



General Assembly

February Session, 2004

Bill No. 5040

LCO No. 388

*00388 _____ *

Referred to Committee on Human Services

Introduced by:

REP. WARD, 86th Dist.

SEN. DELUCA, 32nd Dist.

AN ACT CONCERNING NECESSARY REVISIONS TO HUMAN SERVICES STATUTES.

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

1 Section 1. Subdivision (3) of subsection (a) of section 10-76d of the
2 general statutes, as amended by section 54 of public act 03-3 of the June
3 30 special session, is repealed and the following is substituted in lieu
4 thereof (*Effective from passage*):

5 (3) Beginning with the fiscal year ending June 30, 2004, the
6 Commissioner of Social Services shall make grant payments to local or
7 regional boards of education in amounts representing fifty per cent of
8 the federal portion of Medicaid claims processed for Medicaid eligible
9 special education and related services provided to Medicaid eligible
10 students in the school district based on the rate of federal financial
11 participation in effect on January 1, 2003. Such grant payments shall be
12 made on at least a quarterly basis and may represent estimates of
13 amounts due to local or regional boards of education. Any grant
14 payments made on an estimated basis, including payments made by

15 the Department of Education for the fiscal years prior to the fiscal year
16 ending June 30, 2000, shall be subsequently reconciled to grant
17 amounts due based upon filed and accepted Medicaid claims and
18 Medicaid rates. If, upon review, it is determined that a grant payment
19 or portion of a grant payment was made for ineligible or disallowed
20 Medicaid claims, the local or regional board of education shall
21 reimburse the Department of Social Services for any grant payment
22 amount received based upon ineligible or disallowed Medicaid claims.

23 Sec. 2. Section 69 of public act 03-3 of the June 30 special session is
24 repealed and the following is substituted in lieu thereof (*Effective from*
25 *passage*):

26 (a) Not later than September 30, 2003, the Commissioner of Social
27 Services shall submit an amendment to the Medicaid state plan to
28 allow pharmacies the ability to deny filling Medicaid prescriptions for
29 program beneficiaries who demonstrate a documented and continuous
30 failure to make required copayments, notwithstanding having the
31 financial ability to make such required copayments. Such amendment
32 to the Medicaid state plan shall provide that any person denied
33 prescription drugs pursuant to this section shall, upon payment of all
34 outstanding copayments, be eligible for the filling of prescriptions
35 under the Medicaid program. Such amendment to the Medicaid state
36 plan shall not apply to prescriptions for psychotropic drug therapies.

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

42 (c) The Commissioner of Social Services may implement policies
43 and procedures necessary to carry out the provision of this section
44 while in the process of adopting such policies and procedures in
45 regulation form, provided notice is published in the Connecticut Law
46 Journal within twenty days of implementation. Policies and

47 procedures implemented pursuant to this section shall be valid until
48 the time final regulations are adopted.

49 Sec. 3. Subsection (a) of section 17b-112 of the general statutes, as
50 amended by section 1 of public act 03-28, section 5 of public act 03-268
51 and section 80 of public act 03-3 of the June 30 special session, is
52 repealed and the following is substituted in lieu thereof (*Effective from*
53 *passage*):

54 (a) The Department of Social Services shall administer a temporary
55 family assistance program under which cash assistance shall be
56 provided to eligible families in accordance with the temporary
57 assistance for needy families program, established pursuant to the
58 Personal Responsibility and Work Opportunity Reconciliation Act of
59 1996. Under the temporary family assistance program, benefits shall be
60 provided to a family for not longer than twenty-one months, except as
61 provided in subsections (b) and (c) of this section. For the purpose of
62 calculating said twenty-one-month time limit, months of assistance
63 received on and after January 1, 1996, pursuant to time limits under
64 the aid to families with dependent children program, shall be
65 included. For purposes of this section, "family" means one or more
66 individuals who apply for or receive assistance together under the
67 temporary family assistance program. If the commissioner determines
68 that federal law allows individuals not otherwise in an eligible covered
69 group for the temporary family assistance program to become covered,
70 such family may also, at the discretion of the commissioner, be
71 composed of (1) a pregnant woman, or (2) a parent, both parents or
72 other caretaker relative and at least one child who is under the age of
73 eighteen, or who is under the age of nineteen and a full-time student in
74 a secondary school or its equivalent. A caretaker relative shall be
75 related to the child or children by blood, marriage or adoption or shall
76 be the legal guardian of such a child or pursuing legal proceedings
77 necessary to achieve guardianship. If the commissioner elects to allow
78 state eligibility consistent with any change in federal law, the
79 commissioner may administratively transfer any qualifying family

80 cases under the cash assistance portion of the state-administered
81 general assistance program to the temporary family assistance
82 program without regard to usual eligibility and enrollment
83 procedures. If such families become an ineligible coverage group
84 under the federal law, the commissioner shall administratively transfer
85 such families back to the cash assistance portion of the state-
86 administered general assistance program without regard to usual
87 eligibility and enrollment procedures to the degree that such families
88 are eligible for the state program.

89 Sec. 4. Section 17b-340 of the general statutes, as amended by section
90 17 of public act 03-2, section 45 of public act 03-19 and section 50 of
91 public act 03-3 of the June 30 special session, is repealed and the
92 following is substituted in lieu thereof (*Effective from passage*):

93 (a) The rates to be paid by or for persons aided or cared for by the
94 state or any town in this state to licensed chronic and convalescent
95 nursing homes, chronic disease hospitals associated with chronic and
96 convalescent nursing homes, rest homes with nursing supervision and
97 to licensed residential care homes, as defined by section 19a-490, as
98 amended, and to residential facilities for the mentally retarded which
99 are licensed pursuant to section 17a-227, as amended, and certified to
100 participate in the Title XIX Medicaid program as intermediate care
101 facilities for the mentally retarded, for room, board and services
102 specified in licensing regulations issued by the licensing agency shall
103 be determined annually, except as otherwise provided in this
104 subsection, after a public hearing, by the Commissioner of Social
105 Services, to be effective July first of each year except as otherwise
106 provided in this subsection. Such rates shall be determined on a basis
107 of a reasonable payment for such necessary services, which basis shall
108 take into account as a factor the costs of such services. Cost of such
109 services shall include (1) reasonable costs mandated by collective
110 bargaining agreements with certified collective bargaining agents or
111 other agreements between the employer and employees, provided
112 "employees" shall not include persons employed as managers or chief

