  
563 court shall be paid by the Judicial Department. If the defendant is  
564 indigent, the fee of the person selected by the defendant to observe the

565 examination and to testify on his behalf shall be paid by the Public  
566 Defender Services Commission. The expense of treating a defendant  
567 placed in the custody of the Commissioner of Mental Health and  
568 Addiction Services, the Commissioner of Children and Families or the  
569 Commissioner of Mental Retardation pursuant to subdivision (2) of  
570 subsection (h) of this section, as amended by this act, or subsection (i)  
571 of this section shall be computed and paid for in the same manner as is  
572 provided for persons committed by a probate court under the  
573 provisions of sections 17b-19, 17b-63 to 17b-65, inclusive, 17b-116 to  
574 17b-138, inclusive, 17b-220 to 17b-250, inclusive, 17b-256, 17b-259, 17b-  
575 263, 17b-287, 17b-340 to 17b-350, inclusive, 17b-689, 17b-689b and 17b-  
576 743 to 17b-747, inclusive.

577 Sec. 18. Subsection (e) of section 19a-88 of the general statutes is  
578 repealed and the following is substituted in lieu thereof (*Effective*  
579 *January 1, 2004*):

580 (e) (1) Each person holding a license or certificate issued under  
581 section [19a-514,] 20-74s, 20-195cc or 20-206ll and chapters 370 to 373,  
582 inclusive, 375, 378 to 381a, inclusive, 383 to [388] 383c, inclusive, 384,  
583 384b, 384d, 385, 393a, 395, [398,] 399 or 400a and section 20-206n or 20-  
584 206o shall, annually, during the month of such person's birth, apply for  
585 renewal of such license or certificate to the Department of Public  
586 Health, giving such person's name in full, such person's residence and  
587 business address and such other information as the department  
588 requests.

589 (2) Each person holding a license or certificate issued under section  
590 19a-514 and chapters 384a, 384c, 386, 387, 388 and 398 shall apply for  
591 renewal of such license or certificate once every two years, during the  
592 month of such person's birth, giving such person's name in full, such  
593 person's residence and business address and such other information as  
594 the department requests.

595 (3) Each person holding a license or certificate issued pursuant to

596 section 20-475 or 20-476 shall, annually, during the month of such  
597 person's birth, apply for renewal of such license or certificate to the  
598 department.

599 (4) Each entity holding a license issued pursuant to section 20-475  
600 shall, annually, during the anniversary month of initial licensure,  
601 apply for renewal of such license or certificate to the department.

602 Sec. 19. Subsection (e) of section 19a-88 of the general statutes, as  
603 amended by section 9 of public act 00-226, is repealed and the  
604 following is substituted in lieu thereof (*Effective January 1, 2004*):

605 (e) (1) Each person holding a license or certificate issued under  
606 section [19a-514,] 20-65k, 20-74s, 20-195cc or 20-206ll and chapters 370  
607 to 373, inclusive, 375, 378 to 381a, inclusive, 383 to [388] 383c, inclusive,  
608 384, 384b, 384d, 385, 393a, 395, [398,] 399 or 400a and section 20-206n or  
609 20-206o shall, annually, during the month of such person's birth, apply  
610 for renewal of such license or certificate to the Department of Public  
611 Health, giving such person's name in full, such person's residence and  
612 business address and such other information as the department  
613 requests.

614 (2) Each person holding a license or certificate issued under section  
615 19a-514 and chapters 384a, 384c, 386, 387, 388 and 398 shall apply for  
616 renewal of such license or certificate once every two years, during the  
617 month of such person's birth, giving such person's name in full, such  
618 person's residence and business address and such other information as  
619 the department requests.

620 (3) Each person holding a license or certificate issued pursuant to  
621 section 20-475 or 20-476 shall, annually, during the month of such  
622 person's birth, apply for renewal of such license or certificate to the  
623 department.

624 (4) Each entity holding a license issued pursuant to section 20-475  
625 shall, annually, during the anniversary month of initial licensure,

626 apply for renewal of such license or certificate to the department.

627 Sec. 20. Section 19a-515 of the general statutes, as amended by  
628 section 4 of public act 03-118, is repealed and the following is  
629 substituted in lieu thereof (*Effective January 1, 2004*):

630 (a) Each nursing home administrator's license issued pursuant to the  
631 provisions of sections 19a-511 to 19a-520, inclusive, shall be renewed  
632 [annually] once every two years, in accordance with section 19a-88, as  
633 amended by this act, except for cause, by the Department of Public  
634 Health, upon forms to be furnished by said department and upon the  
635 payment to said department, by each applicant for license renewal, of  
636 the sum of [fifty] one hundred dollars. Each such fee shall be remitted  
637 to the Department of Public Health on or before the date prescribed  
638 under section 19a-88, as amended by this act. Such renewals shall be  
639 granted unless said department finds the applicant has acted or failed  
640 to act in such a manner or under such circumstances as would  
641 constitute grounds for suspension or revocation of such license.

642 (b) [On and after October 1, 2004, each] Each licensee shall complete  
643 a minimum of [twenty] forty hours of continuing education [during  
644 each registration period] every two years. Such two-year period shall  
645 commence on the first date of renewal of the licensee's license after  
646 October 1, 2004. The continuing education shall be in areas related to  
647 the licensee's practice. Qualifying continuing education activities are  
648 courses offered or approved by the Connecticut Association of  
649 Healthcare Facilities, the Connecticut Association of Not-For-Profit  
650 Providers, the Connecticut Chapter of the American College of Health  
651 Care Administrators, any accredited college or university, or programs  
652 presented or approved by the National Continuing Education Review  
653 Service of the National Association of Boards of Examiners of Long  
654 Term Care Administrators, or by federal or state departments or  
655 agencies. [For purposes of this section, "registration period" means the  
656 twelve-month period for which a license has been renewed in  
657 accordance with section 19a-88 and is current and valid.]

658 (c) Each licensee shall obtain a certificate of completion from the  
659 provider of the continuing education for all continuing education  
660 hours that are successfully completed and shall retain such certificate  
661 for a minimum of three years. [following the license renewal date for  
662 which the activity satisfies the continuing education requirements.]  
663 Upon request by the department, the licensee shall submit the  
664 certificate to the department. A licensee who fails to comply with the  
665 continuing education requirements shall be subject to disciplinary  
666 action pursuant to section 19a-517.

667 (d) The continuing education requirements shall be waived for  
668 licensees applying for licensure renewal for the first time. The  
669 department may, for a licensee who has a medical disability or illness,  
670 grant a waiver of the continuing education requirements for a specific  
671 period of time or may grant the licensee an extension of time in which  
672 to fulfill the requirements.

673 Sec. 21. Subsection (b) of section 20-206b of the general statutes is  
674 repealed and the following is substituted in lieu thereof (*Effective*  
675 *January 1, 2004*):

676 (b) Licenses shall be renewed [annually] once every two years in  
677 accordance with the provisions of section 19a-88, as amended by this  
678 act. The fee for renewal shall be [one] two hundred dollars. No license  
679 shall be issued under this section to any applicant against whom  
680 professional disciplinary action is pending or who is the subject of an  
681 unresolved complaint in this or any other state or jurisdiction. Any  
682 certificate granted by the department prior to June 1, 1993, shall be  
683 deemed a valid license permitting continuance of profession subject to  
684 the provisions of this chapter.

685 Sec. 22. Subsection (e) of section 20-206bb of the general statutes is  
686 repealed and the following is substituted in lieu thereof (*Effective*  
687 *January 1, 2004*):

688 (e) Licenses shall be renewed [annually] once every two years in

689 accordance with the provisions of subsection (e) of section 19a-88, as  
690 amended by this act. The fee for renewal shall be [one] two hundred  
691 dollars.

692 Sec. 23. Section 20-239 of the general statutes is repealed and the  
693 following is substituted in lieu thereof (*Effective January 1, 2004*):

694 All licenses issued to master barbers by the Department of Public  
695 Health shall be renewed once every two years, and shall expire in  
696 accordance with the provisions of section 19a-88, as amended by this  
697 act. No person shall carry on the occupation of master barber after the  
698 expiration of his license until he has made application bearing the date  
699 of his insignia card to said department, accompanied by a fee of  
700 [twenty-five] fifty dollars for the renewal of such license for [one year]  
701 two years. Such application shall be in writing, addressed to said  
702 department and signed by the person applying for such renewal.

703 Sec. 24. Section 20-253 of the general statutes is repealed and the  
704 following is substituted in lieu thereof (*Effective January 1, 2004*):

705 License or examination fees shall be paid to the department at the  
706 time of application as follows: (1) For examination as a registered  
707 hairdresser and cosmetician, the sum of fifty dollars; and (2) for  
708 [annual] renewal of any hairdresser and cosmetician license, the sum  
709 of [twenty-five] fifty dollars. Each person engaged in the occupation of  
710 registered hairdresser and cosmetician shall, at all times,  
711 conspicuously display such person's license within the place where  
712 such occupation is being conducted. All hairdresser and cosmetician  
713 licenses, except as otherwise provided in this chapter, shall be renewed  
714 once every two years and shall expire in accordance with the  
715 provisions of section 19a-88, as amended by this act. No person shall  
716 carry on the occupation of hairdressing and cosmetology after the  
717 expiration of such person's license until such person has made  
718 application to the department for the renewal of such license. Such  
719 application shall be in writing, addressed to the department and

720 signed by the person applying for such renewal. The department may  
721 renew any hairdresser and cosmetician license if application for such  
722 renewal is received by the department within ninety days after the  
723 expiration of such license.

724 Sec. 25. Subsection (a) of section 20-275 of the general statutes is  
725 repealed and the following is substituted in lieu thereof (*Effective*  
726 *January 1, 2004*):

727 (a) Each person licensed under the provisions of this chapter shall  
728 [register annually] renew such license once every two years with the  
729 department in accordance with the provisions of section 19a-88, as  
730 amended by this act, on forms provided by the department. [, such  
731 registration to be accompanied by a fee of fifty dollars.] The renewal  
732 fee shall be one hundred dollars.

733 Sec. 26. Subsection (a) of section 20-398 of the general statutes is  
734 repealed and the following is substituted in lieu thereof (*Effective*  
735 *January 1, 2004*):

736 (a) No person may engage in the practice of fitting or selling hearing  
737 aids, or display a sign or in any other way advertise or claim to be a  
738 person who sells or engages in the practice of fitting or selling hearing  
739 aids unless such person has obtained a license under this chapter or as  
740 an audiologist under chapter 399. No audiologist, other than an  
741 audiologist who is a licensed hearing instrument specialist on and after  
742 July 1, 1996, shall engage in the practice of fitting or selling hearing  
743 aids until such audiologist has presented satisfactory evidence to the  
744 commissioner that the audiologist has (1) completed at least six  
745 semester hours of coursework regarding the selection and fitting of  
746 hearing aids and eighty hours of supervised clinical experience with  
747 children and adults in the selection and fitting of hearing aids at an  
748 institution of higher education in a program accredited, at the time of  
749 the audiologist's completion of coursework and clinical experience, by  
750 the American Speech-Language Hearing Association or such successor

751 organization as may be approved by the department, or (2) has  
752 satisfactorily passed the written section of the examination required by  
753 this section for licensure as a hearing instrument specialist. No person  
754 may receive a license, except as provided in subsection (b) of this  
755 section, unless such person has submitted proof satisfactory to the  
756 department that such person has completed a four-year course at an  
757 approved high school or has an equivalent education as determined by  
758 the department; has satisfactorily completed a course of study in the  
759 fitting and selling of hearing aids or a period of training approved by  
760 the department; and has satisfactorily passed a written, oral and  
761 practical examination given by the department. Application for the  
762 examination shall be on forms prescribed and furnished by the  
763 department. Examinations shall be given at least twice yearly. The fee  
764 for the examination shall be one hundred dollars; and for the initial  
765 license and each renewal thereof shall be [~~one~~] two hundred dollars.

766 Sec. 27. Section 20-402 of the general statutes is repealed and the  
767 following is substituted in lieu thereof (*Effective January 1, 2004*):

768 Licenses issued under this chapter shall be renewed [~~annually~~] once  
769 every two years, in accordance with the provisions of section 19a-88, as  
770 amended by this act, on payment of the renewal fee of [~~one~~] two  
771 hundred dollars to the department and on production of evidence of  
772 satisfactory completion of continuing education requirements  
773 established by the Commissioner of Public Health.

774 Sec. 28. Section 19a-491 of the general statutes is repealed and the  
775 following is substituted in lieu thereof (*Effective January 1, 2004*):

776 (a) No person acting individually or jointly with any other person  
777 shall establish, conduct, operate or maintain an institution in this state  
778 without a license as required by this chapter. Application for such  
779 license shall be made to the Department of Public Health upon forms  
780 provided by it and shall contain such information as the department  
781 requires, which may include affirmative evidence of ability to comply

782 with reasonable standards and regulations prescribed under the  
783 provisions of this chapter. The commissioner may require as a  
784 condition of licensure that an applicant sign a consent order providing  
785 reasonable assurances of compliance with the Public Health Code. The  
786 commissioner may issue more than one chronic disease hospital  
787 license to a single institution until such time as the state offers a  
788 rehabilitation hospital license.

789 (b) [No] If any person acting individually or jointly with any other  
790 person shall own real property or any improvements thereon, upon or  
791 within which an institution, as defined in subsection (c) of section 19a-  
792 490, is established, conducted, operated or maintained [without a  
793 certificate that such real property or improvements are in compliance  
794 with those provisions of the Public Health Code relating to] and is not  
795 the licensee of the institution, such person shall submit a copy of the  
796 lease agreement to the department at the time of any change of  
797 ownership and with each license renewal application. The lease  
798 agreement shall, at a minimum, identify the person or entity  
799 responsible for the maintenance and repair of all buildings and  
800 structures within which such an institution is established, conducted  
801 or operated. [Such certificate shall be issued by the commissioner after  
802 an inspection and investigation. Application for such certificate shall  
803 be made biennially to the Department of Public Health upon forms  
804 provided by it and shall contain such information as the department  
805 requires, which may include affirmative evidence of ability to comply  
806 with relevant provisions of the Public Health Code.] If a violation is  
807 found as a result of an inspection or investigation, the commissioner  
808 may require the owner to sign a consent order providing assurances  
809 that repairs or improvements necessary for compliance with the  
810 provisions of the Public Health Code shall be completed within a  
811 specified period of time. The provisions of this subsection shall not  
812 apply to any property or improvements owned by a person licensed in  
813 accordance with the provisions of subsection (a) of this section to  
814 establish, conduct, operate or maintain an institution on or within such

815 property or improvements.

816 [(c) For purposes of this chapter, an institution shall include any  
817 person or public or private agency which either advertises, arranges  
818 for or provides a homemaker health aide or homemaker-home health  
819 aide services in a patient's home or a substantially equivalent  
820 environment.]

821 [(d)] (c) Notwithstanding any regulation to the contrary, the  
822 Commissioner of Public Health shall charge the following fees for the  
823 biennial licensing and inspection of the following institutions: (1)  
824 Chronic and convalescent nursing homes, per site, three hundred fifty  
825 dollars; (2) chronic and convalescent nursing homes, per bed, five  
826 dollars; (3) rest homes with nursing supervision, per site, three  
827 hundred fifty dollars; (4) rest homes with nursing supervision, per bed,  
828 five dollars; [(5) residential care homes, per site, three hundred dollars;  
829 (6) residential care homes, per bed, three dollars; (7) ambulatory  
830 facilities, except those operated by municipal health departments,  
831 health districts, or licensed nonprofit nursing or community health  
832 agencies and well-child clinics] (5) outpatient dialysis units and  
833 outpatient surgical facilities, five hundred dollars; [(8)] (6) mental  
834 health residential facilities, per site, three hundred dollars; [(9)] (7)  
835 mental health residential facilities, per bed, five dollars; [(10)] (8)  
836 hospitals, per site, seven hundred fifty dollars; [(11)] (9) hospitals, per  
837 bed, seven dollars and fifty cents; [(12)] (10) nonstate agency  
838 educational institutions, per infirmary, seventy-five dollars; and [(13)]  
839 (11) nonstate agency educational institutions, per infirmary bed,  
840 twenty-five dollars. [In addition, the Commissioner of Public Health  
841 shall charge a fee of four hundred fifty dollars for the technical  
842 assistance provided for the design, review and development on an  
843 institution's construction, sale or change in ownership.]

844 (d) Notwithstanding any regulation, the commissioner shall charge  
845 the following fees for the triennial licensing and inspection of the  
846 following institutions: (1) Residential care homes, per site, four

847 hundred fifty dollars; and (2) residential care homes, per bed, four  
848 dollars and fifty cents.

849 (e) Notwithstanding any regulation, the commissioner shall charge  
850 the following fees for the licensing and inspection every four years of  
851 the following institutions: (1) Outpatient clinics that provide either  
852 medical or mental health service, and well-child clinics, except those  
853 operated by municipal health departments, health districts or licensed  
854 nonprofit nursing or community health agencies, one thousand  
855 dollars; (2) maternity homes, per site, two hundred dollars; and (3)  
856 maternity homes, per bed, ten dollars.

857 (f) The commissioner shall charge a fee of four hundred fifty dollars  
858 for the technical assistance provided for the design, review and  
859 development of an institution's construction, sale or change in  
860 ownership.

861 ~~[(e)]~~ (g) The commissioner may require as a condition of the  
862 licensure of home health care agencies and homemaker-home health  
863 aide agencies that each agency meet minimum service quality  
864 standards. In the event the commissioner requires such agencies to  
865 meet minimum service quality standards as a condition of their  
866 licensure, [he] the commissioner shall adopt regulations in accordance  
867 with the provisions of chapter 54 to define such minimum service  
868 quality standards, which shall allow for training of homemaker-home  
869 health care aides by adult continuing education.

870 Sec. 29. Subsection (b) of section 19a-77 of the general statutes, as  
871 amended by section 22 of public act 03-252, is repealed and the  
872 following is substituted in lieu thereof (*Effective from passage*):

873 (b) For [registration and] licensing requirement purposes, child day  
874 care services shall not include such services which are:

875 (1) (A) Administered by a public school system, or (B) administered  
876 by a municipal agency or department and located in a public school

877 building; [for students enrolled in that school;]

878 (2) Administered by a private school which is in compliance with  
879 section 10-188 and is approved by the State Board of Education or is  
880 accredited by an accrediting agency recognized by the State Board of  
881 Education;

882 (3) Recreation operations such as but not limited to creative art  
883 studios for children that offer parent-child recreational programs and  
884 classes in music, dance, drama and art that are no longer than two  
885 hours in length, library programs, boys' and girls' clubs, church-related  
886 activities, scouting, camping or community-youth programs;

887 (4) Informal arrangements among neighbors or relatives in their  
888 own homes, provided the relative is limited to any of the following  
889 degrees of kinship by blood or marriage to the child being cared for or  
890 to the child's parent: Child, grandchild, sibling, niece, nephew, aunt,  
891 uncle or child of one's aunt or uncle;

892 (5) Drop-in supplementary child care operations for educational or  
893 recreational purposes and the child receives such care infrequently  
894 where the parents are on the premises;

895 (6) Drop-in supplementary child care operations in retail  
896 establishments where the parents are on the premises for retail  
897 shopping, in accordance with section 19a-77a, as amended, provided  
898 that the drop-in supplementary child-care operation does not charge a  
899 fee and does not refer to itself as a child day care center; or

900 (7) Religious educational activities administered by a religious  
901 institution exclusively for children whose parents or legal guardians  
902 are members of such religious institution.

903 Sec. 30. Section 19a-630 of the general statutes is repealed and the  
904 following is substituted in lieu thereof (*Effective from passage*):

905 As used in this chapter:

906 (1) "Health care facility or institution" means any facility or  
907 institution engaged primarily in providing services for the prevention,  
908 diagnosis or treatment of human health conditions, including, but not  
909 limited to: Outpatient clinics; free standing outpatient surgical  
910 facilities; imaging centers; home health agencies, as defined in section  
911 19a-490, as amended; clinical laboratory or central service facilities  
912 serving one or more health care facilities, practitioners or institutions;  
913 hospitals; [residential care homes;] nursing homes; rest homes;  
914 nonprofit health centers; diagnostic and treatment facilities;  
915 rehabilitation facilities; and mental health facilities. "Health care  
916 facility or institution" includes any parent company, subsidiary,  
917 affiliate or joint venture, or any combination thereof, of any such  
918 facility or institution, but does not include any health care facility  
919 operated by a nonprofit educational institution solely for the students,  
920 faculty and staff of such institution and their dependents, or any  
921 Christian Science sanatorium operated, or listed and certified, by the  
922 First Church of Christ, Scientist, Boston, Massachusetts.

923 (2) "State health care facility or institution" means a hospital or other  
924 such facility or institution operated by the state providing services  
925 which are eligible for reimbursement under Title XVIII or XIX of the  
926 federal Social Security Act, 42 USC Section 301 et seq., as amended.

927 (3) "Office" means the Office of Health Care Access.

928 (4) "Commissioner" means the Commissioner of Health Care Access.

929 (5) "Person" has the meaning assigned to it in section 4-166.

930 Sec. 31. Subsection (i) of section 5-259 of the general statutes, as  
931 amended by section 1 of public act 03-149, is repealed and the  
932 following is substituted in lieu thereof (*Effective from passage*):

933 (i) The Comptroller may provide for coverage of employees of  
934 municipalities, nonprofit corporations, community action agencies,  
935 [and] small employers or members of an association for personal care

936 assistants under the plan or plans procured under subsection (a) of this  
937 section, provided: (1) Participation by each municipality, nonprofit  
938 corporation, community action agency, [or] small employer or  
939 association for personal care assistants shall be on a voluntary basis; (2)  
940 where an employee organization represents employees of a  
941 municipality, nonprofit corporation, community action agency or  
942 small employer, participation in a plan or plans to be procured under  
943 subsection (a) of this section shall be by mutual agreement of the  
944 municipality, nonprofit corporation, community action agency or  
945 small employer and the employee organization only and neither party  
946 may submit the issue of participation to binding arbitration except by  
947 mutual agreement if such binding arbitration is available; (3) no group  
948 of employees shall be refused entry into the plan by reason of past or  
949 future health care costs or claim experience; (4) rates paid by the state  
950 for its employees under subsection (a) of this section are not adversely  
951 affected by this subsection; (5) administrative costs to the plan or plans  
952 provided under this subsection shall not be paid by the state; and (6)  
953 participation in the plan or plans in an amount determined by the state  
954 shall be for the duration of the period of the plan or plans, or for such  
955 other period as mutually agreed by the municipality, nonprofit  
956 corporation, community action agency, [or] small employer or  
957 association for personal care assistants and the Comptroller. The  
958 Comptroller may arrange and procure for the employees under this  
959 subsection health benefit plans that vary from the plan or plans  
960 procured under subsection (a) of this section. Notwithstanding any  
961 provision of law the coverage provided under this subsection may be  
962 offered to employees on either a fully underwritten or risk-pooled  
963 basis at the discretion of the Comptroller, except that coverage offered  
964 to small employers shall be fully underwritten in accordance with part  
965 V of chapter 700c. For the purposes of this subsection, (A)  
966 "municipality" means any town, city, borough, school district, taxing  
967 district, fire district, district department of health, probate district,  
968 housing authority, regional work force development board established  
969 under section 31-3k, flood commission or authority established by

970 special act, regional planning agency, transit district formed under  
971 chapter 103a, or the Children's Center established by number 571 of  
972 the public acts of 1969; (B) "nonprofit corporation" means a nonprofit  
973 corporation organized under 26 USC 501(c)(3) that has a contract with  
974 the state; (C) "community action agency" means a community action  
975 agency, as defined in section 17b-885; [and] (D) "small employer"  
976 means a small employer, as defined in section 38a-564, as amended by  
977 this act; and (E) "association for personal care assistants" means an  
978 organization composed of personal care attendants who are employed  
979 by recipients of service (i) under the home-care program for the elderly  
980 under section 17b-342, (ii) under the personal care assistance program  
981 under section 17b-605a, (iii) in an independent living center pursuant  
982 to sections 17b-613 to 17b-615, inclusive, or (iv) under the program for  
983 individuals with acquired brain injury as described in section 17b-  
984 260a.

985 Sec. 32. Subdivision (4) of section 38a-564 of the general statutes is  
986 repealed and the following is substituted in lieu thereof (*Effective from*  
987 *passage*):

988 (4) "Small employer" means any person, firm, corporation, limited  
989 liability company, partnership or association actively engaged in  
990 business or self-employed for at least three consecutive months who,  
991 on at least fifty per cent of its working days during the preceding  
992 twelve months, employed no more than fifty eligible employees, the  
993 majority of whom were employed within the state of Connecticut.  
994 "Small employer" includes a self-employed individual. In determining  
995 the number of eligible employees, companies which are affiliated  
996 companies, as defined in section 33-840, or which are eligible to file a  
997 combined tax return for purposes of taxation under chapter 208 shall  
998 be considered one employer. Eligible employees shall not include  
999 employees covered through the employer by health insurance plans or  
1000 insurance arrangements issued to or in accordance with a trust  
1001 established pursuant to collective bargaining subject to the federal  
1002 Labor Management Relations Act. Except as otherwise specifically

1003 provided, provisions of sections 12-201, 12-211, 12-212a and 38a-564 to  
1004 38a-572, inclusive, which apply to a small employer shall continue to  
1005 apply until the plan anniversary following the date the employer no  
1006 longer meets the requirements of this definition. "Small employer"  
1007 does not include (A) a municipality procuring health insurance  
1008 pursuant to section 5-259, as amended by this act, (B) a private school  
1009 in this state procuring health insurance through a health insurance  
1010 plan or an insurance arrangement sponsored by an association of such  
1011 private schools, [or] (C) a nonprofit organization procuring health  
1012 insurance pursuant to section 5-259, as amended by this act, unless the  
1013 Secretary of the Office of Policy and Management and the State  
1014 Comptroller make a request in writing to the Insurance Commissioner  
1015 that such nonprofit organization be deemed a small employer for the  
1016 purposes of this chapter, or (D) an association for personal care  
1017 assistants procuring health insurance pursuant to section 5-259, as  
1018 amended by this act.