113 administrators or required to be licensed as nursing home
114 administrators, and (2) compensation for services rendered by
115 proprietors at prevailing wage rates, as determined by application of
116 principles of accounting as prescribed by said commissioner. Cost of
117 such services shall not include amounts paid by the facilities to
118 employees as salary, or to attorneys or consultants as fees, where the
119 responsibility of the employees, attorneys, or consultants is to
120 persuade or seek to persuade the other employees of the facility to
121 support or oppose unionization. Nothing in this subsection shall
122 prohibit inclusion of amounts paid for legal counsel related to the
123 negotiation of collective bargaining agreements, the settlement of
124 grievances or normal administration of labor relations. The
125 commissioner may, in his discretion, allow the inclusion of
126 extraordinary and unanticipated costs of providing services which
127 were incurred to avoid an immediate negative impact on the health
128 and safety of patients. The commissioner may, in his discretion, based
129 upon review of a facility's costs, direct care staff to patient ratio and
130 any other related information, revise a facility's rate for any increases
131 or decreases to total licensed capacity of more than ten beds or changes
132 to its number of licensed rest home with nursing supervision beds and
133 chronic and convalescent nursing home beds. The commissioner may
134 so revise a facility's rate established for the fiscal year ending June 30,
135 1993, and thereafter for any bed increases, decreases or changes in
136 licensure effective after October 1, 1989. Effective July 1, 1991, in
137 facilities which have both a chronic and convalescent nursing home
138 and a rest home with nursing supervision, the rate for the rest home
139 with nursing supervision shall not exceed such facility's rate for its
140 chronic and convalescent nursing home. All such facilities for which
141 rates are determined under this subsection shall report on a fiscal year
142 basis ending on the thirtieth day of September. Such report shall be
143 submitted to the commissioner by the thirty-first day of December. The
144 commissioner may reduce the rate in effect for a facility which fails to
145 report on or before such date by an amount not to exceed ten per cent
146 of such rate. The commissioner shall annually, on or before the

147 fifteenth day of February, report the data contained in the reports of
148 such facilities to the joint standing committee of the General Assembly
149 having cognizance of matters relating to appropriations. For the cost
150 reporting year commencing October 1, 1985, and for subsequent cost
151 reporting years, facilities shall report the cost of using the services of
152 any nursing pool employee by separating said cost into two categories,
153 the portion of the cost equal to the salary of the employee for whom
154 the nursing pool employee is substituting shall be considered a
155 nursing cost and any cost in excess of such salary shall be further
156 divided so that seventy-five per cent of the excess cost shall be
157 considered an administrative or general cost and twenty-five per cent
158 of the excess cost shall be considered a nursing cost, provided if the
159 total nursing pool costs of a facility for any cost year are equal to or
160 exceed fifteen per cent of the total nursing expenditures of the facility
161 for such cost year, no portion of nursing pool costs in excess of fifteen
162 per cent shall be classified as administrative or general costs. The
163 commissioner, in determining such rates, shall also take into account
164 the classification of patients or boarders according to special care
165 requirements or classification of the facility according to such factors
166 as facilities and services and such other factors as he deems reasonable,
167 including anticipated fluctuations in the cost of providing such
168 services. The commissioner may establish a separate rate for a facility
169 or a portion of a facility for traumatic brain injury patients who require
170 extensive care but not acute general hospital care. Such separate rate
171 shall reflect the special care requirements of such patients. If changes
172 in federal or state laws, regulations or standards adopted subsequent
173 to June 30, 1985, result in increased costs or expenditures in an amount
174 exceeding one-half of one per cent of allowable costs for the most
175 recent cost reporting year, the commissioner shall adjust rates and
176 provide payment for any such increased reasonable costs or
177 expenditures within a reasonable period of time retroactive to the date
178 of enforcement. Nothing in this section shall be construed to require
179 the Department of Social Services to adjust rates and provide payment
180 for any increases in costs resulting from an inspection of a facility by

181 the Department of Public Health. Such assistance as the commissioner
182 requires from other state agencies or departments in determining rates
183 shall be made available to him at his request. Payment of the rates
184 established hereunder shall be conditioned on the establishment by
185 such facilities of admissions procedures which conform with this
186 section, section 19a-533, as amended, and all other applicable
187 provisions of the law and the provision of equality of treatment to all
188 persons in such facilities. The established rates shall be the maximum
189 amount chargeable by such facilities for care of such beneficiaries, and
190 the acceptance by or on behalf of any such facility of any additional
191 compensation for care of any such beneficiary from any other person
192 or source shall constitute the offense of aiding a beneficiary to obtain
193 aid to which he is not entitled and shall be punishable in the same
194 manner as is provided in subsection (b) of section 17b-97. For the fiscal
195 year ending June 30, 1992, rates for licensed residential care homes and
196 intermediate care facilities for the mentally retarded may receive an
197 increase not to exceed the most recent annual increase in the Regional
198 Data Resources Incorporated McGraw-Hill Health Care Costs:
199 Consumer Price Index (all urban)-All Items. Rates for newly certified
200 intermediate care facilities for the mentally retarded shall not exceed
201 one hundred fifty per cent of the median rate of rates in effect on
202 January 31, 1991, for intermediate care facilities for the mentally
203 retarded certified prior to February 1, 1991. Notwithstanding any
204 provision of this section, the Commissioner of Social Services [shall not
205 adjust an annual] may increase a rate for a licensed chronic and
206 convalescent nursing home or a rest home with nursing supervision
207 [set for the fiscal years ending June 30, 2004, and June 30, 2005, for any
208 reason other than to: (1) Reflect a percentage increase in subsection (f)
209 of this section; (2) lower a rate; or (3) allow the inclusion of
210 extraordinary and unanticipated costs in accordance with this
211 subsection] if the department determines that the increase is necessary
212 to avoid a filing for bankruptcy protection, imposition of receivership
213 pursuant to sections 19a-541 to 19a-549, inclusive, as amended, or
214 substantial deterioration of the facility's financial condition that may

215 be expected to adversely affect resident care and the continued
216 operation of the facility is necessary based upon area nursing facility
217 utilization and projected bed need, provided no rate shall be increased
218 above one hundred and fifteen per cent of the median rate for the
219 facility's peer grouping, established pursuant to subdivision (2) of
220 subsection (f) of this section, unless authorized by the Secretary of the
221 Office of Policy and Management. Such median rates shall be
222 published annually not later than April first of each year.