1019 Sec. 33. Section 19a-342 of the general statutes, as amended by  
1020 section 1 of public act 03-45, is repealed and the following is  
1021 substituted in lieu thereof (*Effective October 1, 2003*):

1022 (a) As used in this section, "smoke" or "smoking" means the lighting  
1023 or carrying of a lighted cigarette, cigar, pipe or similar device.

1024 (b) (1) Notwithstanding the provisions of section 31-40q, no person  
1025 shall smoke: (A) In any building or portion of a building owned and  
1026 operated or leased and operated by the state or any political  
1027 subdivision thereof; (B) in any area of a health care institution; (C) in  
1028 any area of a retail food store; (D) in any restaurant; (E) in any area of  
1029 an establishment with a permit issued for the sale of alcoholic liquor  
1030 pursuant to section 30-20a, 30-21, 30-21b, 30-22, 30-22c, 30-28, 30-28a,  
1031 30-33a, 30-33b, 30-35a, 30-37a, 30-37c, 30-37e or 30-37f, in any area of an  
1032 establishment with a permit for the sale of alcoholic liquor pursuant to  
1033 section 30-23 issued after May 1, 2003, and, on and after April 1, 2004,  
1034 in any area of an establishment with a permit issued for the sale of

1035 alcoholic liquor pursuant to section 30-22a or 30-26; (F) within a school  
1036 building while school is in session or student activities are being  
1037 conducted; (G) in any passenger elevator, provided no person shall be  
1038 arrested for violating this subsection unless there is posted in such  
1039 elevator a sign which indicates that smoking is prohibited by state law;  
1040 [or] (H) in any dormitory in any public or private institution of higher  
1041 education; or (I) on and after April 1, 2004, in any area of a dog race  
1042 track or a facility equipped with screens for the simulcasting of off-  
1043 track betting race programs or jai alai games. For purposes of this  
1044 subsection, "restaurant" means space, in a suitable and permanent  
1045 building, kept, used, maintained, advertised and held out to the public  
1046 to be a place where meals are regularly served to the public.

1047 (2) This section shall not apply to (A) correctional facilities; (B)  
1048 designated smoking areas in psychiatric facilities; (C) public housing  
1049 projects, as defined in subsection (b) of section 21a-278a; (D)  
1050 classrooms where demonstration smoking is taking place as part of a  
1051 medical or scientific experiment or lesson; (E) smoking rooms  
1052 provided by employers for employees, pursuant to section 31-40q, as  
1053 amended by this act; (F) notwithstanding the provisions of  
1054 subparagraph (E) of subdivision (1) of this subsection, the outdoor  
1055 portion of the premises of any permittee listed in subparagraph (E) of  
1056 subdivision (1) of this subsection, provided, in the case of any seating  
1057 area maintained for the service of food, at least seventy-five per cent of  
1058 the outdoor seating capacity is an area in which smoking is prohibited  
1059 and which is clearly designated with written signage as a nonsmoking  
1060 area, except that any temporary seating area established for special  
1061 events and not used on a regular basis shall not be subject to the  
1062 smoking prohibition or signage requirements of this subparagraph; or  
1063 (G) any tobacco bar, provided no tobacco bar shall expand in size or  
1064 change its location from its size or location as of December 31, 2002.  
1065 For purposes of this subdivision, "outdoor" means an area which has  
1066 no roof or other ceiling enclosure, "tobacco bar" means an  
1067 establishment with a permit for the sale of alcoholic liquor to

1068 consumers issued pursuant to chapter 545 that, in the calendar year  
1069 ending December 31, 2002, generated ten per cent or more of its total  
1070 annual gross income from the on-site sale of tobacco products and the  
1071 rental of on-site humidors, and "tobacco product" means any substance  
1072 that contains tobacco, including, but not limited to, cigarettes, cigars,  
1073 pipe tobacco or chewing tobacco.

1074 (c) The operator of a hotel, motel or similar lodging may allow  
1075 guests to smoke in not more than twenty-five per cent of the rooms  
1076 offered as accommodations to guests.

1077 (d) In each room, elevator, area or building in which smoking is  
1078 prohibited by this section, the person in control of the premises shall  
1079 post or cause to be posted in a conspicuous place signs stating that  
1080 smoking is prohibited by state law. Such signs, except in elevators,  
1081 restaurants, establishments with permits to sell alcoholic liquor to  
1082 consumers issued pursuant to chapter 545, hotels, motels or similar  
1083 lodgings, and health care institutions, shall have letters at least four  
1084 inches high with the principal strokes of letters not less than one-half  
1085 inch wide.

1086 (e) Any person found guilty of smoking in violation of this section,  
1087 failure to post signs as required by this section or the unauthorized  
1088 removal of such signs shall have committed an infraction.

1089 (f) Nothing in this section shall be construed to require any smoking  
1090 area in any building.

1091 (g) The provisions of this section shall supersede and preempt the  
1092 provisions of any municipal law or ordinance relative to smoking  
1093 effective prior to, on or after October 1, 1993.

1094 Sec. 34. Subsection (a) of section 14-41 of the general statutes, as  
1095 amended by section 6 of public act 03-171, is repealed and the  
1096 following is substituted in lieu thereof (*Effective from passage and*  
1097 *applicable as of July 1, 2003*):

1098 (a) Except as provided in section 14-41a, each motor vehicle  
1099 operator's license shall be renewed every six years or every four years  
1100 on the date of the operator's birthday in accordance with a schedule to  
1101 be established by the commissioner. On and after July 1, [2003] 2005,  
1102 the Commissioner of Motor Vehicles shall screen the vision of each  
1103 motor vehicle operator prior to every other renewal of the operator's  
1104 license of such operator in accordance with a schedule adopted by the  
1105 commissioner. Such screening requirement shall apply to every other  
1106 renewal following the initial screening. In lieu of the vision screening  
1107 by the commissioner, such operator may submit the results of a vision  
1108 screening conducted by a licensed health care professional qualified to  
1109 conduct such screening on a form prescribed by the commissioner  
1110 during the twelve months preceding such renewal. No motor vehicle  
1111 operator's license may be renewed unless the operator passes such  
1112 vision screening. The commissioner shall adopt regulations, in  
1113 accordance with the provisions of chapter 54, to implement the  
1114 provisions of this subsection relative to the administration of vision  
1115 screening.

1116 Sec. 35. Subsection (b) of section 13b-99 of the general statutes is  
1117 repealed and the following is substituted in lieu thereof (*Effective from*  
1118 *passage*):

1119 (b) Each such taxicab shall be inspected, [semiannually, by the  
1120 Department of Motor Vehicles or] biennially, at the time of renewal of  
1121 registration of such taxicab, by a repairer or limited repairer licensed  
1122 and authorized by the Commissioner of Motor Vehicles to perform  
1123 such inspections. The commissioner shall set a fee for such an  
1124 inspection.

1125 Sec. 36. Section 14-103 of the general statutes is repealed and the  
1126 following is substituted in lieu thereof (*Effective from passage*):

1127 (a) The commissioner, [by himself or] an inspector authorized by  
1128 [him, and] the commissioner, [or] any officer of the Division of State

1129 Police within the Department of Public Safety [, and] or any local  
1130 police officer, may examine any motor vehicle, its number, equipment  
1131 and identification. Any person who wilfully interferes with or  
1132 obstructs, or attempts to interfere with or obstruct, any such  
1133 examination shall be fined not more than fifty dollars or imprisoned  
1134 not more than thirty days, or both.

1135 (b) The Commissioner of Motor Vehicles may establish and  
1136 maintain a system of voluntary examination of equipment of motor  
1137 vehicles registered in this state or being operated on the highways  
1138 thereof. Such examination may be made by licensed automobile  
1139 dealers and repair garages, not including limited repairers, which have  
1140 been approved by said commissioner for such purpose.

1141 (c) All state and local police officers, whenever they see a motor  
1142 vehicle being operated in apparent violation of any statute relative to  
1143 the equipment of a motor vehicle, may stop such vehicle and may  
1144 issue to the operator a warning of defective equipment directing the  
1145 owner of such vehicle to take it to any inspection station approved by  
1146 the commissioner and have such vehicle [put in] restored to safe  
1147 operating condition and officially inspected as soon as possible, and  
1148 not later than ten days from the date of the issuance of the warning  
1149 notice. Such warning shall be furnished by the commissioner in such  
1150 form as [he] the commissioner prescribes and shall be in triplicate, the  
1151 original of which shall be mailed by the issuing officer to the  
1152 Department of Motor Vehicles. The duplicate copy shall be given to  
1153 the motor vehicle operator and shall be presented to the official  
1154 inspection station at the time the vehicle is submitted for examination.  
1155 The triplicate copy shall be retained by the issuing officer for [his] such  
1156 officer's department records. When the inspection station approves  
1157 such vehicle, its authorized representative shall sign the duplicate copy  
1158 of the warning of defective equipment and mail it to the Department of  
1159 Motor Vehicles. If the Department of Motor Vehicles does not receive  
1160 the duplicate copy, as approved by the inspection station, within  
1161 twenty days from the date of issuance, the commissioner may assess

1162 the owner of the motor vehicle a civil penalty of fifty dollars. If such  
1163 owner fails to pay such penalty within the time prescribed by the  
1164 commissioner, the commissioner, after giving notice and an  
1165 opportunity for a hearing to such motorist, shall suspend the  
1166 registration of the motor vehicle until such time as the penalty is paid  
1167 and the vehicle is [put in] restored to safe operating condition.

1168 [(d) The commissioner shall annually inspect each service bus. The  
1169 fee for the inspection shall be twenty dollars, except that no fee shall be  
1170 charged for any service bus owned by the state or a municipality, as  
1171 defined in section 7-245.]

1172 (d) Each service bus shall be inspected, biennially, at the time of  
1173 renewal of registration of such service bus, by a repairer or limited  
1174 repairer licensed and authorized by the Commissioner of Motor  
1175 Vehicles to perform such inspections. The fee for such inspection shall  
1176 be forty dollars.

1177 Sec. 37. Section 14-164a of the general statutes is repealed and the  
1178 following is substituted in lieu thereof (*Effective from passage*):

1179 (a) No person shall operate a motor vehicle in any race, contest or  
1180 demonstration of speed or skill with a motor vehicle as a public  
1181 exhibition until a permit for such race or exhibition has been obtained  
1182 from the Commissioner of Motor Vehicles. Any person desiring to  
1183 manage, operate or conduct such a motor vehicle race or exhibition  
1184 shall make application in writing to said commissioner at least ten  
1185 days prior to the race or exhibition and such application shall set forth  
1186 in detail the time of such proposed race or exhibition, together with a  
1187 description of the kind and number of motor vehicles to be used and  
1188 such further information as said commissioner may require. Such  
1189 application shall be accompanied by a fee of seventy-five dollars. The  
1190 Commissioner of Motor Vehicles, upon receipt of such application and  
1191 fee, shall cause an inquiry to be made concerning the condition of the  
1192 race track or place of exhibition and all of the appurtenances thereto

1193 and, if the commissioner finds no unusual hazard to participants in  
1194 such race or exhibition or to persons attending such race or exhibition,  
1195 the commissioner may issue a permit naming a definite date for such  
1196 race or exhibition, which may be conducted at any reasonable hour of  
1197 any week day or after twelve o'clock noon on any Sunday. The  
1198 commissioner, with the approval of the legislative body of the city,  
1199 borough or town in which the race or exhibition will be held, may  
1200 issue a permit allowing a start time prior to twelve o'clock noon on any  
1201 Sunday, provided no such race or exhibition shall take place contrary  
1202 to the provisions of any city, borough or town ordinances. The  
1203 commissioner may make regulations as to the conditions under which  
1204 each such race or exhibition may be conducted, including  
1205 requirements as to types of tires suitable for safe use, the age and  
1206 physical condition of the participating operators, the number and  
1207 qualifications of attending personnel, the provision of first-aid and  
1208 medical supplies and equipment, including ambulances, and the  
1209 attendance of doctors or other persons qualified to give emergency  
1210 medical aid, police and fire protection, and such other requirements as  
1211 will eliminate any unusual hazard to participants in such race or  
1212 exhibition or to the spectators. No minor under the age of sixteen years  
1213 may participate in motor cross racing, except that a minor thirteen  
1214 years of age or older may participate in such racing with the written  
1215 permission of the minor's parents or legal guardian. If weather or track  
1216 conditions are such as to make such race or exhibition unusually  
1217 hazardous, the commissioner or other person designated by the  
1218 commissioner may cancel or postpone the same or may require the use  
1219 of tires of a type approved by the commissioner. No person shall  
1220 conduct or participate in any motor vehicle race or contest or  
1221 demonstration of speed or skill in any motor vehicle on the ice of any  
1222 body of water. The provisions of this section shall not apply to a motor  
1223 vehicle with a motor of no more than three horsepower or a go-cart  
1224 type vehicle with a motor of no more than twelve horsepower, when  
1225 operated on a track of one-eighth of a mile or less in length.  
1226 Preliminary preparations and practice runs, performed after eleven

1227 o'clock in the forenoon, on the date designated in the permit and prior  
1228 to cancellation or postponement, shall not be construed to constitute a  
1229 race or exhibition within the meaning of this section. No preliminary  
1230 preparations or practice runs shall be performed before twelve o'clock  
1231 noon on Sunday. For the purposes of this subsection, "motor cross  
1232 racing" means motorcycle racing on a dirt track by participants  
1233 operating motorcycles designed and manufactured exclusively for off-  
1234 road use and powered by an engine having a capacity of not more than  
1235 five hundred cubic centimeters piston displacement.

1236 [(b) The commissioner shall assign an inspector to each such race or  
1237 exhibition and shall charge the person conducting such race or  
1238 exhibition a fee for the services of such inspector at a rate of one  
1239 hundred dollars for four hours or less and two hundred dollars for  
1240 longer than four hours.]

1241 [(c)] (b) Any person participating in or conducting any motor  
1242 vehicle race or exhibition contrary to the provisions of this section shall  
1243 be fined not more than two hundred dollars or imprisoned not more  
1244 than six months, or both.

1245 Sec. 38. Subsection (f) of section 13b-59 of the general statutes is  
1246 repealed and the following is substituted in lieu thereof (*Effective from*  
1247 *passage*):

1248 (f) "Motor vehicle receipts" means all fees and other charges  
1249 required by, or levied pursuant to subsection (c) of section 14-12,  
1250 section 14-15, subsection (a) of section 14-25a, section 14-28, subsection  
1251 (b) of section 14-35, subsection (b) of section 14-41, section 14-41a,  
1252 subsection (b) of section 14-44, sections 14-47 and 14-48b, subsection (a)  
1253 of section 14-49, subsection (b)(1) of section 14-49, except as provided  
1254 under subsection (b)(2) of said section, subsections (c), (d), (e), (f), (g),  
1255 (h), (i), (k), (l), (m), (n), (o), (p), (q), (s), (t), (u), (x), (y) and (aa) of section  
1256 14-49, section 14-49a, subsections (a) and (g) of section 14-50,  
1257 subsections (a)(1), (a)(2), (a)(3), (a)(4), (a)(9), (a)(10) and (a)(14) of

1258 section 14-50a, section 14-59, section 14-61, section 14-65, subsection (c)  
1259 of section 14-66, subsection (e) of section 14-67, subsection (f) of section  
1260 14-67a, sections 14-67d, [and] 14-160 [, subsection (b) of section 14-  
1261 164a, section] and 14-381, subsection (b) of section 14-382 and section  
1262 14-383.

1263 Sec. 39. Section 13b-70 of the general statutes is repealed and the  
1264 following is substituted in lieu thereof (*Effective from passage*):

1265 Each person who pays a motor vehicle related fine, penalty or other  
1266 charge, as defined in subsection (g) of section 13b-59, shall pay, on and  
1267 after July 1, 1989, an additional amount equal to fifty per cent of the  
1268 amount of such fine, penalty or other charge imposed. Any such  
1269 additional amount shall be rounded off to the next highest dollar. The  
1270 provisions of this section shall not apply to any fine, penalty or other  
1271 charge required by or levied pursuant to section 14-64 [,] and section  
1272 14-150. [and subsection (b) of section 14-164a.]

1273 Sec. 40. Section 13a-252 of the general statutes is repealed and the  
1274 following is substituted in lieu thereof (*Effective from passage*):

1275 The ferries crossing the Connecticut River, known as the Rocky Hill  
1276 ferry and the Chester and Hadlyme ferry, shall be maintained and  
1277 operated by the Commissioner of Transportation at the expense of the  
1278 state. The rates of toll or the charges to be made for travel upon said  
1279 ferries shall be fixed by the commissioner with the approval of the  
1280 Secretary of the Office of Policy and Management, except that, after the  
1281 effective date of this section, the rate of toll or charge shall be (1) for a  
1282 motor vehicle and operator five dollars, (2) for each additional  
1283 passenger one dollar and seventy-five cents, and (3) for each walk-on  
1284 and bicycle one dollar and seventy-five cents. All expense of  
1285 maintenance, repairs and operation of said ferries shall be paid by the  
1286 Comptroller on vouchers of the commissioner. The commissioner shall  
1287 include in his report to the General Assembly a report of the receipts  
1288 and expenditures incidental to the control and maintenance of said

1289 ferries. Said Rocky Hill ferry shall be maintained as a state historic  
1290 structure and shall be so marked with an appropriate plaque by the  
1291 commissioner in cooperation with the Connecticut Historical  
1292 Commission.

1293 Sec. 41. Section 13a-175a of the general statutes is repealed and the  
1294 following is substituted in lieu thereof (*Effective from passage*):

1295 For each fiscal year there shall be allocated [fourteen million six]  
1296 twelve million five hundred thousand dollars out of the funds  
1297 appropriated to the Department of Transportation, or from any other  
1298 source, not otherwise prohibited by law, to be used by the towns for  
1299 construction, reconstruction, improvement or maintenance of  
1300 highways, sections of highways, bridges or structures incidental to  
1301 highways and bridges or the improvement thereof, including the  
1302 plowing of snow, the sanding of icy pavements, the trimming and  
1303 removal of trees, the installation, replacement and maintenance of  
1304 traffic signs, signals and markings, and for traffic control and vehicular  
1305 safety programs, traffic and parking planning and administration, and  
1306 other purposes and programs related to highways, traffic and parking,  
1307 and for the purposes of providing and operating essential public  
1308 transportation services and related facilities.

1309 Sec. 42. (NEW) (*Effective from passage*) (a) Notwithstanding the  
1310 provisions of sections 17b-7, 17b-111, 17b-111b, 17b-118, 17b-118a, 17b-  
1311 118b and 17b-221 of the general statutes, the Commissioner of Social  
1312 Services shall operate a State Administered General Assistance  
1313 program in accordance with this section and section 44 of this act and  
1314 sections 17b-78, 17b-119, 17b-131, 17b-257 and 17b-689 of the general  
1315 statutes, as amended by this act. Notwithstanding any provision of the  
1316 general statutes, on and after October 1, 2003, no town shall be  
1317 reimbursed by the state for any general assistance medical benefits  
1318 incurred after September 30, 2003, and on and after March 1, 2004, no  
1319 town shall be reimbursed by the state for any general assistance cash  
1320 benefits or general assistance program administrative costs incurred

1321 after February 29, 2004.

1322 (b) No earlier than September 1, 2003, but not later than October 1,  
1323 2003, the State Administered General Assistance program pursuant to  
1324 this section and any general assistance program operated by a town  
1325 shall provide cash assistance of (1) two hundred dollars per month to a  
1326 single unemployable person upon determination of such person's  
1327 unemployability; (2) two hundred dollars per month for a single  
1328 transitional individual who is required to pay for shelter; and (3) fifty  
1329 dollars per month for a single transitional individual who is not  
1330 required to pay for shelter. No earlier than September 1, 2003, but not  
1331 later than October 1, 2003, eligible families shall receive cash assistance  
1332 in an amount that is fifty dollars less than the standard of assistance  
1333 such family would receive under the temporary family assistance  
1334 program. The standard of assistance paid for individuals residing in  
1335 rated boarding facilities, shall remain at the level in effect on August  
1336 31, 2003. No individual shall be eligible for cash assistance under the  
1337 program if eligible for cash assistance under any other state or federal  
1338 cash assistance program.

1339 (c) To be eligible for cash assistance under the program, a person  
1340 shall (1) be (A) eighteen years of age or older; (B) a minor found by a  
1341 court to be emancipated pursuant to section 46b-150 of the general  
1342 statutes; (C) under eighteen years of age and a member of a family  
1343 eligible for cash or medical assistance under the program; or (D) under  
1344 eighteen years of age and the commissioner determines good cause for  
1345 such person's eligibility, and (2) not have assets exceeding two  
1346 hundred fifty dollars. No person who is a substance abuser and refuses  
1347 or fails to enter available, appropriate treatment shall be eligible for  
1348 cash assistance under the program until such person enters treatment.  
1349 No person whose benefits from the temporary family assistance  
1350 program have terminated as a result of time-limited benefits or for  
1351 compliance with a program requirement shall be eligible for cash  
1352 assistance under the program.

1353 (d) Cash assistance to a transitional individual shall be limited to a  
1354 twenty-four-month period of eligibility with no more than ten months  
1355 of assistance in the first twelve months of eligibility and no more than  
1356 six months of assistance in the second twelve months of eligibility,  
1357 except that such durational limits shall not apply to a transitional  
1358 individual not classified as such solely due to mental illness or  
1359 substance abuse or to a transitional individual who has a dependent  
1360 child under eighteen years of age. Prior to or upon discontinuance of  
1361 assistance, a person previously determined to be a transitional  
1362 individual may petition the commissioner to review the determination  
1363 of his or her status. In such review, the commissioner shall consider  
1364 factors, including, but not limited to: (1) Age; (2) education; (3)  
1365 vocational training; (4) mental and physical health; and (5)  
1366 employment history and shall make a determination of such person's  
1367 ability to obtain gainful employment. Upon determination by the  
1368 commissioner that a transitional individual is not unemployable, the  
1369 person shall be ineligible to receive cash assistance for one year, unless  
1370 such person produces medical verification of a substantial  
1371 deterioration in his or her physical or mental condition or a new  
1372 condition of such severity and duration that it precludes employment  
1373 for a period of at least six months.

1374 Sec. 43. Section 17b-257 of the general statutes, as amended by  
1375 section 18 of public act 03-2, is repealed and the following is  
1376 substituted in lieu thereof (*Effective from passage*):

1377 [(a) The Commissioner of Social Services shall implement a state  
1378 medical assistance program for persons ineligible for Medicaid and on  
1379 or before April 1, 1997, the commissioner shall implement said  
1380 program in the towns in which the fourteen regional or district offices  
1381 of the Department of Social Services are located. The commissioner  
1382 shall establish a schedule for the transfer of recipients of medical  
1383 assistance administered by towns under the general assistance  
1384 program to the state program. To the extent possible, the  
1385 administration of the state medical assistance program shall parallel

1386 that of the Medicaid program as it is administered to recipients of  
1387 temporary family assistance, including eligibility criteria concerning  
1388 income and assets. Payment for medical services shall be made only  
1389 for individuals determined eligible. The rates of payment for medical  
1390 services shall be those of the Medicaid program. Medical services  
1391 covered under the program shall be those covered under the Medicaid  
1392 program, except that nonemergency medical transportation, eye care,  
1393 optical hardware and optometry care, podiatry, chiropractic,  
1394 natureopathy, home health care and long-term care and services  
1395 available pursuant to a home and community-based services waiver  
1396 under Section 1915 of the Social Security Act shall not be covered. On  
1397 or after April 1, 1997, the commissioner shall implement a managed  
1398 care program for medical services provided under this program,  
1399 except services provided pursuant to section 17a-453a.  
1400 Notwithstanding the provisions of sections 4a-51 and 4a-57, the  
1401 commissioner may enter into contracts, including, but not limited to,  
1402 purchase of service agreements to implement the provisions of this  
1403 section.

1404 (b) The Commissioner of Social Services shall impose cost sharing  
1405 requirements on recipients of medical assistance under this section and  
1406 section 17b-259 as follows: (1) A one dollar copayment for each  
1407 outpatient medical service delivered by a state medical assistance  
1408 program provider to a medical assistance recipient, and (2) a one  
1409 dollar copayment for each drug prescription at the time the  
1410 prescription is filled, provided the commissioner may make  
1411 modifications to the prescription cost-sharing requirement for certain  
1412 individuals who have drugs dispensed in less than a thirty-day supply  
1413 and may exempt residents in certain institutional settings from such  
1414 requirement.]

1415 (a) The Commissioner of Social Services shall implement a state  
1416 medical assistance component of the State Administered General  
1417 Assistance program for persons ineligible for Medicaid. Not later than  
1418 October 1, 2003, each person eligible for State Administered General

1419 Assistance shall be entitled to receive medical care through a federally  
1420 qualified health center or other primary care provider as determined  
1421 by the commissioner. The Commissioner of Social Services shall  
1422 determine appropriate service areas and shall, in the commissioner's  
1423 discretion, contract with community health centers, other similar  
1424 clinics, and other primary care providers, if necessary, to assure access  
1425 to primary care services for recipients who live farther than a  
1426 reasonable distance from a federally qualified health center. The  
1427 commissioner shall assign and enroll eligible persons in federally  
1428 qualified health centers and with any other providers contracted for  
1429 the program because of access needs. Not later than October 1, 2003,  
1430 each person eligible for State Administered General Assistance shall be  
1431 entitled to receive hospital services. Medical services under the  
1432 program shall be limited to the services provided by a federally  
1433 qualified health center, hospital, or other provider contracted for the  
1434 program at the commissioner's discretion because of access needs. The  
1435 commissioner shall ensure that ancillary services and specialty services  
1436 are provided by a federally qualified health center, hospital, or other  
1437 providers contracted for the program at the commissioner's discretion.  
1438 Ancillary services include, but are not limited to, radiology, laboratory,  
1439 and other diagnostic services not available from a recipient's assigned  
1440 primary-care provider, and durable medical equipment. Specialty  
1441 services are services provided by a physician with a specialty that are  
1442 not included in ancillary services. In no event, shall ancillary or  
1443 specialty services provided under the program exceed such services  
1444 provided under the State Administered General Assistance program  
1445 on July 1, 2003. Eligibility criteria concerning income shall be the same  
1446 as the medically needy component of the Medicaid program, except  
1447 that earned monthly gross income of up to one hundred fifty dollars  
1448 shall be disregarded. Unearned income shall not be disregarded. No  
1449 person who has family assets exceeding one thousand dollars shall be  
1450 eligible. No person eligible for Medicaid shall be eligible to receive  
1451 medical care through the State Administered General Assistance  
1452 program.

1453       (b) Recipients covered by a general assistance program operated by  
1454 a town shall be assigned and enrolled in federally qualified health  
1455 centers and with any other providers in the same manner as recipients  
1456 of medical assistance under the State Administered General Assistance  
1457 program pursuant to subsection (a) of this section.

1458       (c) On and after October 1, 2003, pharmacy services shall be  
1459 provided to recipients of State Administered General Assistance  
1460 through the federally qualified health center to which they are  
1461 assigned or through a pharmacy with which the health center  
1462 contracts. Prior to said date, pharmacy services shall be provided as  
1463 provided under the Medicaid program. Recipients who are assigned to  
1464 a community health center or similar clinic or primary care provider  
1465 other than a federally qualified health center or to a federally qualified  
1466 health center that does not have a contract for pharmacy services shall  
1467 receive pharmacy services at pharmacies designated by the  
1468 commissioner.

1469       (d) Recipients of State Administered General Assistance shall  
1470 contribute a copayment of one dollar and fifty cents for each  
1471 prescription.

1472       (e) The Commissioner of Social Services shall contract with federally  
1473 qualified health centers or other primary care providers as necessary to  
1474 provide medical services to eligible State Administered General  
1475 Assistance recipients pursuant to this section. The commissioner shall,  
1476 within available appropriations, make payments to such centers based  
1477 on their pro rata share of the cost of services provided or the number  
1478 of clients served, or both. The Commissioner of Social Services shall,  
1479 within available appropriations, make payments to other providers  
1480 based on a methodology determined by the commissioner. The  
1481 Commissioner of Social Services may reimburse for extraordinary  
1482 medical services, provided such services are documented to the  
1483 satisfaction of the commissioner. For purposes of this section, the  
1484 commissioner may contract with a managed care organization or other

1485 entity to perform administrative functions. Provisions of a contract for  
1486 medical services entered into by the commissioner pursuant to this  
1487 section shall supersede any inconsistent provision in the regulations of  
1488 Connecticut state agencies.

1489 (f) Each federally qualified health center participating in the  
1490 program shall, within thirty days of the effective date of this section,  
1491 enroll in the federal Office of Pharmacy Affairs Section 340B drug  
1492 discount program established pursuant to 42 USC 256b to provide  
1493 pharmacy services to recipients at Federal Supply Schedule costs. Each  
1494 such health center may establish an on-site pharmacy or contract with  
1495 a commercial pharmacy to provide such pharmacy services.

1496 (g) The Commissioner of Social Services shall, within available  
1497 appropriations, make payments to hospitals for inpatient services  
1498 based on their pro rata share of the cost of services provided or the  
1499 number of clients served, or both. The Commissioner of Social Services  
1500 shall, within available appropriations, make payments for any  
1501 ancillary or specialty services provided to State Administered General  
1502 Assistance recipients under this section based on a methodology  
1503 determined by the commissioner.

1504 (h) On or before March 1, 2004, the Commissioner of Social Services  
1505 shall seek a waiver of federal law under the Health Insurance  
1506 Flexibility and Accountability demonstration initiative for the purpose  
1507 of extending health insurance coverage under Medicaid to persons  
1508 qualifying for medical assistance under the State Administered  
1509 General Assistance program. The provisions of section 17b-8 shall  
1510 apply to this section.

1511 *Sec. 44. (NEW) (Effective from passage)* (a) An applicant for State  
1512 Administered General Assistance cash or medical benefits aggrieved  
1513 by a decision of the Commissioner of Social Services under the  
1514 program operated pursuant to section 42 of this act and section 17b-  
1515 257, as amended by this act, may request a hearing pursuant to section

1516 17b-60 of the general statutes, but shall not be eligible for State  
1517 Administered General Assistance cash or medical benefits pending a  
1518 hearing decision.

1519 (b) A recipient of State Administered General Assistance cash  
1520 assistance aggrieved by a decision of the Commissioner of Social  
1521 Services under the program operated pursuant to section 42 of this act,  
1522 may request a hearing pursuant to section 17b-60 of the general  
1523 statutes, but shall not be eligible for the continuation of cash assistance  
1524 pending a hearing decision.

1525 (c) A recipient of State Administered General Assistance medical  
1526 program benefits aggrieved by a decision of the Commissioner of  
1527 Social Services under the program operated pursuant to section 17b-  
1528 257 of the general statutes, as amended by this act, may request a  
1529 hearing pursuant to section 17b-60 of the general statutes and shall  
1530 continue to receive medical benefits pending a hearing decision.

1531 Sec. 45. Section 17b-78 of the general statutes is repealed and the  
1532 following is substituted in lieu thereof (*Effective from passage*):

1533 [(a) The Commissioner of Social Services shall adopt regulations, in  
1534 accordance with the provisions of chapter 54, establishing mandatory  
1535 standards for the granting of general assistance financial and medical  
1536 assistance, including the level of financial assistance to be provided by  
1537 the state or at the expense of the town in such cases, which, effective no  
1538 later than August 31, 1997, shall be three hundred fifty dollars per  
1539 month for a single unemployable person upon determination of his  
1540 unemployability, two hundred dollars per month for a transitional  
1541 individual who is required to pay for shelter, and one hundred fifty  
1542 dollars per month for a transitional individual who is not required to  
1543 pay for shelter, subject to the provisions of section 17b-89 and  
1544 subsection (b) of section 17b-104, including the payment of medical  
1545 bills for persons not receiving general assistance financial aid who are  
1546 unable to pay such bills over a two-year period, by towns, including

1547 standards for investigation and eligibility and extent of need and  
1548 procedures for record-keeping, including uniform application and  
1549 billing forms to be used by medical providers as well as towns, and  
1550 other office practices, and establishing time limits for the  
1551 determination of eligibility for financial assistance and for the payment  
1552 of medical bills for persons not receiving general assistance financial  
1553 aid and for the payment of all medical assistance bills, all with the  
1554 intent of aiding the towns and any districts established under section  
1555 17b-117 in the efficient administration of the laws relating to granting  
1556 of general assistance financial and medical assistance. Such regulations  
1557 shall include (1) an earned monthly gross income disregard of up to  
1558 one hundred fifty dollars, (2) a requirement that each town distribute  
1559 monthly financial assistance to each recipient at the general assistance  
1560 office or through a central distribution location, except a town shall  
1561 mail such assistance to a recipient who is incapacitated or residing  
1562 outside such town, (3) a requirement for each recipient to present an  
1563 identification card when receiving such assistance and (4) a prohibition  
1564 against a town charging a fee for the distribution of such assistance.  
1565 The commissioner shall inform the towns and such districts of the  
1566 standards so established and shall advise and assist them in their  
1567 application thereof. The commissioner may recommend regional areas  
1568 within which he considers it reasonable for towns to join in the  
1569 establishment of such districts, and may advise the towns therein of  
1570 such recommendations and his reasons therefor.

1571 (b) Notwithstanding the provisions of sections 4-230 to 4-236,  
1572 inclusive, the Commissioner of Social Services shall adopt regulations,  
1573 in accordance with the provisions of chapter 54, concerning the  
1574 conduct of audits of all general assistance programs in towns where  
1575 the commissioner has determined an audit shall be conducted. The  
1576 regulations shall include a clear statistical methodology for conducting  
1577 such audits and shall provide that such audits be conducted in  
1578 accordance with the generally accepted auditing standards recognized  
1579 by the Comptroller General of the United States and the American

1580 Institute of Certified Public Accountants. The audits shall include: (1)  
1581 A financial review of each town's accounts; (2) a selection and  
1582 sampling methodology for choosing cases to be reviewed in each  
1583 town; and (3) a review of such selected cases to determine compliance  
1584 with significant eligibility, supported work, education and training  
1585 and program regulations.

1586 (c) The department shall analyze the results of general assistance  
1587 audits and fair hearings to identify areas of client and agency error and  
1588 areas which involve program implementation problems.

1589 (d) The Commissioner of Social Services shall adopt regulations, in  
1590 accordance with the provisions of chapter 54, concerning the recovery  
1591 of reimbursements made to towns or districts based on audit findings  
1592 and setting such progressive sanctions as the commissioner deems  
1593 appropriate for any town or district which is found as a result of an  
1594 audit not to be in compliance with the standards established pursuant  
1595 to this section. The regulations shall include a provision allowing the  
1596 commissioner to take action to withhold reimbursement under section  
1597 17b-134 for any such town or district and shall provide for a grace  
1598 period before a sanction is imposed. A town or district may appeal a  
1599 decision of the commissioner to withhold reimbursements or to  
1600 impose a sanction in accordance with the provisions of sections 4-176e,  
1601 4-177, 4-177c, 4-180 and 4-183.]

1602 The Commissioner of Social Services shall adopt regulations, in  
1603 accordance with the provisions of chapter 54, to implement policies  
1604 and procedures necessary to carry out the purposes of sections 42 and  
1605 44 of this act and sections 17b-119, 17b-131, 17b-257 and 17b-689, all as  
1606 amended by this act. The Commissioner of Social Services shall  
1607 implement such policies and procedures while in the process of  
1608 adopting such policies and procedures as regulations, or amending  
1609 existing regulations provided notice of intent to adopt or amend the  
1610 regulations is published in the Connecticut Law Journal within twenty  
1611 days of implementation, and such policies and procedures shall be

1612 valid until the time final regulations are effective. The commissioner  
1613 shall also amend any regulations in existence on the effective date of  
1614 this section to conform to the provisions of sections 42 and 44 of this  
1615 act and sections 17b-78, 17b-119, 17b-131, 17b-257 and 17b-689, all as  
1616 amended by this act.

1617 Sec. 46. Section 17b-689 of the general statutes is repealed and the  
1618 following is substituted in lieu thereof (*Effective from passage*):

1619 (a) For the purposes of this section, sections 42 and 44 of this act and  
1620 sections [17b-63, 17b-78, 17b-118 and 17b-134,] 17b-78, 17b-118, 17b-  
1621 119, 17b-131 and 17b-257, all as amended by this act, (1) an  
1622 "employable person" means one [(1)] (A) who is sixteen years of age or  
1623 older but less than sixty-five years of age; and [(2)] (B) who has no  
1624 documented physical or mental impairment prohibiting such person  
1625 from working or participating in an education, training or other work  
1626 readiness program, or who has such an impairment which is expected  
1627 to last less than two months, as determined by the commissioner; [,  
1628 prohibiting him from working or participating in an education,  
1629 training or other work-readiness program. For the purposes of this  
1630 section and section 17b-134 an "unemployable person" means one (1)  
1631 who is under sixteen years of age or sixty-five years of age or older or  
1632 fifty-five years of age or older with a history of chronic unemployment;  
1633 (2) who has a physical or mental impairment which is expected to last  
1634 at least six months, as determined by the commissioner; (3) who is  
1635 pending receipt of supplemental security income, Social Security  
1636 income or financial assistance through another program administered  
1637 by the Department of Social Services; (4) who is needed to care for a  
1638 child under two years of age or an incapacitated child or spouse; or (5)  
1639 who is a full-time high school student. For purposes of this section and  
1640 said section 17b-134, a "transitional individual" means (A) a person  
1641 who has a documented physical or mental impairment which prevents  
1642 employment and is expected to last at least two months, but less than  
1643 six months as defined by the commissioner, and who, unless  
1644 circumstances precluded participation in the labor force, as determined

1645 by the commissioner, has worked in at least three of the most recent  
1646 five calendar quarters and earned at least five hundred dollars in each  
1647 quarter or who received or was eligible to receive unemployment  
1648 compensation within the previous six months; (B) a person whose  
1649 determination of unemployability or disability, as defined by the  
1650 commissioner, is pending and who provides medical documentation  
1651 of a severe physical or mental impairment which is expected to last at  
1652 least six months; or (C) until such time as the Department of Mental  
1653 Health and Addiction Services implements its basic needs supplement  
1654 program in the region in which the person resides, a person with  
1655 mental illness or a substance abuser in a treatment plan approved by  
1656 the Commissioner of Mental Health and Addiction Services, or by the  
1657 local welfare official] (2) an "unemployable person" means a person  
1658 who (A) is under sixteen years of age or sixty-five years of age or older  
1659 or fifty-five years of age or older with a history of chronic  
1660 unemployment; (B) has a physical or mental impairment prohibiting  
1661 such person from working or participating in an education, training or  
1662 other work-readiness program, which is expected to last at least six  
1663 months, as determined by the commissioner; (C) is pending receipt of  
1664 supplemental security income, Social Security income or financial  
1665 assistance through another program administered by the Department  
1666 of Social Services; (C) is needed to care for a child under two years of  
1667 age or to care for an incapacitated child or spouse; (E) is a full-time  
1668 high school student in good standing; or (F) is a VISTA volunteer; and  
1669 (3) a "transitional individual" means a person (A) who has a  
1670 documented physical or mental impairment which prevents  
1671 employment and is expected to last at least two months, but less than  
1672 six months, as determined by the commissioner, and who has a recent  
1673 connection to the labor market, unless circumstances precluded  
1674 participation in the labor force, as determined by the commissioner; or  
1675 (B) whose determination of unemployability or disability, as defined  
1676 by the commissioner, is pending and who provides medical  
1677 documentation of a severe physical or mental impairment which is  
1678 expected to last at least six months. A person who is a substance

1679 abuser shall be required to participate in treatment, including  
1680 counseling, and shall be eligible for assistance while waiting for  
1681 treatment.

1682 (b) The Commissioner of Social Services, when making  
1683 determinations concerning disabilities or impairments which are  
1684 expected to last a period of six months or longer in accordance with  
1685 subsection (a) of this section, shall make such determinations based on  
1686 the recommendations made by a medical review team.

1687 Sec. 47. Subsection (a) of section 17a-453a of the general statutes is  
1688 repealed and the following is substituted in lieu thereof (*Effective from*  
1689 *passage*):

1690 (a) The Commissioner of Mental Health and Addiction Services  
1691 shall operate a behavioral health managed care program, within  
1692 available appropriations, to: (1) Provide consistent and appropriate  
1693 treatment to eligible recipients; (2) reduce treatment costs for such  
1694 recipients; (3) eliminate duplicated services provided to such  
1695 recipients; and (4) assist such recipients in applying for federally  
1696 funded programs. Said commissioner shall adopt regulations, in  
1697 accordance with chapter 54, to implement said program. For purposes  
1698 of this section "eligible recipient" means an [unemployable, transitional  
1699 or employable individual, as defined in section 17b-689, who is eligible  
1700 for state-administered general assistance, as determined by the  
1701 Department of Social Services, or eligible for general assistance, as  
1702 determined by the municipality] individual eligible for medical  
1703 services under the State Administered General Assistance program,  
1704 pursuant to section 17b-257, as amended by this act, and in need of  
1705 behavioral health services, as determined by the Department of Mental  
1706 Health and Addiction Services. Notwithstanding section 17a-476, 17a-  
1707 676, 17b-257 or any other provision of the general statutes, [to the  
1708 contrary,] services provided under the behavioral health managed care  
1709 program established by this section shall not be restricted to services  
1710 offered under the Medicaid program. The Department of Mental

1711 Health and Addiction Services shall be responsible for all services and  
1712 payments related to the provision of the behavioral health services for  
1713 eligible recipients and may conduct an audit of all aspects of the  
1714 program established by this section including, but not limited to,  
1715 services provided, prior authorizations, payments for services and  
1716 medical records. The commissioner shall analyze the results of such  
1717 audits to identify discrepancies and errors with regard to services and  
1718 payments and areas that involve program implementation and  
1719 operation problems. The commissioner shall adopt regulations, in  
1720 accordance with the provisions of chapter 54, concerning the recovery  
1721 of reimbursements made to providers based on audit findings and  
1722 setting such progressive sanctions as the commissioner deems  
1723 appropriate for any providers found, as a result of an audit, not to be  
1724 in compliance with the standards established pursuant to this section.  
1725 The regulations shall include a provision allowing the commissioner to  
1726 take action to withhold reimbursement for any such provider and shall  
1727 provide for a grace period before a sanction is imposed. A provider  
1728 may appeal a decision of the commissioner to withhold  
1729 reimbursements or to impose a sanction in accordance with the  
1730 provisions of chapter 54.

1731 Sec. 48. Section 17b-131 of the general statutes is repealed and the  
1732 following is substituted in lieu thereof (*Effective from passage*):

1733 When a person in any town, or sent from such town to any licensed  
1734 institution or state humane institution, dies or is found dead therein  
1735 and does not leave sufficient estate or has no legally liable relative able  
1736 to pay the cost of a proper funeral and burial, [the selectmen, or the  
1737 public official charged with the administration of general assistance in]  
1738 the chief executive officer of such town, shall give to such person a  
1739 proper funeral and burial, and [such selectmen or public official may]  
1740 shall pay a sum not exceeding twelve hundred dollars as an allowance  
1741 toward the funeral expenses of such deceased, said sum to be paid,  
1742 upon submission of a proper bill, to the funeral director, cemetery or  
1743 crematory, as the case may be. [On and after October 1, 1991, such]

1744 The Commissioner of Social Services shall reimburse such town for  
1745 such burial. Such payment for funeral and burial expenses shall be  
1746 reduced by (1) the amount in any revocable or irrevocable funeral  
1747 fund, (2) any prepaid funeral contract, (3) the face value of any life  
1748 insurance policy owned by the decedent, and (4) contributions in  
1749 excess of two thousand eight hundred dollars toward such funeral and  
1750 burial expenses from all other sources including friends, relatives and  
1751 all other persons, organizations, veterans and other benefit programs  
1752 and other agencies. [For the purpose of reimbursement from the state,  
1753 such funeral and burial expense shall be considered a general  
1754 assistance expenditure within the meaning of section 17b-134. Any  
1755 person burying or causing to be buried any such person in violation of  
1756 the provisions of this section shall be fined not less than twenty-five  
1757 dollars. This section shall not affect the provisions of section 19a-270.]

1758 Sec. 49. Subsection (a) of section 17b-119 of the general statutes is  
1759 repealed and the following is substituted in lieu thereof (*Effective from*  
1760 *passage*):

1761 [(a) (1) On or before September 30, 1990, for those applicants for or  
1762 recipients of general assistance who have been denied aid under the  
1763 federal Supplemental Security Income Program, or who have been  
1764 notified by the Social Security Administration that their benefits under  
1765 such program will be terminated, each town, through its selectmen or  
1766 the public official charged with the administration of general  
1767 assistance in such town, shall advise the client as to his right of appeal  
1768 and the availability of local legal counsel. The attorney chosen by the  
1769 applicant or recipient shall be reimbursed by the state for his  
1770 reasonable fees, for any case accepted after July 1, 1981, on a  
1771 contingency basis, limited to the amount approved by the Department  
1772 of Social Services, and limited to the amount approved by the Social  
1773 Security Administration when such approval is required by federal  
1774 regulations for such appeals. Such attorney's fees shall not be  
1775 recoverable from such applicant or recipient or his estate. The full  
1776 amount of any interim assistance reimbursement received by the state

1777 shall be applied to reduce any obligation owed to the town by such  
1778 applicant or recipient.

1779 (2) On or after October 1, 1990, for]

1780 (a) For those recipients of [general assistance] State Administered  
1781 General Assistance who have been denied aid under the federal  
1782 Supplemental Security Income Program, or who have been notified by  
1783 the Social Security Administration that their benefits under such  
1784 program will be terminated, [each town, through its selectmen or the  
1785 public official charged with the administration of general assistance in  
1786 such town,] the Commissioner of Social Services shall advise the client  
1787 as to his right of appeal and the availability of local legal counsel. The  
1788 attorney chosen by the recipient shall be reimbursed by the state for  
1789 his reasonable fees, on a contingency basis, limited to the amount  
1790 approved by the Department of Social Services, and limited to the  
1791 amount approved by the Social Security Administration when such  
1792 approval is required by federal regulations for such appeals. Such  
1793 attorney's fees shall not be recoverable from such recipient or his  
1794 estate. The full amount of any interim assistance reimbursement  
1795 received by the state shall be applied to reduce any obligation owed to  
1796 the town by such recipient.

1797 Sec. 50. Section 17b-340 of the general statutes, as amended by  
1798 section 17 of public act 03-2 and section 45 of public act 03-19, is  
1799 repealed and the following is substituted in lieu thereof (*Effective from*  
1800 *passage*):

1801 (a) The rates to be paid by or for persons aided or cared for by the  
1802 state or any town in this state to licensed chronic and convalescent  
1803 nursing homes, chronic disease hospitals associated with chronic and  
1804 convalescent nursing homes, rest homes with nursing supervision and  
1805 to licensed residential care homes, as defined by section 19a-490, and  
1806 to residential facilities for the mentally retarded which are licensed  
1807 pursuant to section 17a-227 and certified to participate in the Title XIX

1808 Medicaid program as intermediate care facilities for the mentally  
1809 retarded, for room, board and services specified in licensing  
1810 regulations issued by the licensing agency shall be determined  
1811 annually, except as otherwise provided in this subsection, after a  
1812 public hearing, by the Commissioner of Social Services, to be effective  
1813 July first of each year except as otherwise provided in this subsection.  
1814 Such rates shall be determined on a basis of a reasonable payment for  
1815 such necessary services, which basis shall take into account as a factor  
1816 the costs of such services. Cost of such services shall include (1)  
1817 reasonable costs mandated by collective bargaining agreements with  
1818 certified collective bargaining agents or other agreements between the  
1819 employer and employees, provided "employees" shall not include  
1820 persons employed as managers or chief administrators or required to  
1821 be licensed as nursing home administrators, and (2) compensation for  
1822 services rendered by proprietors at prevailing wage rates, as  
1823 determined by application of principles of accounting as prescribed by  
1824 said commissioner. Cost of such services shall not include amounts  
1825 paid by the facilities to employees as salary, or to attorneys or  
1826 consultants as fees, where the responsibility of the employees,  
1827 attorneys, or consultants is to persuade or seek to persuade the other  
1828 employees of the facility to support or oppose unionization. Nothing  
1829 in this subsection shall prohibit inclusion of amounts paid for legal  
1830 counsel related to the negotiation of collective bargaining agreements,  
1831 the settlement of grievances or normal administration of labor  
1832 relations. The commissioner may, in his discretion, allow the inclusion  
1833 of extraordinary and unanticipated costs of providing services which  
1834 were incurred to avoid an immediate negative impact on the health  
1835 and safety of patients. The commissioner may, in his discretion, based  
1836 upon review of a facility's costs, direct care staff to patient ratio and  
1837 any other related information, revise a facility's rate for any increases  
1838 or decreases to total licensed capacity of more than ten beds or changes  
1839 to its number of licensed rest home with nursing supervision beds and  
1840 chronic and convalescent nursing home beds. The commissioner may  
1841 so revise a facility's rate established for the fiscal year ending June 30,

1842 1993, and thereafter for any bed increases, decreases or changes in  
1843 licensure effective after October 1, 1989. Effective July 1, 1991, in  
1844 facilities which have both a chronic and convalescent nursing home  
1845 and a rest home with nursing supervision, the rate for the rest home  
1846 with nursing supervision shall not exceed such facility's rate for its  
1847 chronic and convalescent nursing home. All such facilities for which  
1848 rates are determined under this subsection shall report on a fiscal year  
1849 basis ending on the thirtieth day of September. Such report shall be  
1850 submitted to the commissioner by the thirty-first day of December. The  
1851 commissioner may reduce the rate in effect for a facility which fails to  
1852 report on or before such date by an amount not to exceed ten per cent  
1853 of such rate. The commissioner shall annually, on or before the  
1854 fifteenth day of February, report the data contained in the reports of  
1855 such facilities to the joint standing committee of the General Assembly  
1856 having cognizance of matters relating to appropriations. For the cost  
1857 reporting year commencing October 1, 1985, and for subsequent cost  
1858 reporting years, facilities shall report the cost of using the services of  
1859 any nursing pool employee by separating said cost into two categories,  
1860 the portion of the cost equal to the salary of the employee for whom  
1861 the nursing pool employee is substituting shall be considered a  
1862 nursing cost and any cost in excess of such salary shall be further  
1863 divided so that seventy-five per cent of the excess cost shall be  
1864 considered an administrative or general cost and twenty-five per cent  
1865 of the excess cost shall be considered a nursing cost, provided if the  
1866 total nursing pool costs of a facility for any cost year are equal to or  
1867 exceed fifteen per cent of the total nursing expenditures of the facility  
1868 for such cost year, no portion of nursing pool costs in excess of fifteen  
1869 per cent shall be classified as administrative or general costs. The  
1870 commissioner, in determining such rates, shall also take into account  
1871 the classification of patients or boarders according to special care  
1872 requirements or classification of the facility according to such factors  
1873 as facilities and services and such other factors as he deems reasonable,  
1874 including anticipated fluctuations in the cost of providing such  
1875 services. The commissioner may establish a separate rate for a facility

1876 or a portion of a facility for traumatic brain injury patients who require  
1877 extensive care but not acute general hospital care. Such separate rate  
1878 shall reflect the special care requirements of such patients. If changes  
1879 in federal or state laws, regulations or standards adopted subsequent  
1880 to June 30, 1985, result in increased costs or expenditures in an amount  
1881 exceeding one-half of one per cent of allowable costs for the most  
1882 recent cost reporting year, the commissioner shall adjust rates and  
1883 provide payment for any such increased reasonable costs or  
1884 expenditures within a reasonable period of time retroactive to the date  
1885 of enforcement. Nothing in this section shall be construed to require  
1886 the Department of Social Services to adjust rates and provide payment  
1887 for any increases in costs resulting from an inspection of a facility by  
1888 the Department of Public Health. Such assistance as the commissioner  
1889 requires from other state agencies or departments in determining rates  
1890 shall be made available to him at his request. Payment of the rates  
1891 established hereunder shall be conditioned on the establishment by  
1892 such facilities of admissions procedures which conform with this  
1893 section, section 19a-533 and all other applicable provisions of the law  
1894 and the provision of equality of treatment to all persons in such  
1895 facilities. The established rates shall be the maximum amount  
1896 chargeable by such facilities for care of such beneficiaries, and the  
1897 acceptance by or on behalf of any such facility of any additional  
1898 compensation for care of any such beneficiary from any other person  
1899 or source shall constitute the offense of aiding a beneficiary to obtain  
1900 aid to which he is not entitled and shall be punishable in the same  
1901 manner as is provided in subsection (b) of section 17b-97. For the fiscal  
1902 year ending June 30, 1992, rates for licensed residential care homes and  
1903 intermediate care facilities for the mentally retarded may receive an  
1904 increase not to exceed the most recent annual increase in the Regional  
1905 Data Resources Incorporated McGraw-Hill Health Care Costs:  
1906 Consumer Price Index (all urban)-All Items. Rates for newly certified  
1907 intermediate care facilities for the mentally retarded shall not exceed  
1908 one hundred fifty per cent of the median rate of rates in effect on  
1909 January 31, 1991, for intermediate care facilities for the mentally

1910 retarded certified prior to February 1, 1991. Notwithstanding any  
1911 provision of this section, the Commissioner of Social Services shall not  
1912 adjust an annual rate for a licensed chronic and convalescent nursing  
1913 home or a rest home with nursing supervision set for the fiscal years  
1914 ending June 30, 2004, and June 30, 2005, for any reason other than to:  
1915 (1) Reflect a percentage increase in subsection (f) of this section; (2)  
1916 lower a rate; or (3) allow the inclusion of extraordinary and  
1917 unanticipated costs in accordance with this subsection.