223 (b) The Commissioner of Social Services shall adopt regulations in
224 accordance with the provisions of chapter 54 to specify other allowable
225 services. For purposes of this section, other allowable services means
226 those services required by any medical assistance beneficiary residing
227 in such home or hospital which are not already covered in the rate set
228 by the commissioner in accordance with the provisions of subsection
229 (a) of this section.

230 (c) No facility subject to the requirements of this section shall accept
231 payment in excess of the rate set by the commissioner pursuant to
232 subsection (a) of this section for any medical assistance patient from
233 this or any other state. No facility shall accept payment in excess of the
234 reasonable and necessary costs of other allowable services as specified
235 by the commissioner pursuant to the regulations promulgated under
236 subsection (b) of this section for any public assistance patient from this
237 or any other state. Notwithstanding the provisions of this subsection,
238 the commissioner may authorize a facility to accept payment in excess
239 of the rate paid for a medical assistance patient in this state for a
240 patient who receives medical assistance from another state.

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

247 subsections (a) and (b) of this section. The commissioner shall make
248 the recovery prospectively at the time of the next annual rate
249 redetermination.

250 (e) Except as provided in this subsection, the provisions of
251 subsections (c) and (d) of this section shall not apply to any facility
252 subject to the requirements of this section, which on October 1, 1981,
253 (1) was accepting payments from the commissioner in accordance with
254 the provisions of subsection (a) of this section, (2) was accepting
255 medical assistance payments from another state for at least twenty per
256 cent of its patients, and (3) had not notified the commissioner of any
257 intent to terminate its provider agreement, in accordance with section
258 17b-271, provided no patient residing in any such facility on May 22,
259 1984, shall be removed from such facility for purposes of meeting the
260 requirements of this subsection. If the commissioner finds that the
261 number of beds available to medical assistance patients from this state
262 in any such facility is less than fifteen per cent the provisions of
263 subsections (c) and (d) of this section shall apply to that number of
264 beds which is less than said percentage.

265 (f) For the fiscal year ending June 30, 1992, the rates paid by or for
266 persons aided or cared for by the state or any town in this state to
267 facilities for room, board and services specified in licensing regulations
268 issued by the licensing agency, except intermediate care facilities for
269 the mentally retarded and residential care homes, shall be based on the
270 cost year ending September 30, 1989. For the fiscal years ending June
271 30, 1993, and June 30, 1994, such rates shall be based on the cost year
272 ending September 30, 1990. Such rates shall be determined by the
273 Commissioner of Social Services in accordance with this section and
274 the regulations of Connecticut state agencies promulgated by the
275 commissioner and in effect on April 1, 1991, except that:

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

279 which shall include professional fees, dietary expenses, housekeeping
280 expenses, laundry expenses, supplies related to patient care, salaries
281 for indirect care personnel and related fringe benefits; fair rent, which
282 shall be defined in accordance with subsection (f) of section 17-311-52
283 of the regulations of Connecticut state agencies; capital-related costs,
284 which shall include property taxes, insurance expenses, equipment
285 leases and equipment depreciation; and administrative and general
286 costs, which shall include maintenance and operation of plant
287 expenses, salaries for administrative and maintenance personnel and
288 related fringe benefits. The commissioner may provide a rate
289 adjustment for nonemergency transportation services required by
290 nursing facility residents. Such adjustment shall be a fixed amount
291 determined annually by the commissioner based upon a review of
292 costs and other associated information. Allowable costs shall not
293 include costs for ancillary services payable under Part B of the
294 Medicare program.

295 (2) Two geographic peer groupings of facilities shall be established
296 for each level of care, as defined by the Department of Social Services
297 for the determination of rates, for the purpose of determining
298 allowable direct costs. One peer grouping shall be comprised of those
299 facilities located in Fairfield County. The other peer grouping shall be
300 comprised of facilities located in all other counties.

301 (3) For the fiscal year ending June 30, 1992, per diem maximum
302 allowable costs for each cost component shall be as follows: For direct
303 costs, the maximum shall be equal to one hundred forty per cent of the
304 median allowable cost of that peer grouping; for indirect costs, the
305 maximum shall be equal to one hundred thirty per cent of the state-
306 wide median allowable cost; for fair rent, the amount shall be
307 calculated utilizing the amount approved by the Office of Health Care
308 Access pursuant to section 19a-638, as amended; for capital-related
309 costs, there shall be no maximum; and for administrative and general
310 costs, the maximum shall be equal to one hundred twenty-five per cent
311 of the state-wide median allowable cost. For the fiscal year ending June

312 30, 1993, per diem maximum allowable costs for each cost component
313 shall be as follows: For direct costs, the maximum shall be equal to one
314 hundred forty per cent of the median allowable cost of that peer
315 grouping; for indirect costs, the maximum shall be equal to one
316 hundred twenty-five per cent of the state-wide median allowable cost;
317 for fair rent, the amount shall be calculated utilizing the amount
318 approved by the Office of Health Care Access pursuant to section 19a-
319 638, as amended; for capital-related costs, there shall be no maximum;
320 and for administrative and general costs the maximum shall be equal
321 to one hundred fifteen per cent of the state-wide median allowable
322 cost. For the fiscal year ending June 30, 1994, per diem maximum
323 allowable costs for each cost component shall be as follows: For direct
324 costs, the maximum shall be equal to one hundred thirty-five per cent
325 of the median allowable cost of that peer grouping; for indirect costs,
326 the maximum shall be equal to one hundred twenty per cent of the
327 state-wide median allowable cost; for fair rent, the amount shall be
328 calculated utilizing the amount approved by the Office of Health Care
329 Access pursuant to section 19a-638, as amended; for capital-related
330 costs, there shall be no maximum; and for administrative and general
331 costs the maximum shall be equal to one hundred ten per cent of the
332 state-wide median allowable cost. For the fiscal year ending June 30,
333 1995, per diem maximum allowable costs for each cost component
334 shall be as follows: For direct costs, the maximum shall be equal to one
335 hundred thirty-five per cent of the median allowable cost of that peer
336 grouping; for indirect costs, the maximum shall be equal to one
337 hundred twenty per cent of the state-wide median allowable cost; for
338 fair rent, the amount shall be calculated utilizing the amount approved
339 by the Office of Health Care Access pursuant to section 19a-638, as
340 amended; for capital-related costs, there shall be no maximum; and for
341 administrative and general costs the maximum shall be equal to one
342 hundred five per cent of the state-wide median allowable cost. For the
343 fiscal year ending June 30, 1996, and any succeeding fiscal year, except
344 for the fiscal years ending June 30, 2000, and June 30, 2001, for facilities
345 with an interim rate in one or both periods, per diem maximum