1918 (b) The Commissioner of Social Services shall adopt regulations in  
1919 accordance with the provisions of chapter 54 to specify other allowable  
1920 services. For purposes of this section, other allowable services means  
1921 those services required by any medical assistance beneficiary residing  
1922 in such home or hospital which are not already covered in the rate set  
1923 by the commissioner in accordance with the provisions of subsection  
1924 (a) of this section.

1925 (c) No facility subject to the requirements of this section shall accept  
1926 payment in excess of the rate set by the commissioner pursuant to  
1927 subsection (a) of this section for any medical assistance patient from  
1928 this or any other state. No facility shall accept payment in excess of the  
1929 reasonable and necessary costs of other allowable services as specified  
1930 by the commissioner pursuant to the regulations promulgated under  
1931 subsection (b) of this section for any public assistance patient from this  
1932 or any other state. Notwithstanding the provisions of this subsection,  
1933 the commissioner may authorize a facility to accept payment in excess  
1934 of the rate paid for a medical assistance patient in this state for a  
1935 patient who receives medical assistance from another state.

1936 (d) In any instance where the Commissioner of Social Services finds  
1937 that a facility subject to the requirements of this section is accepting  
1938 payment for a medical assistance beneficiary in violation of subsection  
1939 (c) of this section, the commissioner shall proceed to recover through  
1940 the rate set for the facility any sum in excess of the stipulated per diem  
1941 and other allowable costs, as promulgated in regulations pursuant to

1942 subsections (a) and (b) of this section. The commissioner shall make  
1943 the recovery prospectively at the time of the next annual rate  
1944 redetermination.

1945 (e) Except as provided in this subsection, the provisions of  
1946 subsections (c) and (d) of this section shall not apply to any facility  
1947 subject to the requirements of this section, which on October 1, 1981,  
1948 (1) was accepting payments from the commissioner in accordance with  
1949 the provisions of subsection (a) of this section, (2) was accepting  
1950 medical assistance payments from another state for at least twenty per  
1951 cent of its patients, and (3) had not notified the commissioner of any  
1952 intent to terminate its provider agreement, in accordance with section  
1953 17b-271, provided no patient residing in any such facility on May 22,  
1954 1984, shall be removed from such facility for purposes of meeting the  
1955 requirements of this subsection. If the commissioner finds that the  
1956 number of beds available to medical assistance patients from this state  
1957 in any such facility is less than fifteen per cent the provisions of  
1958 subsections (c) and (d) of this section shall apply to that number of  
1959 beds which is less than said percentage.

1960 (f) For the fiscal year ending June 30, 1992, the rates paid by or for  
1961 persons aided or cared for by the state or any town in this state to  
1962 facilities for room, board and services specified in licensing regulations  
1963 issued by the licensing agency, except intermediate care facilities for  
1964 the mentally retarded and residential care homes, shall be based on the  
1965 cost year ending September 30, 1989. For the fiscal years ending June  
1966 30, 1993, and June 30, 1994, such rates shall be based on the cost year  
1967 ending September 30, 1990. Such rates shall be determined by the  
1968 Commissioner of Social Services in accordance with this section and  
1969 the regulations of Connecticut state agencies promulgated by the  
1970 commissioner and in effect on April 1, 1991, except that:

1971 (1) Allowable costs shall be divided into the following five cost  
1972 components: Direct costs, which shall include salaries for nursing  
1973 personnel, related fringe benefits and nursing pool costs; indirect costs,

1974 which shall include professional fees, dietary expenses, housekeeping  
1975 expenses, laundry expenses, supplies related to patient care, salaries  
1976 for indirect care personnel and related fringe benefits; fair rent, which  
1977 shall be defined in accordance with subsection (f) of section 17-311-52  
1978 of the regulations of Connecticut state agencies; capital-related costs,  
1979 which shall include property taxes, insurance expenses, equipment  
1980 leases and equipment depreciation; and administrative and general  
1981 costs, which shall include maintenance and operation of plant  
1982 expenses, salaries for administrative and maintenance personnel and  
1983 related fringe benefits. The commissioner may provide a rate  
1984 adjustment for nonemergency transportation services required by  
1985 nursing facility residents. Such adjustment shall be a fixed amount  
1986 determined annually by the commissioner based upon a review of  
1987 costs and other associated information. Allowable costs shall not  
1988 include costs for ancillary services payable under Part B of the  
1989 Medicare program.

1990 (2) Two geographic peer groupings of facilities shall be established  
1991 for each level of care, as defined by the Department of Social Services  
1992 for the determination of rates, for the purpose of determining  
1993 allowable direct costs. One peer grouping shall be comprised of those  
1994 facilities located in Fairfield County. The other peer grouping shall be  
1995 comprised of facilities located in all other counties.

1996 (3) For the fiscal year ending June 30, 1992, per diem maximum  
1997 allowable costs for each cost component shall be as follows: For direct  
1998 costs, the maximum shall be equal to one hundred forty per cent of the  
1999 median allowable cost of that peer grouping; for indirect costs, the  
2000 maximum shall be equal to one hundred thirty per cent of the state-  
2001 wide median allowable cost; for fair rent, the amount shall be  
2002 calculated utilizing the amount approved by the Office of Health Care  
2003 Access pursuant to section 19a-638; for capital-related costs, there shall  
2004 be no maximum; and for administrative and general costs, the  
2005 maximum shall be equal to one hundred twenty-five per cent of the  
2006 state-wide median allowable cost. For the fiscal year ending June 30,

2007 1993, per diem maximum allowable costs for each cost component  
2008 shall be as follows: For direct costs, the maximum shall be equal to one  
2009 hundred forty per cent of the median allowable cost of that peer  
2010 grouping; for indirect costs, the maximum shall be equal to one  
2011 hundred twenty-five per cent of the state-wide median allowable cost;  
2012 for fair rent, the amount shall be calculated utilizing the amount  
2013 approved by the Office of Health Care Access pursuant to section 19a-  
2014 638; for capital-related costs, there shall be no maximum; and for  
2015 administrative and general costs the maximum shall be equal to one  
2016 hundred fifteen per cent of the state-wide median allowable cost. For  
2017 the fiscal year ending June 30, 1994, per diem maximum allowable  
2018 costs for each cost component shall be as follows: For direct costs, the  
2019 maximum shall be equal to one hundred thirty-five per cent of the  
2020 median allowable cost of that peer grouping; for indirect costs, the  
2021 maximum shall be equal to one hundred twenty per cent of the state-  
2022 wide median allowable cost; for fair rent, the amount shall be  
2023 calculated utilizing the amount approved by the Office of Health Care  
2024 Access pursuant to section 19a-638; for capital-related costs, there shall  
2025 be no maximum; and for administrative and general costs the  
2026 maximum shall be equal to one hundred ten per cent of the state-wide  
2027 median allowable cost. For the fiscal year ending June 30, 1995, per  
2028 diem maximum allowable costs for each cost component shall be as  
2029 follows: For direct costs, the maximum shall be equal to one hundred  
2030 thirty-five per cent of the median allowable cost of that peer grouping;  
2031 for indirect costs, the maximum shall be equal to one hundred twenty  
2032 per cent of the state-wide median allowable cost; for fair rent, the  
2033 amount shall be calculated utilizing the amount approved by the  
2034 Office of Health Care Access pursuant to section 19a-638; for capital-  
2035 related costs, there shall be no maximum; and for administrative and  
2036 general costs the maximum shall be equal to one hundred five per cent  
2037 of the state-wide median allowable cost. For the fiscal year ending June  
2038 30, 1996, and any succeeding fiscal year, except for the fiscal years  
2039 ending June 30, 2000, and June 30, 2001, for facilities with an interim  
2040 rate in one or both periods, per diem maximum allowable costs for

2041 each cost component shall be as follows: For direct costs, the maximum  
2042 shall be equal to one hundred thirty-five per cent of the median  
2043 allowable cost of that peer grouping; for indirect costs, the maximum  
2044 shall be equal to one hundred fifteen per cent of the state-wide median  
2045 allowable cost; for fair rent, the amount shall be calculated utilizing the  
2046 amount approved pursuant to section 19a-638; for capital-related costs,  
2047 there shall be no maximum; and for administrative and general costs  
2048 the maximum shall be equal to the state-wide median allowable cost.  
2049 For the fiscal years ending June 30, 2000, and June 30, 2001, for  
2050 facilities with an interim rate in one or both periods, per diem  
2051 maximum allowable costs for each cost component shall be as follows:  
2052 For direct costs, the maximum shall be equal to one hundred forty-five  
2053 per cent of the median allowable cost of that peer grouping; for  
2054 indirect costs, the maximum shall be equal to one hundred twenty-five  
2055 per cent of the state-wide median allowable cost; for fair rent, the  
2056 amount shall be calculated utilizing the amount approved pursuant to  
2057 section 19a-638; for capital-related costs, there shall be no maximum;  
2058 and for administrative and general costs, the maximum shall be equal  
2059 to the state-wide median allowable cost and such medians shall be  
2060 based upon the same cost year used to set rates for facilities with  
2061 prospective rates. Costs in excess of the maximum amounts established  
2062 under this subsection shall not be recognized as allowable costs, except  
2063 that the Commissioner of Social Services (A) may allow costs in excess  
2064 of maximum amounts for any facility with patient days covered by  
2065 Medicare, including days requiring coinsurance, in excess of twelve  
2066 per cent of annual patient days which also has patient days covered by  
2067 Medicaid in excess of fifty per cent of annual patient days; (B) may  
2068 establish a pilot program whereby costs in excess of maximum  
2069 amounts shall be allowed for beds in a nursing home which has a  
2070 managed care program and is affiliated with a hospital licensed under  
2071 chapter 368v; and (C) may establish rates whereby allowable costs may  
2072 exceed such maximum amounts for beds approved on or after July 1,  
2073 1991, which are restricted to use by patients with acquired immune  
2074 deficiency syndrome or traumatic brain injury.

2075 (4) For the fiscal year ending June 30, 1992, (A) no facility shall  
2076 receive a rate that is less than the rate it received for the rate year  
2077 ending June 30, 1991; (B) no facility whose rate, if determined pursuant  
2078 to this subsection, would exceed one hundred twenty per cent of the  
2079 state-wide median rate, as determined pursuant to this subsection,  
2080 shall receive a rate which is five and one-half per cent more than the  
2081 rate it received for the rate year ending June 30, 1991; and (C) no  
2082 facility whose rate, if determined pursuant to this subsection, would be  
2083 less than one hundred twenty per cent of the state-wide median rate,  
2084 as determined pursuant to this subsection, shall receive a rate which is  
2085 six and one-half per cent more than the rate it received for the rate year  
2086 ending June 30, 1991. For the fiscal year ending June 30, 1993, no  
2087 facility shall receive a rate that is less than the rate it received for the  
2088 rate year ending June 30, 1992, or six per cent more than the rate it  
2089 received for the rate year ending June 30, 1992. For the fiscal year  
2090 ending June 30, 1994, no facility shall receive a rate that is less than the  
2091 rate it received for the rate year ending June 30, 1993, or six per cent  
2092 more than the rate it received for the rate year ending June 30, 1993.  
2093 For the fiscal year ending June 30, 1995, no facility shall receive a rate  
2094 that is more than five per cent less than the rate it received for the rate  
2095 year ending June 30, 1994, or six per cent more than the rate it received  
2096 for the rate year ending June 30, 1994. For the fiscal years ending June  
2097 30, 1996, and June 30, 1997, no facility shall receive a rate that is more  
2098 than three per cent more than the rate it received for the prior rate  
2099 year. For the fiscal year ending June 30, 1998, a facility shall receive a  
2100 rate increase that is not more than two per cent more than the rate that  
2101 the facility received in the prior year. For the fiscal year ending June  
2102 30, 1999, a facility shall receive a rate increase that is not more than  
2103 three per cent more than the rate that the facility received in the prior  
2104 year and that is not less than one per cent more than the rate that the  
2105 facility received in the prior year, exclusive of rate increases associated  
2106 with a wage, benefit and staffing enhancement rate adjustment added  
2107 for the period from April 1, 1999, to June 30, 1999, inclusive. For the  
2108 fiscal year ending June 30, 2000, each facility, except a facility with an

2109 interim rate or replaced interim rate for the fiscal year ending June 30,  
2110 1999, and a facility having a certificate of need or other agreement  
2111 specifying rate adjustments for the fiscal year ending June 30, 2000,  
2112 shall receive a rate increase equal to one per cent applied to the rate the  
2113 facility received for the fiscal year ending June 30, 1999, exclusive of  
2114 the facility's wage, benefit and staffing enhancement rate adjustment.  
2115 For the fiscal year ending June 30, 2000, no facility with an interim rate,  
2116 replaced interim rate or scheduled rate adjustment specified in a  
2117 certificate of need or other agreement for the fiscal year ending June  
2118 30, 2000, shall receive a rate increase that is more than one per cent  
2119 more than the rate the facility received in the fiscal year ending June  
2120 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a  
2121 facility with an interim rate or replaced interim rate for the fiscal year  
2122 ending June 30, 2000, and a facility having a certificate of need or other  
2123 agreement specifying rate adjustments for the fiscal year ending June  
2124 30, 2001, shall receive a rate increase equal to two per cent applied to  
2125 the rate the facility received for the fiscal year ending June 30, 2000,  
2126 subject to verification of wage enhancement adjustments pursuant to  
2127 subdivision (15) of this subsection. For the fiscal year ending June 30,  
2128 2001, no facility with an interim rate, replaced interim rate or  
2129 scheduled rate adjustment specified in a certificate of need or other  
2130 agreement for the fiscal year ending June 30, 2001, shall receive a rate  
2131 increase that is more than two per cent more than the rate the facility  
2132 received for the fiscal year ending June 30, 2000. For the fiscal year  
2133 ending June 30, 2002, each facility shall receive a rate that is two and  
2134 one-half per cent more than the rate the facility received in the prior  
2135 fiscal year. For the fiscal year ending June 30, 2003, each facility shall  
2136 receive a rate that is two per cent more than the rate the facility  
2137 received in the prior fiscal year, except that such increase shall be  
2138 effective January 1, 2003, and such facility rate in effect for the fiscal  
2139 year ending June 30, 2002, shall be paid for services provided until  
2140 December 31, 2002, except any facility that would have been issued a  
2141 lower rate effective July 1, 2002, than for the fiscal year ending June 30,  
2142 2002, due to interim rate status or agreement with the department shall

2143 be issued such lower rate effective July 1, 2002, and have such rate  
2144 increased two per cent effective June 1, 2003. For the fiscal year ending  
2145 June 30, 2004, rates in effect for the period ending June 30, 2003, shall  
2146 remain in effect, except any facility that would have been issued a  
2147 lower rate effective July 1, 2003, than for the fiscal year ending June 30,  
2148 2003, due to interim rate status or agreement with the department shall  
2149 be issued such lower rate effective July 1, 2003. For the fiscal year  
2150 ending June 30, 2005, rates in effect for the period ending June 30, 2004,  
2151 shall remain in effect until December 31, 2004, except any facility that  
2152 would have been issued a lower rate effective July 1, 2004, than for the  
2153 fiscal year ending June 30, 2004, due to interim rate status or  
2154 agreement with the department shall be issued such lower rate  
2155 effective July 1, 2004. Effective January 1, 2005, each facility shall  
2156 receive a rate that is one per cent greater than the rate in effect  
2157 December 31, 2004. The Commissioner of Social Services shall add fair  
2158 rent increases to any other rate increases established pursuant to this  
2159 subdivision for a facility which has undergone a material change in  
2160 circumstances related to fair rent.

2161 (5) For the purpose of determining allowable fair rent, a facility with  
2162 allowable fair rent less than the twenty-fifth percentile of the state-  
2163 wide allowable fair rent shall be reimbursed as having allowable fair  
2164 rent equal to the twenty-fifth percentile of the state-wide allowable fair  
2165 rent, provided for the fiscal years ending June 30, 1996, and June 30,  
2166 1997, the reimbursement may not exceed the twenty-fifth percentile of  
2167 the state-wide allowable fair rent for the fiscal year ending June 30,  
2168 1995. On and after July 1, 1998, the Commissioner of Social Services  
2169 may allow minimum fair rent as the basis upon which reimbursement  
2170 associated with improvements to real property is added. Beginning  
2171 with the fiscal year ending June 30, 1996, any facility with a rate of  
2172 return on real property other than land in excess of eleven per cent  
2173 shall have such allowance revised to eleven per cent. Any facility or its  
2174 related realty affiliate which finances or refinances debt through bonds  
2175 issued by the State of Connecticut Health and Education Facilities

2176 Authority shall report the terms and conditions of such financing or  
2177 refinancing to the Commissioner of Social Services within thirty days  
2178 of completing such financing or refinancing. The Commissioner of  
2179 Social Services may revise the facility's fair rent component of its rate  
2180 to reflect any financial benefit the facility or its related realty affiliate  
2181 received as a result of such financing or refinancing, including but not  
2182 limited to, reductions in the amount of debt service payments or  
2183 period of debt repayment. The commissioner shall allow actual debt  
2184 service costs for bonds issued by the State of Connecticut Health and  
2185 Educational Facilities Authority if such costs do not exceed property  
2186 costs allowed pursuant to subsection (f) of section 17-311-52 of the  
2187 regulations of Connecticut state agencies, provided the commissioner  
2188 may allow higher debt service costs for such bonds for good cause. For  
2189 facilities which first open on or after October 1, 1992, the commissioner  
2190 shall determine allowable fair rent for real property other than land  
2191 based on the rate of return for the cost year in which such bonds were  
2192 issued. The financial benefit resulting from a facility financing or  
2193 refinancing debt through such bonds shall be shared between the state  
2194 and the facility to an extent determined by the commissioner on a case-  
2195 by-case basis and shall be reflected in an adjustment to the facility's  
2196 allowable fair rent.

2197 (6) A facility shall receive cost efficiency adjustments for indirect  
2198 costs and for administrative and general costs if such costs are below  
2199 the state-wide median costs. The cost efficiency adjustments shall  
2200 equal twenty-five per cent of the difference between allowable  
2201 reported costs and the applicable median allowable cost established  
2202 pursuant to this subdivision.

2203 (7) For the fiscal year ending June 30, 1992, allowable operating  
2204 costs, excluding fair rent, shall be inflated using the Regional Data  
2205 Resources Incorporated McGraw-Hill Health Care Costs: Consumer  
2206 Price Index (all urban)-All Items minus one and one-half per cent. For  
2207 the fiscal year ending June 30, 1993, allowable operating costs,  
2208 excluding fair rent, shall be inflated using the Regional Data Resources

2209 Incorporated McGraw-Hill Health Care Costs: Consumer Price Index  
2210 (all urban)-All Items minus one and three-quarters per cent. For the  
2211 fiscal years ending June 30, 1994, and June 30, 1995, allowable  
2212 operating costs, excluding fair rent, shall be inflated using the Regional  
2213 Data Resources Incorporated McGraw-Hill Health Care Costs:  
2214 Consumer Price Index (all urban)-All Items minus two per cent. For  
2215 the fiscal year ending June 30, 1996, allowable operating costs,  
2216 excluding fair rent, shall be inflated using the Regional Data Resources  
2217 Incorporated McGraw-Hill Health Care Costs: Consumer Price Index  
2218 (all urban)-All Items minus two and one-half per cent. For the fiscal  
2219 year ending June 30, 1997, allowable operating costs, excluding fair  
2220 rent, shall be inflated using the Regional Data Resources Incorporated  
2221 McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All  
2222 Items minus three and one-half per cent. For the fiscal year ending  
2223 June 30, 1992, and any succeeding fiscal year, allowable fair rent shall  
2224 be those reported in the annual report of long-term care facilities for  
2225 the cost year ending the immediately preceding September thirtieth.  
2226 The inflation index to be used pursuant to this subsection shall be  
2227 computed to reflect inflation between the midpoint of the cost year  
2228 through the midpoint of the rate year. The Department of Social  
2229 Services shall study methods of reimbursement for fair rent and shall  
2230 report its findings and recommendations to the joint standing  
2231 committee of the General Assembly having cognizance of matters  
2232 relating to human services on or before January 15, 1993.

2233 (8) On and after July 1, 1994, costs shall be rebased no more  
2234 frequently than every two years and no less frequently than every four  
2235 years, as determined by the commissioner. The commissioner shall  
2236 determine whether and to what extent a change in ownership of a  
2237 facility shall occasion the rebasing of the facility's costs.

2238 (9) The method of establishing rates for new facilities shall be  
2239 determined by the commissioner in accordance with the provisions of  
2240 this subsection.

2241 (10) Rates determined under this section shall comply with federal  
2242 laws and regulations.

2243 (11) For the fiscal year ending June 30, 1992, and any succeeding  
2244 fiscal year, one-half of the initial amount payable in June by the state to  
2245 a facility pursuant to this subsection shall be paid to the facility in June  
2246 and the balance of such amount shall be paid in July.

2247 (12) Notwithstanding the provisions of this subsection, interim rates  
2248 issued for facilities on and after July 1, 1991, shall be subject to  
2249 applicable fiscal year cost component limitations established pursuant  
2250 to subdivision (3) of this subsection.

2251 (13) A chronic and convalescent nursing home having an ownership  
2252 affiliation with and operated at the same location as a chronic disease  
2253 hospital may request that the commissioner approve an exception to  
2254 applicable rate-setting provisions for chronic and convalescent nursing  
2255 homes and establish a rate for the fiscal years ending June 30, 1992,  
2256 and June 30, 1993, in accordance with regulations in effect June 30,  
2257 1991. Any such rate shall not exceed one hundred sixty-five per cent of  
2258 the median rate established for chronic and convalescent nursing  
2259 homes established under this section for the applicable fiscal year.

2260 (14) For the fiscal year ending June 30, 1994, and any succeeding  
2261 fiscal year, for purposes of computing minimum allowable patient  
2262 days, utilization of a facility's certified beds shall be determined at a  
2263 minimum of ninety-five per cent of capacity, except for new facilities  
2264 and facilities which are certified for additional beds which may be  
2265 permitted a lower occupancy rate for the first three months of  
2266 operation after the effective date of licensure.

2267 (15) The Commissioner of Social Services shall adjust facility rates  
2268 from April 1, 1999, to June 30, 1999, inclusive, by a per diem amount  
2269 representing each facility's allocation of funds appropriated for the  
2270 purpose of wage, benefit and staffing enhancement. A facility's per  
2271 diem allocation of such funding shall be computed as follows: (A) The

2272 facility's direct and indirect component salary, wage, nursing pool and  
2273 allocated fringe benefit costs as filed for the 1998 cost report period  
2274 deemed allowable in accordance with this section and applicable  
2275 regulations without application of cost component maximums  
2276 specified in subdivision (3) of this subsection shall be totalled; (B) such  
2277 total shall be multiplied by the facility's Medicaid utilization based on  
2278 the 1998 cost report; (C) the resulting amount for the facility shall be  
2279 divided by the sum of the calculations specified in subparagraphs (A)  
2280 and (B) of this subdivision for all facilities to determine the facility's  
2281 percentage share of appropriated wage, benefit and staffing  
2282 enhancement funding; (D) the facility's percentage share shall be  
2283 multiplied by the amount of appropriated wage, benefit and staffing  
2284 enhancement funding to determine the facility's allocated amount; and  
2285 (E) such allocated amount shall be divided by the number of days of  
2286 care paid for by Medicaid on an annual basis including days for  
2287 reserved beds specified in the 1998 cost report to determine the per  
2288 diem wage and benefit rate adjustment amount. The commissioner  
2289 may adjust a facility's reported 1998 cost and utilization data for the  
2290 purposes of determining a facility's share of wage, benefit and staffing  
2291 enhancement funding when reported 1998 information is not  
2292 substantially representative of estimated cost and utilization data for  
2293 the fiscal year ending June 30, 2000, due to special circumstances  
2294 during the 1998 cost report period including change of ownership with  
2295 a part year cost filing or reductions in facility capacity due to facility  
2296 renovation projects. Upon completion of the calculation of the  
2297 allocation of wage, benefit and staffing enhancement funding, the  
2298 commissioner shall not adjust the allocations due to revisions  
2299 submitted to previously filed 1998 annual cost reports. In the event  
2300 that a facility's rate for the fiscal year ending June 30, 1999, is an  
2301 interim rate or the rate includes an increase adjustment due to a rate  
2302 request to the commissioner or other reasons, the commissioner may  
2303 reduce or withhold the per diem wage, benefit and staffing  
2304 enhancement allocation computed for the facility. Any enhancement  
2305 allocations not applied to facility rates shall not be reallocated to other

2306 facilities and such unallocated amounts shall be available for the costs  
2307 associated with interim rates and other Medicaid expenditures. The  
2308 wage, benefit and staffing enhancement per diem adjustment for the  
2309 period from April 1, 1999, to June 30, 1999, inclusive, shall also be  
2310 applied to rates for the fiscal years ending June 30, 2000, and June 30,  
2311 2001, except that the commissioner may increase or decrease the  
2312 adjustment to account for changes in facility capacity or operations.  
2313 Any facility accepting a rate adjustment for wage, benefit and staffing  
2314 enhancements shall apply payments made as a result of such rate  
2315 adjustment for increased allowable employee wage rates and benefits  
2316 and additional direct and indirect component staffing. Adjustment  
2317 funding shall not be applied to wage and salary increases provided to  
2318 the administrator, assistant administrator, owners or related party  
2319 employees. Enhancement payments may be applied to increases in  
2320 costs associated with staffing purchased from staffing agencies  
2321 provided such costs are deemed necessary and reasonable by the  
2322 commissioner. The commissioner shall compare expenditures for  
2323 wages, benefits and staffing for the 1998 cost report period to such  
2324 expenditures in the 1999, 2000 and 2001 cost report periods to verify  
2325 whether a facility has applied additional payments to specified  
2326 enhancements. In the event that the commissioner determines that a  
2327 facility did not apply additional payments to specified enhancements,  
2328 the commissioner shall recover such amounts from the facility through  
2329 rate adjustments or other means. The commissioner may require  
2330 facilities to file cost reporting forms, in addition to the annual cost  
2331 report, as may be necessary, to verify the appropriate application of  
2332 wage, benefit and staffing enhancement rate adjustment payments. For  
2333 the purposes of this subdivision, "Medicaid utilization" means the  
2334 number of days of care paid for by Medicaid on an annual basis  
2335 including days for reserved beds as a percentage of total resident days.

2336       (16) The interim rate established to become effective upon sale of  
2337 any licensed chronic and convalescent home or rest home with nursing  
2338 supervision for which a receivership has been imposed pursuant to

2339 sections 19a-541 to 19a-549, inclusive, as amended by this act, shall not  
2340 exceed the rate in effect for the facility at the time of the imposition of  
2341 the receivership, subject to any annual increases permitted by this  
2342 section; provided if such rate is less than the median rate for the  
2343 facility's peer grouping, as defined in subdivision (2) of this subsection,  
2344 the Commissioner of Social Services may, in the commissioner's  
2345 discretion, establish an increased rate for the facility not to exceed such  
2346 median rate unless the Secretary of the Office of Policy and  
2347 Management, after review of area nursing facility bed availability and  
2348 other pertinent factors, authorizes the Commissioner of Social Services  
2349 to establish a rate higher than the median rate.

2350 (g) For the fiscal year ending June 30, 1993, any intermediate care  
2351 facility for the mentally retarded with an operating cost component of  
2352 its rate in excess of one hundred forty per cent of the median of  
2353 operating cost components of rates in effect January 1, 1992, shall not  
2354 receive an operating cost component increase. For the fiscal year  
2355 ending June 30, 1993, any intermediate care facility for the mentally  
2356 retarded with an operating cost component of its rate that is less than  
2357 one hundred forty per cent of the median of operating cost  
2358 components of rates in effect January 1, 1992, shall have an allowance  
2359 for real wage growth equal to thirty per cent of the increase  
2360 determined in accordance with subsection (q) of section 17-311-52 of  
2361 the regulations of Connecticut state agencies, provided such operating  
2362 cost component shall not exceed one hundred forty per cent of the  
2363 median of operating cost components in effect January 1, 1992. Any  
2364 facility with real property other than land placed in service prior to  
2365 October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a  
2366 rate of return on real property equal to the average of the rates of  
2367 return applied to real property other than land placed in service for the  
2368 five years preceding October 1, 1993. For the fiscal year ending June 30,  
2369 1996, and any succeeding fiscal year, the rate of return on real property  
2370 for property items shall be revised every five years. The commissioner  
2371 shall, upon submission of a request, allow actual debt service,

2372 comprised of principal and interest, in excess of property costs allowed  
2373 pursuant to section 17-311-52 of the regulations of Connecticut state  
2374 agencies, provided such debt service terms and amounts are  
2375 reasonable in relation to the useful life and the base value of the  
2376 property. For the fiscal year ending June 30, 1995, and any succeeding  
2377 fiscal year, the inflation adjustment made in accordance with  
2378 subsection (p) of section 17-311-52 of the regulations of Connecticut  
2379 state agencies shall not be applied to real property costs. For the fiscal  
2380 year ending June 30, 1996, and any succeeding fiscal year, the  
2381 allowance for real wage growth, as determined in accordance with  
2382 subsection (q) of section 17-311-52 of the regulations of Connecticut  
2383 state agencies, shall not be applied. For the fiscal year ending June 30,  
2384 1996, and any succeeding fiscal year, no rate shall exceed three  
2385 hundred seventy-five dollars per day unless the commissioner, in  
2386 consultation with the Commissioner of Mental Retardation,  
2387 determines after a review of program and management costs, that a  
2388 rate in excess of this amount is necessary for care and treatment of  
2389 facility residents. For the fiscal year ending June 30, 2002, rate period,  
2390 the Commissioner of Social Services shall increase the inflation  
2391 adjustment for rates made in accordance with subsection (p) of section  
2392 17-311-52 of the regulations of Connecticut state agencies to update  
2393 allowable fiscal year 2000 costs to include a three and one-half per cent  
2394 inflation factor. For the fiscal year ending June 30, 2003, rate period, the  
2395 commissioner shall increase the inflation adjustment for rates made in  
2396 accordance with subsection (p) of section 17-311-52 of the regulations  
2397 of Connecticut state agencies to update allowable fiscal year 2001 costs  
2398 to include a one and one-half per cent inflation factor, except that such  
2399 increase shall be effective November 1, 2002, and such facility rate in  
2400 effect for the fiscal year ending June 30, 2002, shall be paid for services  
2401 provided until October 31, 2002, except any facility that would have  
2402 been issued a lower rate effective July 1, 2002, than for the fiscal year  
2403 ending June 30, 2002, due to interim rate status or agreement with the  
2404 department shall be issued such lower rate effective July 1, 2002, and  
2405 have such rate updated effective November 1, 2002, in accordance with

2406 applicable statutes and regulations. For the fiscal year ending June 30,  
2407 2004, rates in effect for the period ending June 30, 2003, shall remain in  
2408 effect, except any facility that would have been issued a lower rate  
2409 effective July 1, 2003, than for the fiscal year ending June 30, 2003, due  
2410 to interim rate status or agreement with the department shall be issued  
2411 such lower rate effective July 1, 2003. Effective July 1, 2004, each facility  
2412 shall receive a rate that is three-quarters of one per cent greater than  
2413 the rate in effect June 30, 2004.

2414 (h) (1) For the fiscal year ending June 30, 1993, any residential care  
2415 home with an operating cost component of its rate in excess of one  
2416 hundred thirty per cent of the median of operating cost components of  
2417 rates in effect January 1, 1992, shall not receive an operating cost  
2418 component increase. For the fiscal year ending June 30, 1993, any  
2419 residential care home with an operating cost component of its rate that  
2420 is less than one hundred thirty per cent of the median of operating cost  
2421 components of rates in effect January 1, 1992, shall have an allowance  
2422 for real wage growth equal to sixty-five per cent of the increase  
2423 determined in accordance with subsection (q) of section 17-311-52 of  
2424 the regulations of Connecticut state agencies, provided such operating  
2425 cost component shall not exceed one hundred thirty per cent of the  
2426 median of operating cost components in effect January 1, 1992.  
2427 Beginning with the fiscal year ending June 30, 1993, for the purpose of  
2428 determining allowable fair rent, a residential care home with allowable  
2429 fair rent less than the twenty-fifth percentile of the state-wide  
2430 allowable fair rent shall be reimbursed as having allowable fair rent  
2431 equal to the twenty-fifth percentile of the state-wide allowable fair  
2432 rent. Beginning with the fiscal year ending June 30, 1997, a residential  
2433 care home with allowable fair rent less than three dollars and ten cents  
2434 per day shall be reimbursed as having allowable fair rent equal to  
2435 three dollars and ten cents per day. Property additions placed in  
2436 service during the cost year ending September 30, 1996, or any  
2437 succeeding cost year shall receive a fair rent allowance for such  
2438 additions as an addition to three dollars and ten cents per day if the

2439 fair rent for the facility for property placed in service prior to  
2440 September 30, 1995, is less than or equal to three dollars and ten cents  
2441 per day. For the fiscal year ending June 30, 1996, and any succeeding  
2442 fiscal year, the allowance for real wage growth, as determined in  
2443 accordance with subsection (q) of section 17-311-52 of the regulations  
2444 of Connecticut state agencies, shall not be applied. For the fiscal year  
2445 ending June 30, 1996, and any succeeding fiscal year, the inflation  
2446 adjustment made in accordance with subsection (p) of section  
2447 17-311-52 of the regulations of Connecticut state agencies shall not be  
2448 applied to real property costs. Beginning with the fiscal year ending  
2449 June 30, 1997, minimum allowable patient days for rate computation  
2450 purposes for a residential care home with twenty-five beds or less shall  
2451 be eighty-five per cent of licensed capacity. Beginning with the fiscal  
2452 year ending June 30, 2002, for the purposes of determining the  
2453 allowable salary of an administrator of a residential care home with  
2454 sixty beds or less the department shall revise the allowable base salary  
2455 to thirty-seven thousand dollars to be annually inflated thereafter in  
2456 accordance with section 17-311-52 of the regulations of Connecticut  
2457 state agencies. The rates for the fiscal year ending June 30, 2002, shall  
2458 be based upon the increased allowable salary of an administrator,  
2459 regardless of whether such amount was expended in the 2000 cost  
2460 report period upon which the rates are based. Beginning with the fiscal  
2461 year ending June 30, 2000, the inflation adjustment for rates made in  
2462 accordance with subsection (p) of section 17-311-52 of the regulations  
2463 of Connecticut state agencies shall be increased by two per cent, and  
2464 beginning with the fiscal year ending June 30, 2002, the inflation  
2465 adjustment for rates made in accordance with subsection (c) of said  
2466 section shall be increased by one per cent. Beginning with the fiscal  
2467 year ending June 30, 1999, for the purpose of determining the  
2468 allowable salary of a related party, the department shall revise the  
2469 maximum salary to twenty-seven thousand eight hundred fifty-six  
2470 dollars to be annually inflated thereafter in accordance with section  
2471 17-311-52 of the regulations of Connecticut state agencies and  
2472 beginning with the fiscal year ending June 30, 2001, such allowable

2473 salary shall be computed on an hourly basis and the maximum  
2474 number of hours allowed for a related party other than the proprietor  
2475 shall be increased from forty hours to forty-eight hours per work week.

2476 (2) The commissioner shall, upon determining that a loan to be  
2477 issued to a residential care home by the Connecticut Housing Finance  
2478 Authority is reasonable in relation to the useful life and property cost  
2479 allowance pursuant to section 17-311-52 of the regulations of  
2480 Connecticut state agencies, allow actual debt service, comprised of  
2481 principal, interest and a repair and replacement reserve on the loan, in  
2482 lieu of allowed property costs whether actual debt service is higher or  
2483 lower than such allowed property costs.

2484 (i) Notwithstanding the provisions of this section, the  
2485 Commissioner of Social Services shall establish a fee schedule for  
2486 payments to be made to chronic disease hospitals associated with  
2487 chronic and convalescent nursing homes to be effective on and after  
2488 July 1, 1995. The fee schedule may be adjusted annually beginning July  
2489 1, 1997, to reflect necessary increases in the cost of services.

2490 Sec. 51. (NEW) (*Effective from passage*) The Commissioner of Social  
2491 Services shall design and implement a care enhancement and disease  
2492 management initiative which initiative shall provide for an integrated  
2493 and systematic approach for managing the health care needs of high  
2494 cost Medicaid recipients. Notwithstanding any provision of the  
2495 general statutes, the commissioner may contract with an entity to  
2496 effectuate the purposes of this section, provided such entity has an  
2497 established and demonstrated capability in the design and  
2498 implementation of a disease management initiative. The commissioner  
2499 shall report annually on the status of the care enhancement and  
2500 disease management initiative to the joint standing committees of the  
2501 General Assembly having cognizance of matters relating to  
2502 appropriations and the budgets of state agencies and human services.

2503 Sec. 52. Section 17b-280 of the general statutes, as amended by

2504 section 11 of public act 03-2, is repealed and the following is  
2505 substituted in lieu thereof (*Effective from passage*):

2506 (a) The state shall reimburse for all legend drugs provided under  
2507 the Medicaid, state-administered general assistance, general assistance,  
2508 ConnPACE and Connecticut AIDS drug assistance programs at the  
2509 rate established by the Health Care Finance Administration as the  
2510 federal acquisition cost, or, if no such rate is established, the  
2511 commissioner shall establish and periodically revise the estimated  
2512 acquisition cost in accordance with federal regulations. Effective  
2513 [March 1, 2003] October 1, 2003, the commissioner shall also establish a  
2514 professional fee of three dollars and [sixty] thirty cents for each  
2515 prescription to be paid to licensed pharmacies for dispensing drugs to  
2516 Medicaid, state-administered general assistance, general assistance,  
2517 ConnPACE and Connecticut AIDS drug assistance recipients in  
2518 accordance with federal regulations; and on and after September 4,  
2519 1991, payment for legend and nonlegend drugs provided to Medicaid  
2520 recipients shall be based upon the actual package size dispensed.  
2521 Effective October 1, 1991, reimbursement for over-the-counter drugs  
2522 for such recipients shall be limited to those over-the-counter drugs and  
2523 products published in the Connecticut Formulary, or the cross  
2524 reference list, issued by the commissioner. The cost of all over-the-  
2525 counter drugs and products provided to residents of nursing facilities,  
2526 chronic disease hospitals, and intermediate care facilities for the  
2527 mentally retarded shall be included in the facilities' per diem rate.

2528 (b) The Department of Social Services may provide an enhanced  
2529 dispensing fee to a pharmacy enrolled in the federal Office of  
2530 Pharmacy Affairs Section 340B drug discount program established  
2531 pursuant to 42 USC 256b or a pharmacy under contract to provide  
2532 services under said program.

2533 Sec. 53. (NEW) (*Effective from passage*) The Commissioner of Social  
2534 Services may modify the state medical assistance durable medical  
2535 equipment, medical surgical supply, oxygen, orthotic and prosthetic

2536 devices and hearing aid fee schedules, applicable regulations, policies  
2537 and procedures or purchase of service contracts to achieve any  
2538 expenditure reductions adopted under public act 03-1 of the June 30  
2539 special session. In the event that such modifications require revisions  
2540 to any existing state regulations, the commissioner may make such  
2541 modifications while in the process of adopting the modifications in  
2542 regulation form provided the commissioner publishes notice of any  
2543 modifications of regulations in the Connecticut Law Journal within  
2544 twenty days of implementation of such modifications. Such  
2545 modifications may include, but shall not be limited to: (1) A change in  
2546 the reimbursement to customized manually priced devices to a  
2547 formula based on a percentage of list or acquisition of costs; (2) a  
2548 percentage reduction in payments to all other durable medical  
2549 equipment, medical surgical supply, oxygen, orthotic and prosthetic  
2550 devices and hearing aid providers; (3) the application of any rental  
2551 costs for durable medical equipment when the department  
2552 subsequently purchases the same equipment for a recipient; and (4) the  
2553 selection of a vendor or vendors to be the providers of durable medical  
2554 equipment, medical surgical supply, oxygen, orthotic and prosthetic  
2555 devices and hearing aid services pursuant to a competitive bidding  
2556 process. In no event shall any modifications to the state medical  
2557 assistance fee schedules, regulations, policies and procedures or  
2558 purchase of service contracts implemented by the commissioner  
2559 pursuant to this section be estimated to achieve expenditure reductions  
2560 in an amount less than adopted in public act 03-1 of the June 30 special  
2561 session.

2562 Sec. 54. Subdivision (3) of subsection (a) of section 10-76d of the  
2563 general statutes is repealed and the following is substituted in lieu  
2564 thereof (*Effective from passage*):

2565 (3) Beginning with the fiscal year ending [June 30, 2000] June 30,  
2566 2004, the Commissioner of Social Services shall make grant payments  
2567 to local or regional boards of education in amounts representing [sixty]  
2568 fifty per cent of the federal portion of Medicaid claims processed for

2569 Medicaid eligible special education and related services provided to  
2570 Medicaid eligible students in the school district. Such grant payments  
2571 shall be made on at least a quarterly basis and may represent estimates  
2572 of amounts due to local or regional boards of education. Any grant  
2573 payments made on an estimated basis, including payments made by  
2574 the Department of Education for the fiscal years prior to the fiscal year  
2575 ending June 30, 2000, shall be subsequently reconciled to grant  
2576 amounts due based upon filed and accepted Medicaid claims and  
2577 Medicaid rates. If, upon review, it is determined that a grant payment  
2578 or portion of a grant payment was made for ineligible or disallowed  
2579 Medicaid claims, the local or regional board of education shall  
2580 reimburse the Department of Social Services for any grant payment  
2581 amount received based upon ineligible or disallowed Medicaid claims.

2582 Sec. 55. Section 17b-295 of the general statutes is repealed and the  
2583 following is substituted in lieu thereof (*Effective October 1, 2003*):

2584 (a) The commissioner [may require] shall impose cost sharing  
2585 requirements including the payment of a premium or copayment in  
2586 connection with services provided under the HUSKY Plan, Part B, to  
2587 the extent permitted by federal law, and in accordance with the  
2588 following limitations:

2589 [(1) Until July 1, 1999, the maximum annual aggregate cost sharing  
2590 for a family with an income (A) which exceeds one hundred eighty-  
2591 five per cent of the federal poverty level but does not exceed two  
2592 hundred thirty-five per cent of the federal poverty level shall not be  
2593 more than six hundred fifty dollars, and (B) which exceeds two  
2594 hundred thirty-five per cent of the federal poverty level but does not  
2595 exceed three hundred per cent of the federal poverty level shall not be  
2596 more than one thousand two hundred fifty dollars;

2597 (2) On and after July 1, 1999, the commissioner shall submit a  
2598 schedule for the maximum annual aggregate cost sharing for families  
2599 with an income specified in subparagraphs (A) and (B) of subdivision

2600 (1) of this subsection to the joint standing committees of the General  
2601 Assembly having cognizance of matters relating to human services,  
2602 public health, insurance and appropriations and the budgets of state  
2603 agencies. Within fifteen days of receipt of such schedule, said joint  
2604 standing committees of the General Assembly may advise the  
2605 commissioner of their approval, denial or modifications, if any, of the  
2606 schedule; and]

2607 (1) On and after October 1, 2003, the commissioner may increase the  
2608 maximum annual aggregate cost sharing requirements provided that  
2609 such cost sharing requirements shall not exceed five per cent of the  
2610 family's gross annual income. The commissioner may impose a  
2611 premium requirement on families, whose income exceeds one hundred  
2612 eighty-five per cent of the federal poverty level as a component of the  
2613 family's cost sharing responsibility provided the family's annual  
2614 combined premiums and copayments do not exceed the maximum  
2615 annual aggregate cost sharing requirement; and

2616 ~~[(3)]~~ (2) The commissioner shall require each managed care plan to  
2617 monitor copayments and premiums under the provisions of  
2618 subdivision (1) of this subsection.

2619 (b) (1) Except as provided in subdivision (2) of this subsection, the  
2620 commissioner may impose limitations on the amount, duration and  
2621 scope of benefits under the HUSKY Plan, Part B.

2622 (2) The limitations adopted by the commissioner pursuant to  
2623 subdivision (1) of this subsection shall not preclude coverage of any  
2624 item of durable medical equipment or service that is medically  
2625 necessary.

2626 Sec. 56. Section 17b-292 of the general statutes, as amended by  
2627 section 7 of public act 03-2, is repealed and the following is substituted  
2628 in lieu thereof (*Effective from passage*):

2629 (a) A child who resides in a household with a family income which

2630 exceeds one hundred eighty-five per cent of the federal poverty level  
2631 and does not exceed three hundred per cent of the federal poverty  
2632 level may be eligible for subsidized benefits under the HUSKY Plan,  
2633 Part B. The services and cost sharing requirements under the HUSKY  
2634 Plan, Part B shall be substantially similar to the services and cost  
2635 sharing requirements of the largest commercially available health plan  
2636 offered by a managed care organization, as defined in section 38a-478,  
2637 offered to residents in this state as measured by the number of covered  
2638 lives reported to the Department of Insurance in the most recent  
2639 audited annual report.

2640 (b) A child who resides in a household with a family income over  
2641 three hundred per cent of the federal poverty level may be eligible for  
2642 unsubsidized benefits under the HUSKY Plan, Part B.

2643 (c) Whenever a court or family support magistrate orders a  
2644 noncustodial parent to provide health insurance for a child, such  
2645 parent may provide for coverage under the HUSKY Plan, Part B.

2646 (d) To the extent allowed under federal law, the commissioner shall  
2647 not pay for services or durable medical equipment under the HUSKY  
2648 Plan, Part B if the enrollee has other insurance coverage for the services  
2649 or such equipment.

2650 (e) A newborn child who otherwise meets the eligibility criteria for  
2651 the HUSKY Plan, Part B shall be eligible for benefits retroactive to his  
2652 date of birth, provided an application is filed on behalf of the child  
2653 within thirty days of such date.

2654 [(f) The commissioner shall implement presumptive eligibility for  
2655 children applying for Medicaid. Such presumptive eligibility  
2656 determinations shall be in accordance with applicable federal law and  
2657 regulations. The commissioner shall adopt regulations, in accordance  
2658 with chapter 54, to establish standards and procedures for the  
2659 designation of organizations as qualified entities to grant presumptive  
2660 eligibility. In establishing such regulations, the commissioner shall

2661 ensure the representation of state-wide and local organizations that  
2662 provide services to children of all ages in each region of the state.]

2663        [(g)] (f) The commissioner shall enter into a contract with an entity  
2664 to be a single point of entry servicer for applicants and enrollees under  
2665 the HUSKY Plan, Part A and Part B. The servicer shall jointly market  
2666 both Part A and Part B together as the HUSKY Plan. Such servicer shall  
2667 develop and implement public information and outreach activities  
2668 with community programs. Such servicer shall electronically transmit  
2669 data with respect to enrollment and disenrollment in the HUSKY Plan,  
2670 Part B to the commissioner. [who may transmit such data to the  
2671 Children's Health Council.]

2672        [(h) To the extent permitted by federal law, the single point of entry  
2673 servicer may be one of the entities authorized to grant presumptive  
2674 eligibility under the HUSKY Plan, Part A.]

2675        [(i)] (g) The single point of entry servicer shall send an application  
2676 and supporting documents to the commissioner for determination of  
2677 eligibility of a child who resides in a household with a family income  
2678 of one hundred eighty-five per cent or less of the federal poverty level.  
2679 The servicer shall enroll eligible beneficiaries in the applicant's choice  
2680 of managed care plan.

2681        [(j)] (h) Not more than twelve months after the determination of  
2682 eligibility for benefits under the HUSKY Plan, Part A and Part B and  
2683 annually thereafter, the commissioner or the servicer, as the case may  
2684 be, shall determine if the child continues to be eligible for the plan. The  
2685 commissioner or the servicer shall mail an application form to each  
2686 participant in the plan for the purposes of obtaining information to  
2687 make a determination on eligibility. To the extent permitted by federal  
2688 law, in determining eligibility for benefits under the HUSKY Plan, Part  
2689 A and Part B with respect to family income, the commissioner or the  
2690 servicer shall rely upon information provided in such form by the  
2691 participant unless the commissioner or the servicer has reason to

2692 believe that such information is inaccurate or incomplete. The  
2693 determination of eligibility shall be coordinated with health plan open  
2694 enrollment periods.

2695 [(k)] (i) The commissioner shall implement the HUSKY Plan, Part B  
2696 while in the process of adopting necessary policies and procedures in  
2697 regulation form in accordance with the provisions of section 17b-10.