346 allowable costs for each cost component shall be as follows: For direct
347 costs, the maximum shall be equal to one hundred thirty-five per cent
348 of the median allowable cost of that peer grouping; for indirect costs,
349 the maximum shall be equal to one hundred fifteen per cent of the
350 state-wide median allowable cost; for fair rent, the amount shall be
351 calculated utilizing the amount approved pursuant to section 19a-638,
352 as amended; for capital-related costs, there shall be no maximum; and
353 for administrative and general costs the maximum shall be equal to the
354 state-wide median allowable cost. For the fiscal years ending June 30,
355 2000, and June 30, 2001, for facilities with an interim rate in one or both
356 periods, per diem maximum allowable costs for each cost component
357 shall be as follows: For direct costs, the maximum shall be equal to one
358 hundred forty-five per cent of the median allowable cost of that peer
359 grouping; for indirect costs, the maximum shall be equal to one
360 hundred twenty-five per cent of the state-wide median allowable cost;
361 for fair rent, the amount shall be calculated utilizing the amount
362 approved pursuant to section 19a-638, as amended; for capital-related
363 costs, there shall be no maximum; and for administrative and general
364 costs, the maximum shall be equal to the state-wide median allowable
365 cost and such medians shall be based upon the same cost year used to
366 set rates for facilities with prospective rates. Costs in excess of the
367 maximum amounts established under this subsection shall not be
368 recognized as allowable costs, except that the Commissioner of Social
369 Services (A) may allow costs in excess of maximum amounts for any
370 facility with patient days covered by Medicare, including days
371 requiring coinsurance, in excess of twelve per cent of annual patient
372 days which also has patient days covered by Medicaid in excess of fifty
373 per cent of annual patient days; (B) may establish a pilot program
374 whereby costs in excess of maximum amounts shall be allowed for
375 beds in a nursing home which has a managed care program and is
376 affiliated with a hospital licensed under chapter 368v; and (C) may
377 establish rates whereby allowable costs may exceed such maximum
378 amounts for beds approved on or after July 1, 1991, which are
379 restricted to use by patients with acquired immune deficiency

380 syndrome or traumatic brain injury.

381 (4) For the fiscal year ending June 30, 1992, (A) no facility shall
382 receive a rate that is less than the rate it received for the rate year
383 ending June 30, 1991; (B) no facility whose rate, if determined pursuant
384 to this subsection, would exceed one hundred twenty per cent of the
385 state-wide median rate, as determined pursuant to this subsection,
386 shall receive a rate which is five and one-half per cent more than the
387 rate it received for the rate year ending June 30, 1991; and (C) no
388 facility whose rate, if determined pursuant to this subsection, would be
389 less than one hundred twenty per cent of the state-wide median rate,
390 as determined pursuant to this subsection, shall receive a rate which is
391 six and one-half per cent more than the rate it received for the rate year
392 ending June 30, 1991. For the fiscal year ending June 30, 1993, no
393 facility shall receive a rate that is less than the rate it received for the
394 rate year ending June 30, 1992, or six per cent more than the rate it
395 received for the rate year ending June 30, 1992. For the fiscal year
396 ending June 30, 1994, no facility shall receive a rate that is less than the
397 rate it received for the rate year ending June 30, 1993, or six per cent
398 more than the rate it received for the rate year ending June 30, 1993.
399 For the fiscal year ending June 30, 1995, no facility shall receive a rate
400 that is more than five per cent less than the rate it received for the rate
401 year ending June 30, 1994, or six per cent more than the rate it received
402 for the rate year ending June 30, 1994. For the fiscal years ending June
403 30, 1996, and June 30, 1997, no facility shall receive a rate that is more
404 than three per cent more than the rate it received for the prior rate
405 year. For the fiscal year ending June 30, 1998, a facility shall receive a
406 rate increase that is not more than two per cent more than the rate that
407 the facility received in the prior year. For the fiscal year ending June
408 30, 1999, a facility shall receive a rate increase that is not more than
409 three per cent more than the rate that the facility received in the prior
410 year and that is not less than one per cent more than the rate that the
411 facility received in the prior year, exclusive of rate increases associated
412 with a wage, benefit and staffing enhancement rate adjustment added
413 for the period from April 1, 1999, to June 30, 1999, inclusive. For the

414 fiscal year ending June 30, 2000, each facility, except a facility with an
415 interim rate or replaced interim rate for the fiscal year ending June 30,
416 1999, and a facility having a certificate of need or other agreement
417 specifying rate adjustments for the fiscal year ending June 30, 2000,
418 shall receive a rate increase equal to one per cent applied to the rate the
419 facility received for the fiscal year ending June 30, 1999, exclusive of
420 the facility's wage, benefit and staffing enhancement rate adjustment.
421 For the fiscal year ending June 30, 2000, no facility with an interim rate,
422 replaced interim rate or scheduled rate adjustment specified in a
423 certificate of need or other agreement for the fiscal year ending June
424 30, 2000, shall receive a rate increase that is more than one per cent
425 more than the rate the facility received in the fiscal year ending June
426 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a
427 facility with an interim rate or replaced interim rate for the fiscal year
428 ending June 30, 2000, and a facility having a certificate of need or other
429 agreement specifying rate adjustments for the fiscal year ending June
430 30, 2001, shall receive a rate increase equal to two per cent applied to
431 the rate the facility received for the fiscal year ending June 30, 2000,
432 subject to verification of wage enhancement adjustments pursuant to
433 subdivision (15) of this subsection. For the fiscal year ending June 30,
434 2001, no facility with an interim rate, replaced interim rate or
435 scheduled rate adjustment specified in a certificate of need or other
436 agreement for the fiscal year ending June 30, 2001, shall receive a rate
437 increase that is more than two per cent more than the rate the facility
438 received for the fiscal year ending June 30, 2000. For the fiscal year
439 ending June 30, 2002, each facility shall receive a rate that is two and
440 one-half per cent more than the rate the facility received in the prior
441 fiscal year. For the fiscal year ending June 30, 2003, each facility shall
442 receive a rate that is two per cent more than the rate the facility
443 received in the prior fiscal year, except that such increase shall be
444 effective January 1, 2003, and such facility rate in effect for the fiscal
445 year ending June 30, 2002, shall be paid for services provided until
446 December 31, 2002, except any facility that would have been issued a
447 lower rate effective July 1, 2002, than for the fiscal year ending June 30,