2698 [(l)] (j) The commissioner shall adopt regulations, in accordance  
2699 with chapter 54, to establish residency requirements and income  
2700 eligibility for participation in the HUSKY Plan, Part B and procedures  
2701 for a simplified mail-in application process. Notwithstanding the  
2702 provisions of section 17b-257b, such regulations shall provide that any  
2703 child adopted from another country by an individual who is a citizen  
2704 of the United States and a resident of this state shall be eligible for  
2705 benefits under the HUSKY Plan, Part B upon arrival in this state.

2706 Sec. 57. Subsection (c) of section 17b-297 of the general statutes is  
2707 repealed and the following is substituted in lieu thereof (*Effective from*  
2708 *passage*):

2709 (c) The commissioner shall, within available appropriations,  
2710 contract with [qualified entities authorized to grant presumptive  
2711 eligibility,] severe need schools and community-based organizations  
2712 for purposes of public education, outreach and recruitment of eligible  
2713 children, including the distribution of applications and information  
2714 regarding enrollment in the HUSKY Plan, Part A and Part B. In  
2715 awarding such contracts, the commissioner shall consider the  
2716 marketing, outreach and recruitment efforts of organizations. For the  
2717 purposes of this subsection, (1) "community-based organizations" shall  
2718 include, but not be limited to, day care centers, schools, school-based  
2719 health clinics, community-based diagnostic and treatment centers and  
2720 hospitals, and (2) "severe need school" means a school in which forty  
2721 per cent or more of the lunches served are served to students who are  
2722 eligible for free or reduced price lunches.

2723 Sec. 58. Subsection (a) of section 17b-492 of the general statutes, as  
2724 amended by section 15 of public act 03-2, is repealed and the following  
2725 is substituted in lieu thereof (*Effective October 1, 2003*):

2726 (a) Eligibility for participation in the program shall be limited to any  
2727 resident (1) who is sixty-five years of age or older or who is disabled,  
2728 (2) (A) whose annual income, if unmarried, is less than thirteen  
2729 thousand eight hundred dollars, except after April 1, 2002, such annual  
2730 income is less than twenty thousand dollars, or whose annual income,  
2731 if married, when combined with that of the resident's spouse is less  
2732 than sixteen thousand six hundred dollars, except after April 1, 2002,  
2733 such combined annual income is less than twenty-seven thousand one  
2734 hundred dollars, or (B) in the event the program is granted a waiver to  
2735 be eligible for federal financial participation, then, after July 1, 2002,  
2736 whose annual income, if unmarried, is less than twenty-five thousand  
2737 eight hundred dollars, or whose annual income, if married, when  
2738 combined with that of the resident's spouse is less than thirty-four  
2739 thousand eight hundred dollars, (3) who is not insured under a policy  
2740 which provides full or partial coverage for prescription drugs once a  
2741 deductible amount is met, [and] (4) whose available assets are below  
2742 one hundred thousand dollars if unmarried and one hundred twenty-  
2743 five thousand dollars if married, (A) the asset limit for a married  
2744 resident shall be determined by combining the value of assets available  
2745 to both spouses, and (B) for purposes of this section, available assets  
2746 are those that are considered available in determining eligibility in the  
2747 Connecticut Home Care Program for the Elderly, and (5) on and after  
2748 September 15, 1991, who pays an annual thirty-dollar registration fee  
2749 to the Department of Social Services. Effective January 1, 2002, the  
2750 commissioner shall commence accepting applications from individuals  
2751 who will become eligible to participate in the program as of April 1,  
2752 2002. On January 1, 1998, and annually thereafter, the commissioner  
2753 shall increase the income limits established under this subsection over  
2754 those of the previous fiscal year to reflect the annual inflation  
2755 adjustment in Social Security income, if any. Each such adjustment

2756 shall be determined to the nearest one hundred dollars.

2757 Sec. 59. Section 17b-95 of the general statutes is repealed and the  
2758 following is substituted in lieu thereof (*Effective from passage*):

2759 (a) [Upon] Subject to the provisions of subsection (b) of this section,  
2760 upon the death of a parent of a child who has, at any time, been a  
2761 beneficiary under the program of aid to families with dependent  
2762 children, the temporary family assistance program or the state-  
2763 administered general assistance program, or upon the death of any  
2764 person who has at any time been a beneficiary of aid under the state  
2765 supplement program, medical assistance program, aid to families with  
2766 dependent children program, temporary family assistance program or  
2767 state-administered general assistance program, and, on or after  
2768 September 1, 2003, the Connecticut Pharmaceutical Assistance  
2769 Contract to the Elderly and Disabled Program, except as provided in  
2770 subsection (b) of section 17b-93, the state shall have a claim against  
2771 such parent's or person's estate for all amounts paid on behalf of each  
2772 such child or for the support of either parent or such child or such  
2773 person under the state supplement program, medical assistance  
2774 program, aid to families with dependent children program, temporary  
2775 family assistance program or state-administered general assistance  
2776 program and on or after September 1, 2003, to a beneficiary of aid  
2777 under the Connecticut Pharmaceutical Assistance Contract to the  
2778 Elderly and Disabled Program, for which the state has not been  
2779 reimbursed, to the extent that the amount which the surviving spouse,  
2780 parent or dependent children of the decedent would otherwise take  
2781 from such estate is not needed for their support.

2782 (b) In the case of any person dying after October 1, 1959, the claim  
2783 for medical payments, even though such payments were made prior  
2784 thereto, shall be restricted to medical disbursements actually made for  
2785 care of such deceased beneficiary. [Such claims] In the case of any  
2786 person dying after September 1, 2003, the claim for ConnPACE  
2787 program benefits shall be restricted to benefits actually received on or

2788 after July 1, 2003.

2789 (c) Claims pursuant to this section shall have priority over all  
2790 unsecured claims against such estate, except (1) expenses of last  
2791 sickness not to exceed three hundred seventy-five dollars, (2) funeral  
2792 and burial expenses in accordance with section 17b-84, and (3)  
2793 administrative expenses, including probate fees and taxes, and  
2794 including fiduciary fees not exceeding the following commissions on  
2795 the value of the whole estates accounted for by such fiduciaries: On the  
2796 first two thousand dollars or portion thereof, five per cent; on the next  
2797 eight thousand dollars or portion thereof, four per cent; on the excess  
2798 over ten thousand dollars, three per cent. Upon petition by any  
2799 fiduciary, the Probate Court, after a hearing thereon, may authorize  
2800 compensation in excess of the above schedule for extraordinary  
2801 services. Notice of any such petition and hearing shall be given to the  
2802 Commissioner of Administrative Services in Hartford at least ten days  
2803 in advance of such hearing. The allowable funeral and burial payment  
2804 herein shall be reduced by the amount of any prepaid funeral  
2805 arrangement. Any amount paid from the estate under this section to  
2806 any person which exceeds the limits provided herein shall be repaid to  
2807 the estate by such person, and such amount may be recovered in a civil  
2808 action with interest at six per cent from the date of demand.

2809 (d) For purposes of this section, all sums due on or after July 1, 2003,  
2810 to any individual after the death of a public assistance beneficiary  
2811 pursuant to the terms of an annuity contract purchased at any time  
2812 with assets of a public assistance beneficiary, shall be deemed to be  
2813 part of the estate of the deceased beneficiary and shall be payable to  
2814 the state by the recipient of such annuity payments to the extent  
2815 necessary to achieve full reimbursement of any public assistance  
2816 benefits paid to, or on behalf of, the deceased beneficiary irrespective  
2817 of any provision of law. The recipient of beneficiary payments from  
2818 any such annuity contract shall be solely liable to the state of  
2819 Connecticut for reimbursement of public assistance benefits paid to, or  
2820 on behalf of, the deceased beneficiary to the extent of any payments

2821 received by such recipient pursuant to the annuity contract.

2822 Sec. 60. Subsection (b) of section 17b-104 of the general statutes, as  
2823 amended by section 38 of public act 03-19, is repealed and the  
2824 following is substituted in lieu thereof (*Effective from passage*):

2825 (b) On July 1, 1988, and annually thereafter, the commissioner shall  
2826 increase the payment standards over those of the previous fiscal year  
2827 under the aid to families with dependent children program, temporary  
2828 family assistance program, the state-administered general assistance  
2829 program and for the general assistance program by the percentage  
2830 increase, if any, in the most recent calendar year average in the  
2831 consumer price index for urban consumers over the average for the  
2832 previous calendar year, provided the annual increase, if any, shall not  
2833 exceed five per cent, except that the payment standards for the fiscal  
2834 years ending June 30, 1992, June 30, 1993, June 30, 1994, June 30, 1995,  
2835 June 30, 1996, June 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000,  
2836 June 30, 2001, June 30, 2002, [and] June 30, 2003, June 30, 2004, and  
2837 June 30, 2005, shall not be increased. On January 1, 1994, the payment  
2838 standards shall be equal to the standards of need in effect July 1, 1993.

2839 Sec. 61. Subsection (a) of section 17b-106 of the general statutes is  
2840 repealed and the following is substituted in lieu thereof (*Effective from*  
2841 *passage*):

2842 (a) On July 1, 1985, the Commissioner of Social Services shall  
2843 increase the adult payment standards for the state supplement to the  
2844 federal Supplemental Security Income Program by four and  
2845 three-tenths per cent over the standards for the fiscal year ending June  
2846 30, 1985, provided the commissioner shall apply the appropriate  
2847 disregards. Notwithstanding the provisions of any regulation to the  
2848 contrary, effective July 1, 1994, the commissioner shall reduce the  
2849 appropriate unearned income disregard for recipients of the state  
2850 supplement to the federal Supplemental Security Income Program by  
2851 seven per cent, provided if sufficient funds are available within

2852 accounts in the Department of Social Services and are transferred to  
2853 the old age assistance account, the aid to the blind account and the aid  
2854 to the disabled account, the commissioner shall increase the unearned  
2855 income disregard for recipients of the state supplement to the federal  
2856 Supplemental Security Income Program to a level not to exceed that in  
2857 effect on June 30, 1994. On July 1, 1989, and annually thereafter, the  
2858 Commissioner of Social Services shall increase the adult payment  
2859 standards over those of the previous fiscal year for the state  
2860 supplement to the federal Supplemental Security Income Program by  
2861 the percentage increase, if any, in the most recent calendar year  
2862 average in the consumer price index for urban consumers over the  
2863 average for the previous calendar year, provided the annual increase,  
2864 if any, shall not exceed five per cent, except that the adult payment  
2865 standards for the fiscal years ending June 30, 1993, June 30, 1994, June  
2866 30, 1995, June 30, 1996, June 30, 1997, June 30, 1998, June 30, 1999, June  
2867 30, 2000, June 30, 2001, June 30, 2002, [and] June 30, 2003, June 30, 2004,  
2868 and June 30, 2005, shall not be increased. Effective October 1, 1991, the  
2869 coverage of excess utility costs for recipients of the state supplement to  
2870 the federal Supplemental Security Income Program is eliminated.  
2871 Notwithstanding the provisions of this section, the Commissioner of  
2872 Social Services may increase the personal needs allowance component  
2873 of the adult payment standard as necessary to meet federal  
2874 maintenance of effort requirements.

2875 Sec. 62. Section 17b-261a of the general statutes is repealed and the  
2876 following is substituted in lieu thereof (*Effective from passage*):

2877 (a) The Commissioner of Social Services shall seek a waiver of  
2878 federal law for the purpose of establishing that the penalty period  
2879 during which an applicant for or recipient of assistance for long-term  
2880 care under the Medicaid program is ineligible for Medicaid-funded  
2881 services due to a transfer of assets for less than fair market value shall  
2882 begin in the month the applicant is found otherwise eligible for  
2883 Medicaid coverage of services rather than in the month of the transfer  
2884 of assets. This section shall only apply to transfers that occur on or

2885 after the effective date of the waiver. The provisions of section 17b-8  
2886 shall apply to this section.

2887 (b) Any transfer or assignment of assets resulting in the imposition  
2888 of a penalty period shall be presumed to be made with the intent, on  
2889 the part of the transferor or the transferee, to enable the transferor to  
2890 obtain or maintain eligibility for medical assistance. This presumption  
2891 may be rebutted only by clear and convincing evidence that the  
2892 transferor's eligibility or potential eligibility for medical assistance was  
2893 not a basis for the transfer or assignment.

2894 (c) Any transfer or assignment of assets resulting in the  
2895 establishment or imposition of a penalty period shall create a debt, as  
2896 defined in section 36a-645, that shall be due and owing by the  
2897 transferor or transferee to the Department of Social Services in an  
2898 amount equal to the amount of the medical assistance provided to or  
2899 on behalf of the transferor on or after the date of the transfer of assets,  
2900 but said amount shall not exceed the fair market value of the assets at  
2901 the time of transfer. The Commissioner of Social Services, the  
2902 Commissioner of Administrative Services and the Attorney General  
2903 shall have the power or authority to seek administrative, legal or  
2904 equitable relief as provided by other statutes or by common law.

2905 (d) The Commissioner of Social Services, upon the request of a  
2906 nursing facility, may grant financial relief to a nursing facility if the  
2907 nursing facility establishes that (1) it is experiencing severe financial  
2908 hardship due to the transfer of asset penalty period beginning in the  
2909 month the applicant is found otherwise eligible for Medicaid coverage  
2910 of services rather than in the month of the transfer of assets; and (2) it  
2911 has made every effort permissible under state and federal law to  
2912 recover the funds that are due to it for caring for the individual. No  
2913 request for financial relief may be made by a nursing facility unless the  
2914 individual who is the subject of the imposition of the penalty period  
2915 has resided in the nursing facility for at least ninety days with no  
2916 payment having been made on the individual's behalf during that

2917 period. If the department agrees to grant financial relief to the nursing  
2918 facility in the form of providing Medicaid payment to the facility, the  
2919 department shall seek recoupment of said payment from the  
2920 individual and the transferee by pursuing all means available to it  
2921 under state and federal law.

2922 (e) The Commissioner of Social Services may waive the imposition  
2923 of a penalty period when the transferor (1) suffers from dementia at  
2924 the time of application for medical assistance and cannot explain  
2925 transfers that would otherwise result in the imposition of a penalty  
2926 period; or (2) suffered from dementia at the time of the transfer; or (3)  
2927 was exploited into making such a transfer. Waiver of the imposition of  
2928 a penalty period does not prohibit the establishment of a debt in  
2929 accordance with subsection (c) of this section.

2930 (f) In reviewing transfers of assets for purposes of determining  
2931 eligibility for medical assistance, the department shall consider those  
2932 transfers of assets involving real property that occurred within sixty  
2933 months preceding the date on which an institutionalized individual  
2934 has applied for medical assistance under the Medicaid state plan,  
2935 except transfers of real property that are exempt under department  
2936 regulations. Transfers of assets that do not involve real property  
2937 remain subject to the look-back provisions contained in federal law.

2938 (g) The Commissioner of Social Services may establish threshold  
2939 limits, which shall be the cumulative amount of transfers that may be  
2940 made within any year of the look-back period without resulting in the  
2941 imposition of a transfer of assets penalty.

2942 (h) The Commissioner of Social Services, pursuant to section 17b-10,  
2943 shall implement the policies and procedures necessary to carry out the  
2944 provisions of this section while in the process of adopting such  
2945 regulations and procedures in regulation form, provided notice of  
2946 intent to adopt regulations is published in the Connecticut Law Journal  
2947 within twenty days after implementation. Such policies and

2948 procedures shall be valid until the time final regulations are effective.

2949 Sec. 63. Section 17b-261 of the general statutes, as amended by  
2950 section 2 of public act 03-2 and section 7 of public act 03-268, is  
2951 amended by adding subsection (h) as follows (*Effective from passage*):

2952 (NEW) (h) An institutionalized spouse applying for Medicaid and  
2953 having a spouse living in the community shall be required, to the  
2954 maximum extent permitted by law, to divert income to such  
2955 community spouse in order to raise the community spouse's income to  
2956 the level of the minimum monthly needs allowance, as described in  
2957 Section 1924 of the Social Security Act. Such diversion of income shall  
2958 occur before the community spouse is allowed to retain assets in excess  
2959 of the community spouse protected amount described in Section 1924  
2960 of the Social Security Act. The Commissioner of Social Services,  
2961 pursuant to section 17b-10, may implement the provisions of this  
2962 subsection while in the process of adopting regulations, provided the  
2963 commissioner prints notice of intent to adopt the regulations in the  
2964 Connecticut Law Journal within twenty days of adopting such policy.  
2965 Such policy shall be valid until the time final regulations are effective.

2966 Sec. 64. Subsection (c) of section 10-303 of the general statutes is  
2967 repealed and the following is substituted in lieu thereof (*Effective from*  
2968 *passage*):

2969 (c) The Board of Education and Services for the Blind may maintain  
2970 a nonlapsing account and accrue interest thereon for state and local  
2971 vending machine income which shall be used for the payment of fringe  
2972 benefits, training and support to vending facilities operators, [and] to  
2973 provide entrepreneurial and independent-living training and  
2974 equipment to children who are blind or visually impaired and adults  
2975 who are blind and for other vocational rehabilitation programs and  
2976 services for adults who are blind.

2977 Sec. 65. (*Effective from passage*) For the fiscal year ending June 30,  
2978 2004, the sum of two hundred eighty-three thousand dollars shall be

2979 disbursed from the nonlapsing account maintained pursuant to  
2980 subsection (c) of section 10-303 of the general statutes, as amended by  
2981 this act, for the purpose of retiring obligations associated with the  
2982 contract for tee shirts manufactured by the Industries program, and  
2983 not more than five hundred thousand dollars shall be disbursed from  
2984 said account for the purpose of funding competitive employment or  
2985 sheltered employment of blind and visually impaired adults.

2986 Sec. 66. Section 17b-239a of the general statutes is repealed and the  
2987 following is substituted in lieu thereof (*Effective from passage*):

2988 [For the fiscal year ending June 30, 2002, and the fiscal year ending  
2989 June 30, 2003, the] The Department of Social Services may, within  
2990 available funds, make payments to all short-term general hospitals  
2991 located in distressed municipalities, as defined in section 32-9p, with a  
2992 population greater than seventy thousand and to all short-term general  
2993 hospitals located in targeted investment communities with enterprise  
2994 zones, as defined in section 32-70, with a population greater than one  
2995 hundred thousand. The payment amount for each hospital shall be  
2996 determined by the Commissioner of Social Services based upon the  
2997 ratio that the number of inpatient discharges paid by Medicaid on a  
2998 fee-for-service basis to the hospital for the most recently filed cost  
2999 report period bears to the total hospital discharges paid by Medicaid  
3000 on a fee-for-service basis for all qualifying hospitals. Notwithstanding  
3001 the provisions of this section, no payment shall be made to a facility  
3002 licensed as a children's hospital.

3003 Sec. 67. Subsection (d) of section 17b-239 of the general statutes is  
3004 repealed and the following is substituted in lieu thereof (*Effective from*  
3005 *passage*):

3006 (d) The state shall also pay to such hospitals for each outpatient  
3007 clinic and emergency room visit a reasonable rate to be established  
3008 annually by the commissioner for each hospital, such rate to be  
3009 determined by the reasonable cost of such services. The emergency

3010 room visit rates in effect June 30, 1991, shall remain in effect through  
3011 June 30, 1993, except those which would have been decreased effective  
3012 July 1, 1991, or July 1, 1992, shall be decreased. Nothing contained  
3013 herein shall authorize a payment by the state for such services to any  
3014 hospital in excess of the charges made by such hospital for comparable  
3015 services to the general public. For those outpatient hospital services  
3016 paid on the basis of a ratio of cost to charges, the ratios in effect June  
3017 30, 1991, shall be reduced effective July 1, 1991, by the most recent  
3018 annual increase in the consumer price index for medical care. For those  
3019 outpatient hospital services paid on the basis of a ratio of cost to  
3020 charges, the ratios computed to be effective July 1, 1994, shall be  
3021 reduced by the most recent annual increase in the consumer price  
3022 index for medical care. The emergency room visit rates in effect June  
3023 30, 1994, shall remain in effect through December 31, 1994. The  
3024 Commissioner of Social Services shall establish a fee schedule for  
3025 outpatient hospital services to be effective on and after January 1, 1995.  
3026 Except with respect to the rate periods beginning July 1, 1999, and July  
3027 1, 2000, such fee schedule shall be adjusted annually beginning July 1,  
3028 1996, to reflect necessary increases in the cost of services.  
3029 Notwithstanding the provisions of this subsection, the fee schedule for  
3030 the rate period beginning July 1, 2000, shall be increased by ten and  
3031 one-half per cent, effective June 1, 2001. Notwithstanding the  
3032 provisions of this subsection, outpatient rates in effect as of June 30,  
3033 2003, shall remain in effect through June 30, 2005.

3034 Sec. 68. Subsection (g) of section 17b-239 of the general statutes is  
3035 repealed and the following is substituted in lieu thereof (*Effective from*  
3036 *passage*):

3037 (g) Effective June 1, 2001, the commissioner shall establish inpatient  
3038 hospital rates in accordance with the method specified in regulations  
3039 adopted pursuant to this section and applied for the rate period  
3040 beginning October 1, 2000, except that the commissioner shall update  
3041 each hospital's target amount per discharge to the actual allowable cost  
3042 per discharge based upon the 1999 cost report filing multiplied by

3043 sixty-two and one-half per cent if such amount is higher than the target  
3044 amount per discharge for the rate period beginning October 1, 2000, as  
3045 adjusted for the ten per cent incentive identified in Section 4005 of  
3046 Public Law 101-508. If a hospital's rate is increased pursuant to this  
3047 subsection, the hospital shall not receive the ten per cent incentive  
3048 identified in Section 4005 of Public Law 101-508. For rate periods  
3049 beginning October 1, 2001, [and October 1, 2002] through September  
3050 30, 2005, the commissioner shall not apply an annual adjustment factor  
3051 to the target amount per discharge.

3052 Sec. 69. (NEW) (*Effective from passage*) (a) Not later than September  
3053 30, 2003, the Commissioner of Social Services shall submit an  
3054 amendment to the Medicaid state plan to allow pharmacies the ability  
3055 to deny filling Medicaid prescriptions for program beneficiaries who  
3056 demonstrate a documented and continuous failure to make required  
3057 copayments, notwithstanding having the financial ability to make such  
3058 required copayments. Such amendment to the Medicaid state plan  
3059 shall provide that any person denied prescription drugs pursuant to  
3060 this section shall, upon payment of all outstanding copayments, be  
3061 eligible for the filling of prescriptions under the Medicaid program.  
3062 Such amendment to the Medicaid state plan shall not apply to  
3063 prescriptions for psychotropic drug therapies.

3064 (b) For purposes of this section, continuous failure to make required  
3065 copayments means the failure to: (1) Make a required copayment  
3066 within six months from the date a prescription is filled, or (2) make  
3067 required copayments on six or more prescriptions when such  
3068 prescriptions are filled during any six-month period.

3069 Sec. 70. Subsection (c) of section 4 of public act 01-8 of the June  
3070 special session is repealed and the following is substituted in lieu  
3071 thereof (*Effective from passage*):

3072 [(c) Upon completion of the study and report required under  
3073 subsection (a) of this section, the]

3074 (c) The Commissioner of Social Services shall take such action as  
3075 may be necessary to amend the Medicaid state plan to provide for  
3076 coverage of optional adult rehabilitation services supplied by various  
3077 providers of mental health services, pursuant to a contract with the  
3078 Department of Mental Health and Addiction Services, for adults with  
3079 mental health needs who are clients of said department. For the fiscal  
3080 years ending June 30, [2002] 2004, and June 30, [2003,] 2005, up to three  
3081 million dollars in each such fiscal year of any moneys received by the  
3082 state as federal reimbursement for optional Medicaid adult  
3083 rehabilitation services shall be credited to the Community Mental  
3084 Health Restoration subaccount within the account established under  
3085 section 1 of [this act] public act 01-8 of the June special session and  
3086 shall be available for use for the purposes of the subaccount. The  
3087 Commissioner of Social Services shall adopt regulations, in accordance  
3088 with the provisions of chapter 54, to implement optional rehabilitation  
3089 services under the Medicaid program. The commissioner shall  
3090 implement policies and procedures to administer such services while  
3091 in the process of adopting such policies or procedures in regulation  
3092 form, provided notice of intention to adopt the regulations is printed  
3093 in the Connecticut Law Journal within forty-five days of  
3094 implementation, and any such policies or procedures shall be valid  
3095 until the time final regulations are effective.

3096 Sec. 71. (*Effective from passage*) Any appropriation or portion thereof,  
3097 made to The University of Connecticut Health Center under section 1  
3098 or 11 of public act 03-1 of the June 30 special session may be  
3099 transferred by the Secretary of the Office of Policy and Management to  
3100 the disproportionate share account in the Department of Social  
3101 Services for purposes of maximizing federal reimbursement.

3102 Sec. 72. (NEW) (*Effective October 1, 2003*) (a) Notwithstanding any  
3103 provision of the general statutes or the regulations of Connecticut state  
3104 agencies, the Commissioner of Social Services, in consultation with the  
3105 Office of Policy and Management, shall enter into contracts with  
3106 managed care organizations to provide services for eligible individuals

3107 enrolled in a managed care plan under the HUSKY Plan, Part A. The  
3108 managed care plan shall be substantially similar to the State Employee  
3109 Non-Gatekeeper POE Plan as of the effective date of this section and  
3110 shall comply with all Medicaid federal law and regulations. For the  
3111 fiscal years ending June 30, 2004, and June 30, 2005, the copayment  
3112 requirements shall not exceed three dollars per medical service and  
3113 one dollar and fifty cents per prescription drug. The commissioner  
3114 shall require the managed care organizations to assess a monthly cost  
3115 sharing requirement for eligible individuals as follows: (1) For a family  
3116 with an income that is at or above fifty per cent of the federal poverty  
3117 level but below one hundred per cent of the federal poverty level, an  
3118 amount of ten dollars per person with a family share not to exceed  
3119 twenty-five dollars per month; and (2) for a family with an income that  
3120 is at or above one hundred per cent of the federal poverty level but  
3121 does not exceed one hundred eighty-five per cent of the federal  
3122 poverty level, an amount of twenty dollars per person with a family  
3123 share not to exceed fifty dollars per month.

3124 (b) Individuals participating in HUSKY Plan, Part A, not enrolled in  
3125 managed care, shall be assessed similar copayments and cost sharing  
3126 requirements as described under subsection (a) of this section. The  
3127 commissioner may deny coverage or discontinue eligibility for any  
3128 recipient who is two months in arrears on premium requirements.  
3129 Termination shall not occur until thirty days after the recipient is  
3130 notified.

3131 (c) The commissioner shall amend the state Medicaid plan and seek  
3132 any federal waivers necessary to implement the provisions of this  
3133 section.

3134 (d) The commissioner shall implement the changes pursuant to this  
3135 section while in the process of adopting necessary policies and  
3136 procedures in regulation form in accordance with the provisions of  
3137 section 17b-10 of the general statutes.

3138 Sec. 73. Section 17b-290 of the general statutes is repealed and the  
3139 following is substituted in lieu thereof (*Effective from passage*):

3140 As used in sections 17b-289 to 17b-303, inclusive, section 72 of this  
3141 act, and section 16 of public act 97-1 of the October 29 special session\*:

3142 (1) "Applicant" means an individual over the age of eighteen years  
3143 who is a natural or adoptive parent or a legal guardian; a caretaker  
3144 relative, foster parent or stepparent with whom the child resides; or a  
3145 noncustodial parent under order of a court or family support  
3146 magistrate to provide health insurance, who applies for coverage  
3147 under the HUSKY Plan, Part B on behalf of a child and shall include a  
3148 child who is eighteen years of age or emancipated in accordance with  
3149 the provisions of sections 46b-150 to 46b-150e, inclusive, and who is  
3150 applying on his own behalf or on behalf of a minor dependent for  
3151 coverage under such plan;

3152 (2) "Child" means an individual under nineteen years of age;

3153 (3) "Coinsurance" means the sharing of health care expenses by the  
3154 insured and an insurer in a specified ratio;

3155 (4) "Commissioner" means the Commissioner of Social Services;

3156 (5) "Copayment" means a payment made on behalf of an enrollee for  
3157 a specified service under the HUSKY Plan, Part B;

3158 (6) "Cost sharing" means arrangements made on behalf of an  
3159 enrollee whereby an applicant pays a portion of the cost of health  
3160 services, sharing costs with the state and includes copayments,  
3161 premiums, deductibles and coinsurance;

3162 (7) "Deductible" means the amount of out-of-pocket expenses that  
3163 would be paid for health services on behalf of an enrollee before  
3164 becoming payable by the insurer;

3165 (8) "Department" means the Department of Social Services;

3166 (9) "Durable medical equipment" means durable medical  
3167 equipment, as defined in Section 1395x(n) of the Social Security Act;

3168 (10) "Eligible beneficiary" means a child who meets the  
3169 requirements specified in section 17b-292, except a child excluded  
3170 under the provisions of Subtitle J of Public Law 105-33 or a child of any  
3171 municipal employee eligible for employer-sponsored insurance on or  
3172 after October 30, 1997, provided a child of such a municipal employee  
3173 may be eligible for coverage under the HUSKY Plan, Part B if  
3174 dependent coverage was terminated due to an extreme economic  
3175 hardship on the part of the employee, as determined by the  
3176 commissioner;

3177 (11) "Enrollee" means an eligible beneficiary who receives services  
3178 from a managed care plan under the HUSKY Plan, Part B;

3179 (12) "Family" means any combination of the following: (A) An  
3180 individual; (B) the individual's spouse; (C) any child of the individual  
3181 or such spouse; or (D) the legal guardian of any such child if the  
3182 guardian resides with the child;

3183 (13) "HUSKY Plan, Part A" means assistance provided to children  
3184 pursuant to section 17b-261;

3185 (14) "HUSKY Plan, Part B" means the health insurance plan for  
3186 children established pursuant to the provisions of sections 17b-289 to  
3187 17b-303, inclusive, and section 16 of public act 97-1 of the October 29  
3188 special session\*;

3189 (15) "HUSKY Plus programs" means two supplemental health  
3190 insurance programs established pursuant to section 17b-294 for  
3191 medically eligible enrollees of the HUSKY Plan, Part B whose medical  
3192 needs cannot be accommodated within the basic benefit package  
3193 offered to enrollees. One program shall supplement coverage for those  
3194 medically eligible enrollees with intensive physical health needs and  
3195 the other program shall supplement coverage for those medically

3196 eligible enrollees with intensive behavioral health needs;

3197 (16) "Income" means income as calculated in the same manner as  
3198 under the Medicaid program pursuant to section 17b-261;

3199 (17) "Managed care plan" means a plan offered by an entity that  
3200 contracts with the department to provide benefits to enrollees on a  
3201 prepaid basis;

3202 (18) "Parent" means a natural parent, stepparent, adoptive parent,  
3203 guardian or custodian of a child;

3204 (19) "Premium" means any required payment made by an  
3205 individual to offset or pay in full the capitation rate under the HUSKY  
3206 Plan, Part B;

3207 (20) "Preventive care and services" means: (A) Child preventive  
3208 care, including periodic and interperiodic well-child visits, routine  
3209 immunizations, health screenings and routine laboratory tests; (B)  
3210 prenatal care, including care of all complications of pregnancy; (C) care  
3211 of newborn infants, including attendance at high-risk deliveries and  
3212 normal newborn care; (D) WIC evaluations; (E) child abuse assessment  
3213 required under sections 17a-106a and 46b-129a; (F) preventive dental  
3214 care for children; and (G) periodicity schedules and reporting based on  
3215 the standards specified by the American Academy of Pediatrics;

3216 (21) "Primary and preventive health care services" means the  
3217 services of licensed physicians, optometrists, nurses, nurse  
3218 practitioners, midwives and other related health care professionals  
3219 which are provided on an outpatient basis, including routine well-  
3220 child visits, diagnosis and treatment of illness and injury, laboratory  
3221 tests, diagnostic x-rays, prescription drugs, radiation therapy,  
3222 chemotherapy, hemodialysis, emergency room services, and outpatient  
3223 alcohol and substance abuse services, as defined by the commissioner;

3224 (22) "Qualified entity" means any entity: (A) Eligible for payments

3225 under a state plan approved under Medicaid and which provides  
3226 medical services under the HUSKY Plan, Part A, or (B) that is a  
3227 qualified entity, as defined in 42 USC 1396r-1a, as amended by Section  
3228 708 of Public Law 106-554 and that is determined by the commissioner  
3229 to be capable of making the determination of eligibility. The  
3230 commissioner shall provide qualified entities with such forms as are  
3231 necessary for an application to be made on behalf of a child under the  
3232 HUSKY Plan, Part A and information on how to assist parents,  
3233 guardians and other persons in completing and filing such forms;

3234 (23) "WIC" means the federal Special Supplemental Food Program  
3235 for Women, Infants and Children administered by the Department of  
3236 Public Health pursuant to section 19a-59c.

3237 Sec. 74. Section 19a-533 of the general statutes is amended by adding  
3238 subsection (h) as follows (*Effective from passage*):

3239 (NEW) (h) Notwithstanding the provisions of this section, a nursing  
3240 home may, without regard to the order of its waiting list, admit an  
3241 applicant who seeks to transfer from a nursing home that is closing.

3242 Sec. 75. (NEW) (*Effective from passage*) The Commissioner of Social  
3243 Services, in accordance with federal law, may implement policy to  
3244 simplify program administration and increase payment accuracy in the  
3245 food stamp program, while in the process of adopting such policy as  
3246 regulation, provided notice of such policy is published in the  
3247 Connecticut Law Journal within twenty days of implementation.

3248 Sec. 76. Section 19a-547 of the general statutes is repealed and the  
3249 following is substituted in lieu thereof (*Effective from passage*):

3250 (a) The court may [name] appoint any responsible individual [to act  
3251 as a receiver, except any state employee or the owner, administrator or  
3252 any] whose name is proposed by the Commissioner of Public Health  
3253 and the Commissioner of Social Services to act as a receiver. Such  
3254 individual shall be a nursing home administrator licensed in the state

3255 of Connecticut with substantial experience in operating Connecticut  
3256 nursing homes. On or before July 1, 2004, the Commissioner of Social  
3257 Services shall adopt regulations governing qualifications for proposed  
3258 receivers consistent with this subsection. No state employee or owner,  
3259 administrator or other person with a financial interest in [such] the  
3260 facility may serve as a receiver for that facility. No person appointed to  
3261 act as a receiver shall be permitted to have a current financial interest  
3262 in the facility; nor shall such person appointed as a receiver be  
3263 permitted to have a financial interest in the facility for a period of five  
3264 years from the date the receivership ceases.

3265 (b) The court may remove such receiver in accordance with section  
3266 52-513. A nursing home receiver appointed pursuant to this section  
3267 shall be entitled to a reasonable receiver's fee as determined by the  
3268 court. The receiver shall be liable only in his official capacity for injury  
3269 to person and property by reason of the conditions of the nursing  
3270 home. He shall not be personally liable, except for acts or omissions  
3271 constituting gross, wilful or wanton negligence.

3272 [(b)] (c) The court, in its discretion, may require a bond of such  
3273 receiver in accordance with section 52-506.

3274 [(c)] (d) The court may require the Commissioner of Public Health  
3275 to provide for the payment of any receiver's fees authorized in  
3276 subsection (a) of this section upon a showing by such receiver to the  
3277 satisfaction of the court that (1) the assets of the nursing home facility  
3278 are not sufficient to make such payment, and (2) no other source of  
3279 payment is available, including the submission of claims in a  
3280 bankruptcy proceeding. The state shall have a claim for any court-  
3281 ordered fees and expenses of the receiver which shall have priority  
3282 over all other claims of secured and unsecured creditors and other  
3283 persons whether or not the nursing home facility is in bankruptcy, to  
3284 the extent allowed under state or federal law.

3285 Sec. 77. Section 19a-545 of the general statutes is repealed and the

3286 following is substituted in lieu thereof (*Effective from passage*):

3287 (a) A receiver appointed pursuant to the provisions of sections 19a-  
3288 541 to 19a-549, inclusive, in operating such facility, shall have the same  
3289 powers as a receiver of a corporation under section 52-507, except as  
3290 provided in subsection [(b)] (c) of this section and shall exercise such  
3291 powers to remedy the conditions which constituted grounds for the  
3292 imposition of receivership, assure adequate health care for the patients  
3293 and preserve the assets and property of the owner. If a facility is  
3294 placed in receivership it shall be the duty of the receiver to notify  
3295 patients and family, except where medically contraindicated. Such  
3296 receiver may correct or eliminate any deficiency in the structure or  
3297 furnishings of the facility which endangers the safety or health of the  
3298 residents while they remain in the facility, provided the total cost of  
3299 correction does not exceed three thousand dollars. The court may  
3300 order expenditures for this purpose in excess of three thousand dollars  
3301 on application from such receiver. If any resident is transferred or  
3302 discharged such receiver shall provide for: (1) Transportation of the  
3303 resident and such resident's belongings and medical records to the  
3304 place where such resident is being transferred or discharged; (2) aid in  
3305 locating an alternative placement and discharge planning in  
3306 accordance with section 19a-535; (3) preparation for transfer to  
3307 mitigate transfer trauma, including but not limited to, participation by  
3308 the resident or the resident's guardian in the selection of the resident's  
3309 alternative placement, explanation of alternative placements and  
3310 orientation concerning the placement chosen by the resident or the  
3311 resident's guardian; and (4) custodial care of all property or assets of  
3312 residents which are in the possession of an owner of the facility. The  
3313 receiver shall preserve all property, assets and records of residents  
3314 which the receiver has custody of and shall provide for the prompt  
3315 transfer of the property, assets and records to the alternative placement  
3316 of any transferred resident. In no event may the receiver transfer all  
3317 residents and close a facility without a court order and without  
3318 preparing a discharge plan for each resident in accordance with section

3319 19a-535.

3320 (b) Not later than ninety days after appointment as a receiver, such  
3321 receiver shall: (1) Determine whether the facility can continue to  
3322 operate and provide adequate care to residents in substantial  
3323 compliance with applicable federal and state law within the facility's  
3324 state payments as established by the Commissioner of Social Services  
3325 pursuant to subsection (f) of section 17b-340, as amended by this act,  
3326 together with income from self-pay residents, Medicare payments and  
3327 other current income and shall report such determination to the court;  
3328 and (2) seek facility purchase proposals. If the receiver determines that  
3329 the facility will be unable to continue to operate in compliance with  
3330 said requirements, the receiver shall request an immediate order of the  
3331 court to close the facility and make arrangements for the orderly  
3332 transfer of residents pursuant to subsection (a) of this section; unless  
3333 the receiver determines that a transfer of the facility to a qualified  
3334 purchaser is expected within ninety days. If a transfer is not completed  
3335 within one hundred eighty days of the appointment of the receiver, the  
3336 receiver shall request an immediate order of the court to close the  
3337 facility and make arrangements for the orderly transfer of residents  
3338 pursuant to subsection (a) of this section.

3339 ~~[(b)]~~ (c) The court may limit the powers of a receiver appointed  
3340 pursuant to the provisions of sections 19a-541 to 19a-549, inclusive, to  
3341 those necessary to solve a specific problem.

3342 Sec. 78. Subsection (b) of section 17b-352 of the general statutes is  
3343 repealed and the following is substituted in lieu thereof (*Effective from*  
3344 *passage*):

3345 (b) Any facility which intends to (1) transfer all or part of its  
3346 ownership or control prior to being initially licensed; (2) introduce any  
3347 additional function or service into its program of care or expand an  
3348 existing function or service; or (3) terminate a service or decrease  
3349 substantially its total bed capacity, shall submit a complete request for

3350 permission to implement such transfer, addition, expansion, increase,  
3351 termination or decrease with such information as the department  
3352 requires to the Department of Social Services, provided no permission  
3353 or request for permission to close a facility is required when a facility  
3354 in receivership is closed by order of the Superior Court pursuant to  
3355 section 19a-545, as amended by this act. The Office of the Long-Term  
3356 Care Ombudsman pursuant to section 17b-400 shall be notified by the  
3357 facility of any proposed actions pursuant to this subsection at the same  
3358 time [as] the request for permission is submitted to the department  
3359 and when a facility in receivership is closed by order of the Superior  
3360 Court pursuant to section 19a-545, as amended by this act.

3361 Sec. 79. (NEW) (*Effective from passage*) (a) The Commissioner of  
3362 Social Services shall reimburse pathologists, licensed pursuant to  
3363 chapter 370 of the general statutes, who provide medical services to  
3364 individuals under programs administered by the department, for the  
3365 professional component of their service, with no distinction made as to  
3366 whether such service is provided in a hospital or outpatient setting. In  
3367 no event shall such rate exceed the prevailing rate paid to physicians  
3368 for similar physician services.

3369 (b) For the fiscal years ending June 30, 2004, and June 30, 2005, any  
3370 increase in reimbursement shall not exceed the aggregate sum of one  
3371 hundred fifty thousand dollars for each fiscal year.

3372 Sec. 80. Subsection (a) of section 17b-112 of the general statutes, as  
3373 amended by section 1 of public act 03-28 and section 5 of public act 03-  
3374 268, is repealed and the following is substituted in lieu thereof  
3375 (*Effective from passage*):

3376 (a) The Department of Social Services shall administer a temporary  
3377 family assistance program under which cash assistance shall be  
3378 provided to eligible families in accordance with the temporary  
3379 assistance for needy families program, established pursuant to the  
3380 Personal Responsibility and Work Opportunity Reconciliation Act of

3381 1996. Under the temporary family assistance program, benefits shall be  
3382 provided to a family for not longer than twenty-one months, except as  
3383 provided in subsections (b) and (c) of this section. For the purpose of  
3384 calculating said twenty-one-month time limit, months of assistance  
3385 received on and after January 1, 1996, pursuant to time limits under  
3386 the aid to families with dependent children program, shall be  
3387 included. For purposes of this section, "family" means one or more  
3388 individuals who apply for or receive assistance together under the  
3389 temporary family assistance program. If the commissioner determines  
3390 that federal law allows individuals not otherwise in an eligible covered  
3391 group for the temporary family assistance program to become covered,  
3392 such family may also, at the discretion of the commissioner, be  
3393 composed of (1) a pregnant woman, or (2) a parent, both parents or  
3394 other caretaker relative and at least one child who is under the age of  
3395 eighteen, or who is under the age of nineteen and a full-time student in  
3396 a secondary school or its equivalent. A caretaker relative shall be  
3397 related to the child or children by blood, marriage or adoption or shall  
3398 be the legal guardian of such a child or pursuing legal proceedings  
3399 necessary to achieve guardianship. If the commissioner elects to allow  
3400 state eligibility consistent with any change in federal law, the  
3401 commissioner may administratively transfer any qualifying family  
3402 cases under the cash assistance portion of the State Administered  
3403 General Assistance Program to the temporary family assistance  
3404 program without regard to usual eligibility and enrollment  
3405 procedures. If such families become ineligible coverage group under  
3406 the federal law, the commissioner shall administratively transfer such  
3407 families back to the cash assistance portion of the State Administered  
3408 General Assistance Program without regard to usual eligibility and  
3409 enrollment procedures to the degree that such families are eligible for  
3410 the state program.

3411 Sec. 81. Subsection (a) of section 17b-244 of the general statutes is  
3412 repealed and the following is substituted in lieu thereof (*Effective from*  
3413 *passage*):

3414 (a) The room and board component of the rates to be paid by the  
3415 state to private facilities and facilities operated by regional education  
3416 service centers which are licensed to provide residential care pursuant  
3417 to section 17a-227, but not certified to participate in the Title XIX  
3418 Medicaid program as intermediate care facilities for persons with  
3419 mental retardation, shall be determined annually by the Commissioner  
3420 of Social Services, except that rates effective April 30, 1989, shall  
3421 remain in effect through October 31, 1989. Any facility with real  
3422 property other than land placed in service prior to July 1, 1991, shall,  
3423 for the fiscal year ending June 30, 1995, receive a rate of return on real  
3424 property equal to the average of the rates of return applied to real  
3425 property other than land placed in service for the five years preceding  
3426 July 1, 1993. For the fiscal year ending June 30, 1996, and any  
3427 succeeding fiscal year, the rate of return on real property for property  
3428 items shall be revised every five years. The commissioner shall, upon  
3429 submission of a request by such facility, allow actual debt service,  
3430 comprised of principal and interest, on the loan or loans in lieu of  
3431 property costs allowed pursuant to section 17-313b-5 of the regulations  
3432 of Connecticut state agencies, whether actual debt service is higher or  
3433 lower than such allowed property costs, provided such debt service  
3434 terms and amounts are reasonable in relation to the useful life and the  
3435 base value of the property. In the case of facilities financed through the  
3436 Connecticut Housing Finance Authority, the commissioner shall allow  
3437 actual debt service, comprised of principal, interest and a reasonable  
3438 repair and replacement reserve on the loan or loans in lieu of property  
3439 costs allowed pursuant to section 17-313b-5 of the regulations of  
3440 Connecticut state agencies, whether actual debt service is higher or  
3441 lower than such allowed property costs, provided such debt service  
3442 terms and amounts are determined by the commissioner at the time  
3443 the loan is entered into to be reasonable in relation to the useful life  
3444 and base value of the property. The commissioner may allow fees  
3445 associated with mortgage refinancing provided such refinancing will  
3446 result in state reimbursement savings, after comparing costs over the  
3447 terms of the existing proposed loans. For the fiscal year ending June 30,

3448 1992, the inflation factor used to determine rates shall be one-half of  
3449 the gross national product percentage increase for the period between  
3450 the midpoint of the cost year through the midpoint of the rate year. For  
3451 fiscal year ending June 30, 1993, the inflation factor used to determine  
3452 rates shall be two-thirds of the gross national product percentage  
3453 increase from the midpoint of the cost year to the midpoint of the rate  
3454 year. For the fiscal years ending June 30, 1996, and June 30, 1997, no  
3455 inflation factor shall be applied in determining rates. The  
3456 Commissioner of Social Services shall prescribe uniform forms on  
3457 which such facilities shall report their costs. Such rates shall be  
3458 determined on the basis of a reasonable payment for necessary  
3459 services. Any increase in grants, gifts, fund-raising or endowment  
3460 income used for the payment of operating costs by a private facility in  
3461 the fiscal year ending June 30, 1992, shall be excluded by the  
3462 commissioner from the income of the facility in determining the rates  
3463 to be paid to the facility for the fiscal year ending June 30, 1993,  
3464 provided any operating costs funded by such increase shall not  
3465 obligate the state to increase expenditures in subsequent fiscal years.  
3466 Nothing contained in this section shall authorize a payment by the  
3467 state to any such facility in excess of the charges made by the facility  
3468 for comparable services to the general public. The service component  
3469 of the rates to be paid by the state to private facilities and facilities  
3470 operated by regional education service centers which are licensed to  
3471 provide residential care pursuant to section 17a-227, but not certified  
3472 to participate in the Title XIX Medicaid programs as intermediate care  
3473 facilities for persons with mental retardation, shall be determined  
3474 annually by the Commissioner of Mental Retardation.

3475 Sec. 82. (NEW) (*Effective from passage*) A pharmacist, when filling a  
3476 prescription under the Medicaid, ConnPACE, Connecticut AIDS drug  
3477 assistance or the State Administered General Assistance programs,  
3478 shall fill such prescription utilizing the most cost-efficient dosage,  
3479 consistent with the prescription of a prescribing practitioner as defined  
3480 in section 20-571 of the general statutes, unless such pharmacist

3481 receives permission to do otherwise pursuant to the prior  
3482 authorization requirements set forth in sections 17b-274, as amended,  
3483 and 17b-491a of the general statutes.

3484 Sec. 83. Section 17b-274d of the general statutes, as amended by  
3485 section 19 of public act 03-2 and section 63 of public act 03-278, is  
3486 repealed and the following is substituted in lieu thereof (*Effective from*  
3487 *passage*):

3488 (a) Pursuant to 42 USC 1396r-8, there is established a Medicaid  
3489 Pharmaceutical and Therapeutics Committee within the Department of  
3490 Social Services. Said committee shall convene on or before March 31,  
3491 2003.

3492 (b) The Medicaid Pharmaceutical and Therapeutics Committee shall  
3493 be comprised as specified in 42 USC 1396r-8 and shall consist of  
3494 ~~[eleven]~~ fourteen members appointed by the Governor. Five members  
3495 shall be physicians licensed pursuant to chapter 370, ~~[five]~~ including  
3496 one general practitioner, one pediatrician, one geriatrician, one  
3497 psychiatrist and one specialist in family planning, four members shall  
3498 be pharmacists licensed pursuant to chapter 400j, two members shall  
3499 be visiting nurses, one specializing in adult care and one specializing  
3500 in psychiatric care, one member shall be a clinician designated by the  
3501 Commissioner of Mental Health and Addiction Services, one member  
3502 shall be a representative of pharmaceutical manufacturers and one  
3503 member shall be a consumer representative. The committee may, on an  
3504 ad hoc basis, seek the participation of other state agencies or other  
3505 interested parties in its deliberations. The members shall serve for  
3506 terms of two years from the date of their appointment. Members may  
3507 be appointed to more than one term. The Commissioner of Social  
3508 Services, or the commissioner's designee, shall convene the committee  
3509 following the Governor's designation of appointments. The  
3510 administrative staff of the Department of Social Services shall serve as  
3511 staff for said committee and assist with all ministerial duties. The  
3512 Governor shall ensure that the committee membership includes

3513 Medicaid participating physicians and pharmacists, with experience  
3514 serving all segments of the Medicaid population. [Not less than one of  
3515 the committee members shall be a representative of the pharmaceutical  
3516 manufacturers.]

3517 (c) Committee members shall select a chairperson and vice-  
3518 chairperson from the committee membership on an annual basis.

3519 (d) The committee shall meet at least quarterly, and may meet at  
3520 other times at the discretion of the chairperson and committee  
3521 membership. The committee shall comply with all regulations adopted  
3522 by the department, including notice of any meeting of the committee,  
3523 pursuant to the requirements of chapter 54.

3524 (e) On or before July 1, 2003, the Department of Social Services, in  
3525 consultation with the Medicaid and Pharmaceutical Therapeutics  
3526 Committee, shall adopt a preferred drug list for use in the Medicaid  
3527 and ConnPACE programs. To the extent feasible, the department shall  
3528 review all drugs included in the preferred drug list at least every  
3529 twelve months, and may recommend additions to, and deletions from,  
3530 the preferred drug list, to ensure that the preferred drug list provides  
3531 for medically appropriate drug therapies for Medicaid and ConnPACE  
3532 patients. For the fiscal year ending June 30, 2004, such drug list shall be  
3533 limited to three classes of drugs, including proton pump inhibitors and  
3534 two other classes of drugs determined by the Commissioner of Social  
3535 Services. The commissioner shall notify the joint standing committees  
3536 of the General Assembly having cognizance of matters relating to  
3537 human services and appropriation of the classes of drugs on the list by  
3538 January 1, 2004.

3539 (f) Except for mental-health-related drugs and antiretroviral drugs,  
3540 reimbursement for a drug not included in the preferred drug list is  
3541 subject to prior authorization.

3542 (g) The Department of Social Services shall publish and disseminate  
3543 the preferred drug list to all Medicaid providers in the state.