448 2002, due to interim rate status or agreement with the department shall
449 be issued such lower rate effective July 1, 2002, and have such rate
450 increased two per cent effective June 1, 2003. For the fiscal year ending
451 June 30, 2004, rates in effect for the period ending June 30, 2003, shall
452 remain in effect, except any facility that would have been issued a
453 lower rate effective July 1, 2003, than for the fiscal year ending June 30,
454 2003, due to interim rate status or agreement with the department shall
455 be issued such lower rate effective July 1, 2003. For the fiscal year
456 ending June 30, 2005, rates in effect for the period ending June 30, 2004,
457 shall remain in effect until December 31, 2004, except any facility that
458 would have been issued a lower rate effective July 1, 2004, than for the
459 fiscal year ending June 30, 2004, due to interim rate status or
460 agreement with the department shall be issued such lower rate
461 effective July 1, 2004. Effective January 1, 2005, each facility shall
462 receive a rate that is one per cent greater than the rate in effect
463 December 31, 2004. The Commissioner of Social Services shall add fair
464 rent increases to any other rate increases established pursuant to this
465 subdivision for a facility which has undergone a material change in
466 circumstances related to fair rent.

467 (5) For the purpose of determining allowable fair rent, a facility with
468 allowable fair rent less than the twenty-fifth percentile of the state-
469 wide allowable fair rent shall be reimbursed as having allowable fair
470 rent equal to the twenty-fifth percentile of the state-wide allowable fair
471 rent, provided for the fiscal years ending June 30, 1996, and June 30,
472 1997, the reimbursement may not exceed the twenty-fifth percentile of
473 the state-wide allowable fair rent for the fiscal year ending June 30,
474 1995. On and after July 1, 1998, the Commissioner of Social Services
475 may allow minimum fair rent as the basis upon which reimbursement
476 associated with improvements to real property is added. Beginning
477 with the fiscal year ending June 30, 1996, any facility with a rate of
478 return on real property other than land in excess of eleven per cent
479 shall have such allowance revised to eleven per cent. Any facility or its
480 related realty affiliate which finances or refinances debt through bonds
481 issued by the State of Connecticut Health and Education Facilities

482 Authority shall report the terms and conditions of such financing or
483 refinancing to the Commissioner of Social Services within thirty days
484 of completing such financing or refinancing. The Commissioner of
485 Social Services may revise the facility's fair rent component of its rate
486 to reflect any financial benefit the facility or its related realty affiliate
487 received as a result of such financing or refinancing, including, but not
488 limited to, reductions in the amount of debt service payments or
489 period of debt repayment. The commissioner shall allow actual debt
490 service costs for bonds issued by the State of Connecticut Health and
491 Educational Facilities Authority if such costs do not exceed property
492 costs allowed pursuant to subsection (f) of section 17-311-52 of the
493 regulations of Connecticut state agencies, provided the commissioner
494 may allow higher debt service costs for such bonds for good cause. For
495 facilities which first open on or after October 1, 1992, the commissioner
496 shall determine allowable fair rent for real property other than land
497 based on the rate of return for the cost year in which such bonds were
498 issued. The financial benefit resulting from a facility financing or
499 refinancing debt through such bonds shall be shared between the state
500 and the facility to an extent determined by the commissioner on a case-
501 by-case basis and shall be reflected in an adjustment to the facility's
502 allowable fair rent.

503 (6) A facility shall receive cost efficiency adjustments for indirect
504 costs and for administrative and general costs if such costs are below
505 the state-wide median costs. The cost efficiency adjustments shall
506 equal twenty-five per cent of the difference between allowable
507 reported costs and the applicable median allowable cost established
508 pursuant to this subdivision.

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

515 Incorporated McGraw-Hill Health Care Costs: Consumer Price Index
516 (all urban)-All Items minus one and three-quarters per cent. For the
517 fiscal years ending June 30, 1994, and June 30, 1995, allowable
518 operating costs, excluding fair rent, shall be inflated using the Regional
519 Data Resources Incorporated McGraw-Hill Health Care Costs:
520 Consumer Price Index (all urban)-All Items minus two per cent. For
521 the fiscal year ending June 30, 1996, allowable operating costs,
522 excluding fair rent, shall be inflated using the Regional Data Resources
523 Incorporated McGraw-Hill Health Care Costs: Consumer Price Index
524 (all urban)-All Items minus two and one-half per cent. For the fiscal
525 year ending June 30, 1997, allowable operating costs, excluding fair
526 rent, shall be inflated using the Regional Data Resources Incorporated
527 McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All
528 Items minus three and one-half per cent. For the fiscal year ending
529 June 30, 1992, and any succeeding fiscal year, allowable fair rent shall
530 be those reported in the annual report of long-term care facilities for
531 the cost year ending the immediately preceding September thirtieth.
532 The inflation index to be used pursuant to this subsection shall be
533 computed to reflect inflation between the midpoint of the cost year
534 through the midpoint of the rate year. The Department of Social
535 Services shall study methods of reimbursement for fair rent and shall
536 report its findings and recommendations to the joint standing
537 committee of the General Assembly having cognizance of matters
538 relating to human services on or before January 15, 1993.

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

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

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

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

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

557 (13) A chronic and convalescent nursing home having an ownership
558 affiliation with and operated at the same location as a chronic disease
559 hospital may request that the commissioner approve an exception to
560 applicable rate-setting provisions for chronic and convalescent nursing
561 homes and establish a rate for the fiscal years ending June 30, 1992,
562 and June 30, 1993, in accordance with regulations in effect June 30,
563 1991. Any such rate shall not exceed one hundred sixty-five per cent of
564 the median rate established for chronic and convalescent nursing
565 homes established under this section for the applicable fiscal year.

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

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

578 facility's direct and indirect component salary, wage, nursing pool and
579 allocated fringe benefit costs as filed for the 1998 cost report period
580 deemed allowable in accordance with this section and applicable
581 regulations without application of cost component maximums
582 specified in subdivision (3) of this subsection shall be totalled; (B) such
583 total shall be multiplied by the facility's Medicaid utilization based on
584 the 1998 cost report; (C) the resulting amount for the facility shall be
585 divided by the sum of the calculations specified in subparagraphs (A)
586 and (B) of this subdivision for all facilities to determine the facility's
587 percentage share of appropriated wage, benefit and staffing
588 enhancement funding; (D) the facility's percentage share shall be
589 multiplied by the amount of appropriated wage, benefit and staffing
590 enhancement funding to determine the facility's allocated amount; and
591 (E) such allocated amount shall be divided by the number of days of
592 care paid for by Medicaid on an annual basis including days for
593 reserved beds specified in the 1998 cost report to determine the per
594 diem wage and benefit rate adjustment amount. The commissioner
595 may adjust a facility's reported 1998 cost and utilization data for the
596 purposes of determining a facility's share of wage, benefit and staffing
597 enhancement funding when reported 1998 information is not
598 substantially representative of estimated cost and utilization data for
599 the fiscal year ending June 30, 2000, due to special circumstances
600 during the 1998 cost report period including change of ownership with
601 a part year cost filing or reductions in facility capacity due to facility
602 renovation projects. Upon completion of the calculation of the
603 allocation of wage, benefit and staffing enhancement funding, the
604 commissioner shall not adjust the allocations due to revisions
605 submitted to previously filed 1998 annual cost reports. In the event
606 that a facility's rate for the fiscal year ending June 30, 1999, is an
607 interim rate or the rate includes an increase adjustment due to a rate
608 request to the commissioner or other reasons, the commissioner may
609 reduce or withhold the per diem wage, benefit and staffing
610 enhancement allocation computed for the facility. Any enhancement
611 allocations not applied to facility rates shall not be reallocated to other

612 facilities and such unallocated amounts shall be available for the costs
613 associated with interim rates and other Medicaid expenditures. The
614 wage, benefit and staffing enhancement per diem adjustment for the
615 period from April 1, 1999, to June 30, 1999, inclusive, shall also be
616 applied to rates for the fiscal years ending June 30, 2000, and June 30,
617 2001, except that the commissioner may increase or decrease the
618 adjustment to account for changes in facility capacity or operations.
619 Any facility accepting a rate adjustment for wage, benefit and staffing
620 enhancements shall apply payments made as a result of such rate
621 adjustment for increased allowable employee wage rates and benefits
622 and additional direct and indirect component staffing. Adjustment
623 funding shall not be applied to wage and salary increases provided to
624 the administrator, assistant administrator, owners or related party
625 employees. Enhancement payments may be applied to increases in
626 costs associated with staffing purchased from staffing agencies
627 provided such costs are deemed necessary and reasonable by the
628 commissioner. The commissioner shall compare expenditures for
629 wages, benefits and staffing for the 1998 cost report period to such
630 expenditures in the 1999, 2000 and 2001 cost report periods to verify
631 whether a facility has applied additional payments to specified
632 enhancements. In the event that the commissioner determines that a
633 facility did not apply additional payments to specified enhancements,
634 the commissioner shall recover such amounts from the facility through
635 rate adjustments or other means. The commissioner may require
636 facilities to file cost reporting forms, in addition to the annual cost
637 report, as may be necessary, to verify the appropriate application of
638 wage, benefit and staffing enhancement rate adjustment payments. For
639 the purposes of this subdivision, "Medicaid utilization" means the
640 number of days of care paid for by Medicaid on an annual basis
641 including days for reserved beds as a percentage of total resident days.

642 (16) The interim rate established to become effective upon sale of
643 any licensed chronic and convalescent home or rest home with nursing
644 supervision for which a receivership has been imposed pursuant to
645 sections 19a-541 to 19a-549, inclusive, as amended, or which is being

646 operated under federal bankruptcy protection shall not exceed the rate
647 in effect for the facility at the time of the imposition of the receivership
648 or commencement of the federal bankruptcy proceeding, subject to any
649 annual increases permitted by this section; provided if such rate is less
650 than the median rate for the facility's peer grouping, as defined in
651 subdivision (2) of this subsection, the Commissioner of Social Services
652 may, in the commissioner's discretion, establish an increased rate for
653 the facility not to exceed such median rate unless the Secretary of the
654 Office of Policy and Management, after review of area nursing facility
655 bed availability and other pertinent factors, authorizes the
656 Commissioner of Social Services to establish a rate higher than the
657 median rate.

658 (g) For the fiscal year ending June 30, 1993, any intermediate care
659 facility for the mentally retarded with an operating cost component of
660 its rate in excess of one hundred forty per cent of the median of
661 operating cost components of rates in effect January 1, 1992, shall not
662 receive an operating cost component increase. For the fiscal year
663 ending June 30, 1993, any intermediate care facility for the mentally
664 retarded with an operating cost component of its rate that is less than
665 one hundred forty per cent of the median of operating cost
666 components of rates in effect January 1, 1992, shall have an allowance
667 for real wage growth equal to thirty per cent of the increase
668 determined in accordance with subsection (q) of section 17-311-52 of
669 the regulations of Connecticut state agencies, provided such operating
670 cost component shall not exceed one hundred forty per cent of the
671 median of operating cost components in effect January 1, 1992. Any
672 facility with real property other than land placed in service prior to
673 October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a
674 rate of return on real property equal to the average of the rates of
675 return applied to real property other than land placed in service for the
676 five years preceding October 1, 1993. For the fiscal year ending June 30,
677 1996, and any succeeding fiscal year, the rate of return on real property
678 for property items shall be revised every five years. The commissioner
679 shall, upon submission of a request, allow actual debt service,