3544 (h) The committee shall ensure that the pharmaceutical  
3545 manufacturers agreeing to provide a supplemental rebate pursuant to  
3546 42 USC 1396r-8(c) have an opportunity to present evidence supporting  
3547 inclusion of a product on the preferred drug list unless a court of  
3548 competent jurisdiction, in a final decision, determines that the  
3549 Secretary of Health and Human Services does not have authority to  
3550 allow such supplemental rebates, provided the inability to utilize  
3551 supplemental rebates pursuant to this subsection shall not impair the  
3552 committee's authority to maintain a preferred drug list. Upon timely  
3553 notice, the department shall ensure that any drug that has been  
3554 approved or had any of its particular uses approved by the United  
3555 States Food and Drug Administration under a priority review  
3556 classification, will be reviewed by the Medicaid Pharmaceutical and  
3557 Therapeutics Committee at the next regularly scheduled meeting. To  
3558 the extent feasible, upon notice by a pharmaceutical manufacturer, the  
3559 department shall also schedule a product review for any new product  
3560 at the next regularly scheduled meeting of the Medicaid  
3561 Pharmaceutical and Therapeutics Committee.

3562 (i) Factors considered by the department and the Medicaid  
3563 Pharmaceutical and Therapeutics Committee in developing the  
3564 preferred drug list shall include, but not be limited to, clinical efficacy,  
3565 safety and cost effectiveness of a product.

3566 (j) The Medicaid Pharmaceutical and Therapeutics Committee may  
3567 also make recommendations to the department regarding the prior  
3568 authorization of any prescribed drug covered by Medicaid in  
3569 accordance with the plan developed and implemented pursuant to  
3570 section 17b-491a.

3571 (k) Medicaid recipients may appeal any department preferred drug  
3572 list determinations utilizing the Medicaid fair hearing process  
3573 administered by the Department of Social Services established  
3574 pursuant to chapter 54.

3575        (l) The provisions of this section shall apply to the State  
3576        Administered General Assistance program.

3577        Sec. 84. Subsection (c) of section 17b-274 of the general statutes, as  
3578        amended by section 52 of public act 03-2, is repealed and the following  
3579        is substituted in lieu thereof (*Effective from passage*):

3580        (c) The Commissioner of Social Services shall implement a  
3581        procedure by which a pharmacist shall obtain approval from an  
3582        independent pharmacy consultant acting on behalf of the Department  
3583        of Social Services, under an administrative services only contract,  
3584        whenever the pharmacist dispenses a brand name drug product to a  
3585        Medicaid, state-administered general assistance, general assistance or  
3586        ConnPACE recipient and a chemically equivalent generic drug  
3587        product substitution is available, [at a lower cost,] provided such  
3588        procedure shall not require approval for other than initial  
3589        prescriptions for such drug product. In cases where the brand name  
3590        drug is less costly than the chemically equivalent generic drug when  
3591        factoring in manufacturers' rebates, the pharmacist shall dispense the  
3592        brand name drug. If such approval is not granted or denied within two  
3593        hours of receipt by the commissioner of the request for approval, it  
3594        shall be deemed granted. Notwithstanding any provision of this  
3595        section, a pharmacist shall not dispense any initial maintenance drug  
3596        prescription for which there is a chemically equivalent generic  
3597        substitution that is for less than fifteen days without the department's  
3598        granting of prior authorization, provided prior authorization shall not  
3599        otherwise be required for atypical antipsychotic drugs if the individual  
3600        is currently taking such drug at the time the pharmacist receives the  
3601        prescription. The pharmacist may appeal a denial of reimbursement to  
3602        the department based on the failure of such pharmacist to substitute a  
3603        generic drug product in accordance with this section.

3604        Sec. 85. (NEW) (*Effective from passage*) The Commissioner of Social  
3605        Services shall, consistent with federal law, make changes to the cost-  
3606        based reimbursement methodology in the Medicaid program for

3607 federally qualified health centers. On or before March 1, 2004, the  
3608 commissioner shall report to the joint standing committees of the  
3609 General Assembly having cognizance of matters relating to  
3610 appropriations and the budgets of state agencies and human services  
3611 on the status of the changes to the cost-based reimbursement  
3612 methodology.

3613 Sec. 86. Section 17b-349 of the general statutes is amended by  
3614 adding subsections (h) and (i) as follows (*Effective from passage*):

3615 (NEW) (h) For the fiscal year ending June 30, 2004, and, any grant  
3616 awards made to a community health center or its successor for the  
3617 purpose of supporting the community health center infrastructure  
3618 services to the uninsured or expansion initiative projects shall be in the  
3619 same proportion to its grant award made in the fiscal year ending June  
3620 30, 2003, as the total appropriation for such grant awards for the fiscal  
3621 year ending June 30, 2004, is to the total appropriation for such grant  
3622 awards for the prior fiscal year, provided, if any portion of the amount  
3623 is not required by a given community health center, the differential  
3624 shall be distributed among all the other health centers according to  
3625 their share of total funding.

3626 (NEW) (i) For the fiscal year ending June 30, 2005, and, any grant  
3627 awards made to a community health center or its successor for the  
3628 purpose of supporting the community health center infrastructure  
3629 services to the uninsured or expansion initiative projects shall be in the  
3630 same proportion to its grant award made in the fiscal year ending June  
3631 30, 2004, as the total appropriation for such grant awards for the fiscal  
3632 year ending June 30, 2005, is to the total appropriation for such grant  
3633 awards for the prior fiscal year, provided, if any portion of the amount  
3634 is not required by a given community health center, the differential  
3635 shall be distributed among all the other health centers according to  
3636 their share of total funding.

3637 Sec. 87. (*Effective from passage*) On or before July 1, 2004, the

3638 Department of Social Services shall, within the limits of available  
3639 Medicaid funding, implement a pilot project in Greater Hartford with  
3640 a chronic disease hospital colocated with a skilled nursing facility and  
3641 with the facilities, medical staff and all necessary personnel for the  
3642 diagnosis, care and treatment of chronic or geriatric mental conditions  
3643 that require prolonged hospital or restorative care. For purposes of this  
3644 section, "chronic disease hospital" means a long-term hospital with  
3645 facilities, medical staff and all necessary personnel for the diagnosis,  
3646 care and treatment of chronic physical and geriatric mental health  
3647 conditions that require prolonged hospital or restorative care.

3648 Sec. 88. (NEW) (*Effective from passage*) Notwithstanding any  
3649 provision of the general statutes and the regulations of Connecticut  
3650 state agencies, the Commissioner of Social Services may reimburse the  
3651 Department of Mental Health and Addiction Services for targeted case  
3652 management services that it provides to its target population, which,  
3653 for purposes of this section, shall include individuals with severe and  
3654 persistent psychiatric illness and individuals with persistent substance  
3655 dependence.

3656 Sec. 89. (*Effective from passage*) For the fiscal year ending June 30,  
3657 2005, the Secretary of the Office of Policy and Management is  
3658 authorized to transfer funds from the private provider account of the  
3659 Office of Policy and Management to state agencies to effectuate the rate  
3660 increase for private providers.

3661 Sec. 90. Subsection (a) of section 19a-639a of the general statutes is  
3662 repealed and the following is substituted in lieu thereof (*Effective from*  
3663 *passage*):

3664 (a) Except as required in subsection (b) of this section, the provisions  
3665 of section 19a-638, as amended, and subsection (a) of section 19a-639  
3666 shall not apply to: (1) An outpatient clinic or program operated  
3667 exclusively by, or contracted to be operated exclusively for, a  
3668 municipality or municipal agency, a health district, as defined in

3669 section 19a-240, or a board of education; (2) a residential facility for the  
3670 mentally retarded licensed pursuant to section 17a-227 and certified to  
3671 participate in the Title XIX Medicaid program as an intermediate care  
3672 facility for the mentally retarded; (3) an outpatient rehabilitation  
3673 service agency that was in operation on January 1, 1998, that is  
3674 operated exclusively on an outpatient basis and that is eligible to  
3675 receive reimbursement under section 17b-243; (4) a clinical laboratory;  
3676 (5) an assisted living services agency; (6) an outpatient service offering  
3677 chronic dialysis; (7) a program of ambulatory services established and  
3678 conducted by a health maintenance organization; (8) a home health  
3679 agency; (9) a clinic operated by the Americares Foundation; (10) a  
3680 nursing home; [(11) a residential care home; or (12)] or (11) a rest  
3681 home. However, the exemptions provided in this section shall not  
3682 apply when a nursing home [, residential care home] or rest home is,  
3683 or will be created, acquired, operated or in any other way related to or  
3684 affiliated with, or under the complete or partial ownership or control  
3685 of a facility or institution or affiliate subject to the provisions of section  
3686 19a-638, as amended, or subsection (a) of section 19a-639.

3687       Sec. 91. (*Effective from passage*) The Commissioner of Mental  
3688 Retardation, in conjunction with the Commissioner of Social Services,  
3689 shall, within available appropriations, prepare a plan to establish and  
3690 operate a pilot program to provide residential accommodations with  
3691 assisted living services to individuals on the Department of Mental  
3692 Retardation's waiting list for residential placement or support. Such  
3693 plan shall describe the necessary elements of such a pilot program,  
3694 including, but not limited to, coordination of staffing issues and  
3695 applications for federal Department of Health and Human Services  
3696 Demonstration Grants, and any necessary Medicaid waivers. Not later  
3697 than January 1, 2004, the Commissioner of Mental Retardation shall  
3698 submit a report containing such plan, in accordance with section 11-4a  
3699 of the general statutes, to the joint standing committees of the General  
3700 Assembly having cognizance of matters relating to public health and  
3701 human services.

3702 Sec. 92. Section 29-315 of the general statutes is repealed and the  
3703 following is substituted in lieu thereof (*Effective from passage*):

3704 (a) (1) When any building is to be built having more than four  
3705 stories and is to be used for human occupancy, such building shall  
3706 have an automatic fire extinguishing system approved by the State Fire  
3707 Marshal on each floor.

3708 (2) When any building is (A) to be built as an educational  
3709 occupancy, (B) eligible for a school building project grant pursuant to  
3710 chapter 173, and (C) put out to bid on or after July 1, 2004, such  
3711 building shall have an automatic fire extinguishing system approved  
3712 by the State Fire Marshal on each floor. "Educational occupancy" shall  
3713 have the same meaning as in the Fire Safety Code.

3714 (b) Each hotel or motel having six or more guest rooms and  
3715 providing sleeping accommodations for more than sixteen persons for  
3716 which a building permit for new occupancy is issued on or after  
3717 January 1, 1987, shall have an automatic fire extinguishing system  
3718 installed on each floor in accordance with regulations adopted by the  
3719 Commissioner of Public Safety.

3720 (c) Not later than October 1, 1992, each hotel or motel having more  
3721 than four stories shall have an automatic fire extinguishing system  
3722 approved by the State Fire Marshal on each floor.

3723 (d) (1) Not later than January 1, 1995, each residential building  
3724 having more than four stories and occupied primarily by elderly  
3725 persons shall have an automatic fire extinguishing system approved by  
3726 the State Fire Marshal on each floor. Not later than January 1, 1994, the  
3727 owner or manager of or agency responsible for such residential  
3728 building shall submit plans for the installation of such system, signed  
3729 and sealed by a licensed professional engineer, to the local fire marshal  
3730 within whose jurisdiction such building is located or to the State Fire  
3731 Marshal, as the case may be. For the purposes of this subsection, the  
3732 phrase "occupied primarily by elderly persons" means that on October

3733 1, 1993, or on the date of any inspection, if later, a minimum of eighty  
3734 per cent of the dwelling units available for human occupancy in a  
3735 residential building have at least one resident who has attained the age  
3736 of sixty-five years.

3737 (2) Each residential building having more than twelve living units  
3738 and occupied primarily by elderly persons, as defined in subdivision  
3739 (1) of this subsection, or designed to be so occupied, for which a  
3740 building permit for new occupancy is issued or which is substantially  
3741 renovated on or after January 1, 1997, shall have an automatic fire  
3742 extinguishing system approved by the State Fire Marshal on each floor.

3743 (e) No building inspector shall grant a building permit unless a fire  
3744 extinguishing system as required by subsection (a) or (b) of this section  
3745 is included in the final, approved building plans and no fire marshal or  
3746 building inspector shall permit occupancy of such a building unless  
3747 such fire extinguishing system is installed and operable. The State Fire  
3748 Marshal may require fire extinguishing systems approved by him to be  
3749 installed in other occupancies where they are required in the interest of  
3750 safety because of special occupancy hazards.

3751 (f) Not later than July 1, 2005, each chronic and convalescent nursing  
3752 home or rest home with nursing supervision licensed pursuant to  
3753 chapter 368v shall have an automatic fire extinguishing system  
3754 approved by the State Fire Marshal on each floor. Not later than July 1,  
3755 2004, the owner or authorized agent of each such home shall submit  
3756 plans for the installation of such system, signed and sealed by a  
3757 licensed professional engineer, to the local fire marshal and building  
3758 official within whose jurisdiction such home is located or to the State  
3759 Fire Marshal, as the case may be, and shall apply for a building permit  
3760 for the installation of such system.

3761 (g) Any person who fails to install an automatic fire extinguishing  
3762 system in violation of any provision of this section shall be subject to a  
3763 civil penalty of not more than one thousand dollars for each day such

3764 violation continues. The Attorney General, upon request of the State  
3765 Fire Marshal, shall institute a civil action to recover such penalty.

3766 Sec. 93. Section 20-417d of the general statutes is repealed and the  
3767 following is substituted in lieu thereof (*Effective October 1, 2003*):

3768 (a) A new home construction contractor shall (1) prior to entering  
3769 into a contract with a consumer for new home construction, provide to  
3770 the consumer a copy of the new home construction contractor's  
3771 certificate of registration and a written notice that (A) discloses that the  
3772 certificate of registration does not represent in any manner that such  
3773 contractor's registration constitutes an endorsement of the quality of  
3774 such person's work or of such contractor's competency by the  
3775 commissioner, (B) advises the consumer to contact the Department of  
3776 Consumer Protection to determine (i) if such contractor is registered in  
3777 this state as a new home construction contractor, (ii) if any complaints  
3778 have been filed against such contractor, and (iii) the disposition of any  
3779 such complaints, and (C) advises the consumer to request from such  
3780 contractor a list of consumers of the last twelve new homes  
3781 constructed to completion by the contractor during the previous  
3782 twenty-four months, or if the contractor has not constructed at least  
3783 twelve new homes to completion during the previous twenty-four  
3784 months, then a list of all consumers for whom the contractor has  
3785 constructed a new home to completion during the previous twenty-  
3786 four months, and to contact several individuals on the list to discuss  
3787 the quality of such contractor's new home construction work, (2) state  
3788 in any advertisement, including any advertisement in a telephone  
3789 directory, the fact that such contractor is registered, and (3) include  
3790 such contractor's registration number in any such advertisement. The  
3791 new home construction contractor, or his agent, shall also discuss with  
3792 the consumer the installation of an automatic fire extinguishing system  
3793 in a new home.

3794 (b) A new home construction contractor shall include in every  
3795 contract with a consumer a provision advising the consumer that the

3796 consumer may be contacted by such contractor's prospective  
3797 consumers concerning the quality and timeliness of such contractor's  
3798 new home construction work, unless the consumer advises such  
3799 contractor, in writing, at the time the contract is executed, that the  
3800 consumer prefers not to be contacted.

3801 (c) The written notice required in subsection (a) of this section shall  
3802 be in capital letters not less than ten-point bold face type, and may  
3803 include a statement in substantially the following form:

3804 "NEW HOME CONSTRUCTION CONTRACTOR

3805 REGISTRATION NOTICE

3806 A CERTIFICATE OF REGISTRATION AS A NEW HOME  
3807 CONSTRUCTION CONTRACTOR DOES NOT REPRESENT IN ANY  
3808 MANNER THAT THE CONNECTICUT DEPARTMENT OF  
3809 CONSUMER PROTECTION ENDORSES THE QUALITY OF THE  
3810 CONTRACTOR'S NEW HOME CONSTRUCTION WORK OR THE  
3811 CONTRACTOR'S COMPETENCY TO ENGAGE IN NEW HOME  
3812 CONSTRUCTION.

3813 ACCORDINGLY, YOU ARE ADVISED TO:

3814 (1) REQUEST FROM THE CONTRACTOR A LIST OF  
3815 CONSUMERS OF THE LAST TWELVE NEW HOMES  
3816 CONSTRUCTED TO COMPLETION BY THE CONTRACTOR  
3817 DURING THE PREVIOUS TWENTY-FOUR MONTHS, OR IF THE  
3818 CONTRACTOR HAS NOT CONSTRUCTED AT LEAST TWELVE  
3819 NEW HOMES TO COMPLETION DURING THE PREVIOUS  
3820 TWENTY-FOUR MONTHS, THEN A LIST OF ALL CONSUMERS  
3821 FOR WHOM THE CONTRACTOR HAS CONSTRUCTED A NEW  
3822 HOME TO COMPLETION DURING THE PREVIOUS TWENTY-  
3823 FOUR MONTHS,

3824 (2) CONTACT SEVERAL INDIVIDUALS ON THE LIST TO

3825 DISCUSS THE QUALITY AND THE TIMELINESS OF THE  
3826 CONTRACTOR'S NEW HOME CONSTRUCTION WORK, AND

3827 (3) CONTACT THE DEPARTMENT OF CONSUMER  
3828 PROTECTION TO VERIFY THE REGISTRATION INFORMATION  
3829 PRESENTED BY THE CONTRACTOR AND TO ASCERTAIN THE  
3830 CONTRACTOR'S COMPLAINT HISTORY WITH THE  
3831 DEPARTMENT.

3832 IN ADDITION, YOU ARE ADVISED TO DISCUSS WITH THE  
3833 NEW HOME CONSTRUCTION CONTRACTOR:

3834 (1) WHETHER THE CONTRACTOR HAS A CUSTOMER SERVICE  
3835 POLICY AND IF SO, THE IDENTITY OF THE PERSON  
3836 DESIGNATED TO ASSIST YOU IN RESOLVING ANY COMPLAINT  
3837 ABOUT THE CONTRACTOR'S WORK, [AND]

3838 (2) WHETHER THE CONTRACTOR WILL HOLD YOU  
3839 HARMLESS FOR WORK PERFORMED BY ANY SUBCONTRACTOR  
3840 HIRED BY THE CONTRACTOR, AND

3841 (3) THE INSTALLATION OF AN AUTOMATIC FIRE  
3842 EXTINGUISHING SYSTEM.

3843 THIS NOTICE DOES NOT CONTAIN AN EXHAUSTIVE LIST OF  
3844 THE INQUIRIES YOU SHOULD MAKE BEFORE CONTRACTING  
3845 WITH A NEW HOME CONSTRUCTION CONTRACTOR.  
3846 ADDITIONAL INFORMATION TO ASSIST YOU IN YOUR  
3847 SELECTION OF A NEW HOME CONSTRUCTION CONTRACTOR  
3848 MAY BE OBTAINED BY CONTACTING THE CONNECTICUT  
3849 DEPARTMENT OF CONSUMER PROTECTION."

3850 (d) No person shall: (1) Present, or attempt to present as such  
3851 person's own, the certificate of another; (2) knowingly give false  
3852 evidence of a material nature to the commissioner for the purpose of  
3853 procuring a certificate; (3) represent such person falsely as, or

3854 impersonate, a registered new home construction contractor; (4) use or  
3855 attempt to use a certificate which has expired or which has been  
3856 suspended or revoked; (5) engage in the business of a new home  
3857 construction contractor or hold himself or herself out as a new home  
3858 construction contractor without having a current certificate of  
3859 registration under sections 20-417a to 20-417i, inclusive, as amended,  
3860 and subsection (b) of section 20-421, as amended; (6) represent in any  
3861 manner that such person's registration constitutes an endorsement of  
3862 the quality of such person's work or of such person's competency by  
3863 the commissioner; or (7) fail to refund a deposit paid to a new home  
3864 construction contractor not later than ten days after a written request  
3865 mailed or delivered to the new home construction contractor's last  
3866 known address, if (A) the consumer has complied with the terms of the  
3867 written contract up to the time of the request, (B) no substantial  
3868 portion of the contracted work has been performed at the time of the  
3869 request, (C) more than thirty days has elapsed since the starting date  
3870 specified in the written contract or more than thirty days has elapsed  
3871 since the date of the contract if such contract does not specify a starting  
3872 date, and (D) the new home construction contractor has failed to  
3873 provide a reasonable explanation to the consumer concerning such  
3874 contractor's failure to perform a substantial portion of the contracted  
3875 work. For purposes of this subdivision, "substantial portion of the  
3876 contracted work" includes, but is not limited to, work performed by  
3877 the new home construction contractor to (i) secure permits and  
3878 approvals, (ii) redraft plans or obtain engineer, architect, surveyor or  
3879 other approvals for changes requested by the consumer or made  
3880 necessary by site conditions discovered after the contract is executed,  
3881 (iii) schedule site work or arrange for other contractors to perform  
3882 services related to the construction of the consumer's new home, and  
3883 (iv) do any other work referred to in the contract as a "substantial  
3884 portion of the contracted work.

3885       Sec. 94. (*Effective from passage*) Section 16 of public act 03-171 shall  
3886 take effect January 1, 2004.

3887        Sec. 95. (*Effective from passage and applicable as of July 1, 2003*) Section  
 3888 14-121 of the general statutes is repealed.

3889        Sec. 96. (*Effective from passage*) Sections 17b-259a, 17b-293 and 17b-  
 3890 362a of the general statutes are repealed.

3891        Sec. 97. (*Effective March 1, 2004*) (a) Sections 17b-19, 17b-62 to 17b-65,  
 3892 inclusive, 17b-111a, 17b-116 to 17b-117, inclusive, 17b-120, 17b-121,  
 3893 17b-123, 17b-134, 17b-135, 17b-220, 17b-259 and 17b-287 of the general  
 3894 statutes are repealed.

3895        (b) In codifying the provisions of this act, the Legislative  
 3896 Commissioners shall delete the references to sections 17b-19, 17b-62 to  
 3897 17b-65, inclusive, 17b-111a, 17b-116 to 17b-117, inclusive, 17b-120, 17b-  
 3898 121, 17b-123, 17b-134, 17b-135, 17b-220, 17b-259 and 17b-287 that  
 3899 appear in the following sections of the general statutes: 7-406, 8-358,  
 3900 10a-194a, 17a-453a, 17a-600, 17b-13, 17b-78, 17b-117, 17b-118, 17b-124,  
 3901 17b-126 to 17b-129, inclusive, 17b-221, 17b-250, 17b-256d, 18-87, 19a-  
 3902 255, 19a-539, 31-3d, 36a-42, 51-344a, 52-57, as amended by section 116  
 3903 of public act 03-19, and 54-56d.

This act shall take effect as follows:	
Section 1	<i>from passage</i>
Sec. 2	<i>from passage</i>
Sec. 3	<i>from passage</i>
Sec. 4	<i>from passage</i>
Sec. 5	<i>from passage</i>
Sec. 6	<i>from passage</i>
Sec. 7	<i>from passage</i>
Sec. 8	<i>from passage</i>
Sec. 9	<i>from passage</i>
Sec. 10	<i>from passage</i>
Sec. 11	<i>from passage</i>
Sec. 12	<i>from passage</i>
Sec. 13	<i>from passage</i>
Sec. 14	<i>from passage</i>
Sec. 15	<i>from passage</i>

Sec. 16	<i>from passage</i>
Sec. 17	<i>from passage</i>
Sec. 18	<i>January 1, 2004</i>
Sec. 19	<i>January 1, 2004</i>
Sec. 20	<i>January 1, 2004</i>
Sec. 21	<i>January 1, 2004</i>
Sec. 22	<i>January 1, 2004</i>
Sec. 23	<i>January 1, 2004</i>
Sec. 24	<i>January 1, 2004</i>
Sec. 25	<i>January 1, 2004</i>
Sec. 26	<i>January 1, 2004</i>
Sec. 27	<i>January 1, 2004</i>
Sec. 28	<i>January 1, 2004</i>
Sec. 29	<i>from passage</i>
Sec. 30	<i>from passage</i>
Sec. 31	<i>from passage</i>
Sec. 32	<i>from passage</i>
Sec. 33	<i>October 1, 2003</i>
Sec. 34	<i>from passage and applicable as of July 1, 2003</i>
Sec. 35	<i>from passage</i>
Sec. 36	<i>from passage</i>
Sec. 37	<i>from passage</i>
Sec. 38	<i>from passage</i>
Sec. 39	<i>from passage</i>
Sec. 40	<i>from passage</i>
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Sec. 51	<i>from passage</i>
Sec. 52	<i>from passage</i>
Sec. 53	<i>from passage</i>
Sec. 54	<i>from passage</i>

Sec. 55	October 1, 2003
Sec. 56	<i>from passage</i>
Sec. 57	<i>from passage</i>
Sec. 58	October 1, 2003
Sec. 59	<i>from passage</i>
Sec. 60	<i>from passage</i>
Sec. 61	<i>from passage</i>
Sec. 62	<i>from passage</i>
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Sec. 68	<i>from passage</i>
Sec. 69	<i>from passage</i>
Sec. 70	<i>from passage</i>
Sec. 71	<i>from passage</i>
Sec. 72	October 1, 2003
Sec. 73	<i>from passage</i>
Sec. 74	<i>from passage</i>
Sec. 75	<i>from passage</i>
Sec. 76	<i>from passage</i>
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Sec. 88	<i>from passage</i>
Sec. 89	<i>from passage</i>
Sec. 90	<i>from passage</i>
Sec. 91	<i>from passage</i>
Sec. 92	<i>from passage</i>
Sec. 93	October 1, 2003

Sec. 94	<i>from passage</i>
Sec. 95	<i>from passage and applicable as of July 1, 2003</i>
Sec. 96	<i>from passage</i>
Sec. 97	<i>March 1, 2004</i>