680 comprised of principal and interest, in excess of property costs allowed
681 pursuant to section 17-311-52 of the regulations of Connecticut state
682 agencies, provided such debt service terms and amounts are
683 reasonable in relation to the useful life and the base value of the
684 property. For the fiscal year ending June 30, 1995, and any succeeding
685 fiscal year, the inflation adjustment made in accordance with
686 subsection (p) of section 17-311-52 of the regulations of Connecticut
687 state agencies shall not be applied to real property costs. For the fiscal
688 year ending June 30, 1996, and any succeeding fiscal year, the
689 allowance for real wage growth, as determined in accordance with
690 subsection (q) of section 17-311-52 of the regulations of Connecticut
691 state agencies, shall not be applied. For the fiscal year ending June 30,
692 1996, and any succeeding fiscal year, no rate shall exceed three
693 hundred seventy-five dollars per day unless the commissioner, in
694 consultation with the Commissioner of Mental Retardation,
695 determines after a review of program and management costs, that a
696 rate in excess of this amount is necessary for care and treatment of
697 facility residents. For the fiscal year ending June 30, 2002, rate period,
698 the Commissioner of Social Services shall increase the inflation
699 adjustment for rates made in accordance with subsection (p) of section
700 17-311-52 of the regulations of Connecticut state agencies to update
701 allowable fiscal year 2000 costs to include a three and one-half per cent
702 inflation factor. For the fiscal year ending June 30, 2003, rate period, the
703 commissioner shall increase the inflation adjustment for rates made in
704 accordance with subsection (p) of section 17-311-52 of the regulations
705 of Connecticut state agencies to update allowable fiscal year 2001 costs
706 to include a one and one-half per cent inflation factor, except that such
707 increase shall be effective November 1, 2002, and such facility rate in
708 effect for the fiscal year ending June 30, 2002, shall be paid for services
709 provided until October 31, 2002, except any facility that would have
710 been issued a lower rate effective July 1, 2002, than for the fiscal year
711 ending June 30, 2002, due to interim rate status or agreement with the
712 department shall be issued such lower rate effective July 1, 2002, and
713 have such rate updated effective November 1, 2002, in accordance with

714 applicable statutes and regulations. For the fiscal year ending June 30,
715 2004, rates in effect for the period ending June 30, 2003, shall remain in
716 effect, except any facility that would have been issued a lower rate
717 effective July 1, 2003, than for the fiscal year ending June 30, 2003, due
718 to interim rate status or agreement with the department shall be issued
719 such lower rate effective July 1, 2003. Effective July 1, 2004, each facility
720 shall receive a rate that is three-quarters of one per cent greater than
721 the rate in effect June 30, 2004.

722 (h) (1) For the fiscal year ending June 30, 1993, any residential care
723 home with an operating cost component of its rate in excess of one
724 hundred thirty per cent of the median of operating cost components of
725 rates in effect January 1, 1992, shall not receive an operating cost
726 component increase. For the fiscal year ending June 30, 1993, any
727 residential care home with an operating cost component of its rate that
728 is less than one hundred thirty per cent of the median of operating cost
729 components of rates in effect January 1, 1992, shall have an allowance
730 for real wage growth equal to sixty-five per cent of the increase
731 determined in accordance with subsection (q) of section 17-311-52 of
732 the regulations of Connecticut state agencies, provided such operating
733 cost component shall not exceed one hundred thirty per cent of the
734 median of operating cost components in effect January 1, 1992.
735 Beginning with the fiscal year ending June 30, 1993, for the purpose of
736 determining allowable fair rent, a residential care home with allowable
737 fair rent less than the twenty-fifth percentile of the state-wide
738 allowable fair rent shall be reimbursed as having allowable fair rent
739 equal to the twenty-fifth percentile of the state-wide allowable fair
740 rent. Beginning with the fiscal year ending June 30, 1997, a residential
741 care home with allowable fair rent less than three dollars and ten cents
742 per day shall be reimbursed as having allowable fair rent equal to
743 three dollars and ten cents per day. Property additions placed in
744 service during the cost year ending September 30, 1996, or any
745 succeeding cost year shall receive a fair rent allowance for such
746 additions as an addition to three dollars and ten cents per day if the
747 fair rent for the facility for property placed in service prior to

748 September 30, 1995, is less than or equal to three dollars and ten cents
749 per day. For the fiscal year ending June 30, 1996, and any succeeding
750 fiscal year, the allowance for real wage growth, as determined in
751 accordance with subsection (q) of section 17-311-52 of the regulations
752 of Connecticut state agencies, shall not be applied. For the fiscal year
753 ending June 30, 1996, and any succeeding fiscal year, the inflation
754 adjustment made in accordance with subsection (p) of section
755 17-311-52 of the regulations of Connecticut state agencies shall not be
756 applied to real property costs. Beginning with the fiscal year ending
757 June 30, 1997, minimum allowable patient days for rate computation
758 purposes for a residential care home with twenty-five beds or less shall
759 be eighty-five per cent of licensed capacity. Beginning with the fiscal
760 year ending June 30, 2002, for the purposes of determining the
761 allowable salary of an administrator of a residential care home with
762 sixty beds or less the department shall revise the allowable base salary
763 to thirty-seven thousand dollars to be annually inflated thereafter in
764 accordance with section 17-311-52 of the regulations of Connecticut
765 state agencies. The rates for the fiscal year ending June 30, 2002, shall
766 be based upon the increased allowable salary of an administrator,
767 regardless of whether such amount was expended in the 2000 cost
768 report period upon which the rates are based. Beginning with the fiscal
769 year ending June 30, 2000, the inflation adjustment for rates made in
770 accordance with subsection (p) of section 17-311-52 of the regulations
771 of Connecticut state agencies shall be increased by two per cent, and
772 beginning with the fiscal year ending June 30, 2002, the inflation
773 adjustment for rates made in accordance with subsection (c) of said
774 section shall be increased by one per cent. Beginning with the fiscal
775 year ending June 30, 1999, for the purpose of determining the
776 allowable salary of a related party, the department shall revise the
777 maximum salary to twenty-seven thousand eight hundred fifty-six
778 dollars to be annually inflated thereafter in accordance with section
779 17-311-52 of the regulations of Connecticut state agencies and
780 beginning with the fiscal year ending June 30, 2001, such allowable
781 salary shall be computed on an hourly basis and the maximum

782 number of hours allowed for a related party other than the proprietor
783 shall be increased from forty hours to forty-eight hours per work week.

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

792 (i) Notwithstanding the provisions of this section, the
793 Commissioner of Social Services shall establish a fee schedule for
794 payments to be made to chronic disease hospitals associated with
795 chronic and convalescent nursing homes to be effective on and after
796 July 1, 1995. The fee schedule may be adjusted annually beginning July
797 1, 1997, to reflect necessary increases in the cost of services.

798 Sec. 5. Section 4 of public act 01-8 of the June special session, as
799 amended by section 70 of public act 03-3 of the June 30 special session,
800 is repealed and the following is substituted in lieu thereof (*Effective*
801 *from passage*):

802 (a) The Department of Mental Health and Addiction Services, in
803 consultation with the Department of Social Services, shall conduct a
804 study concerning the implementation of adult rehabilitation services
805 under Medicaid. Not later than February 1, 2002, the departments shall
806 jointly submit a report of their findings and recommendations to the
807 Governor and to the joint standing committees of the General
808 Assembly having cognizance of matters relating to public health,
809 human services and appropriations and the budgets of state agencies,
810 in accordance with the provisions of section 11-4a. The report shall
811 include, but not be limited to, an implementation plan, a cost benefit
812 analysis and a description of the plan's impact on existing services.

813 (b) The Department of Mental Health and Addiction Services and
814 the Department of Social Services shall conduct a study concerning the
815 advisability of entering into an interagency agreement pursuant to
816 which the Department of Mental Health and Addiction Services would
817 provide clinical management of mental health services, including, but
818 not limited to, review and authorization of services, implementation of
819 quality assurance and improvement initiatives and provision of case
820 management services, for aged, blind or disabled adults enrolled in the
821 Medicaid program to the extent permitted under federal law. Not later
822 than February 1, 2002, the departments shall jointly submit a report of
823 their findings and recommendations to the Governor and to the joint
824 standing committees of the General Assembly having cognizance of
825 matters relating to public health, human services and appropriations
826 and the budgets of state agencies, in accordance with the provisions of
827 section 11-4a.

828 (c) The Commissioner of Social Services shall take such action as
829 may be necessary to amend the Medicaid state plan to provide for
830 coverage of optional adult rehabilitation services supplied by [various]
831 providers of mental health services [, pursuant to a contract with] or
832 substance abuse rehabilitation services for adults with serious and
833 persistent mental illness or who have alcoholism or other substance
834 abuse conditions, that are certified by the Department of Mental
835 Health and Addiction Services. [, for adults with mental health needs
836 who are clients of said department.] For the fiscal years ending June
837 30, 2004, and June 30, 2005, up to three million dollars in each such
838 fiscal year of any moneys received by the state as federal
839 reimbursement for optional Medicaid adult rehabilitation services
840 shall be credited to the Community Mental Health Restoration
841 subaccount within the account established under section 17a-485 and
842 shall be available for use for the purposes of the subaccount. The
843 Commissioner of Social Services shall adopt regulations, in accordance
844 with the provisions of chapter 54, to implement optional rehabilitation
845 services under the Medicaid program. The commissioner shall
846 implement policies and procedures to administer such services while

847 in the process of adopting such policies or procedures in regulation
848 form, provided notice of intention to adopt the regulations is printed
849 in the Connecticut Law Journal within forty-five days of
850 implementation, and any such policies or procedures shall be valid
851 until the time final regulations are effective.

852 (d) The Commissioner of Mental Health and Addiction Services
853 shall have the authority to certify providers of mental health or
854 substance abuse rehabilitation services for adults with serious and
855 persistent mental illness or who have alcoholism or other substance
856 abuse conditions for the purpose of coverage of optional rehabilitation
857 services. The Commissioner of Mental Health and Addiction Services
858 shall adopt regulations, in accordance with the provisions of chapter
859 54, to implement certification of such providers. The commissioner
860 shall implement policies and procedures for purposes of such
861 certification while in the process of adopting such policies or
862 procedures in regulation form, provided notice of intention to adopt
863 the regulations is printed in the Connecticut Law Journal within
864 twenty days of implementation and any such policies and procedures
865 shall be valid until the time the regulations are effective.

866 Sec. 6. Subsection (h) of section 17b-292 of the general statutes, as
867 amended by section 7 of public act 03-2 and section 56 of public act 03-
868 3 of the June 30 special session, is repealed and the following is
869 substituted in lieu thereof (*Effective from passage*):

870 (h) Not more than twelve months after the determination of
871 eligibility for benefits under the HUSKY Plan, Part A and Part B and
872 annually thereafter, the commissioner or the servicer, as the case may
873 be, shall determine if the child continues to be eligible for the plan. The
874 commissioner or the servicer shall mail an application form to each
875 participant in the plan for the purposes of obtaining information to
876 make a determination on eligibility. [To the extent permitted by federal
877 law, in determining eligibility for benefits under the HUSKY Plan, Part
878 A and Part B with respect to family income, the commissioner or the

879 servicer shall rely upon information provided in such form by the
880 participant unless the commissioner or the servicer has reason to
881 believe that such information is inaccurate or incomplete.] The
882 determination of eligibility shall be coordinated with health plan open
883 enrollment periods.

884 Sec. 7. Subsection (e) of section 17b-112 of the general statutes, as
885 amended by section 1 of public act 03-28 and section 5 of public act 03-
886 268, is repealed and the following is substituted in lieu thereof
887 (*Effective from passage*):

888 (d) Under said program (1) no family shall be eligible that has total
889 gross earnings exceeding the federal poverty level, however, in the
890 calculation of the benefit amount for eligible families and previously
891 eligible families that become ineligible temporarily because of receipt
892 of workers' compensation benefits by a family member who
893 subsequently returns to work immediately after the period of receipt of
894 such benefits, earned income shall be disregarded up to the federal
895 poverty level; (2) the increase in benefits to a family in which an infant
896 is born after the initial ten months of participation in the program shall
897 be limited to an amount equal to fifty per cent of the average
898 incremental difference between the amounts paid per each family size;
899 and (3) a disqualification penalty shall be established for failure to
900 cooperate with the biometric identifier system. Except when
901 determining eligibility for a six-month extension of benefits pursuant
902 to subsection (c) of this section, the commissioner shall disregard the
903 first fifty dollars per month of income attributable to current child
904 support that a family receives in determining eligibility and benefit
905 levels for temporary family assistance. Any current child support in
906 excess of fifty dollars per month collected by the department on behalf
907 of an eligible child shall be considered in determining eligibility but
908 shall not be considered when calculating benefits and shall be taken as
909 reimbursement for assistance paid under this section.

910 Sec. 8. Subsection (c) of section 17a-126 of the general statutes is

911 repealed and the following is substituted in lieu thereof (*Effective from*
912 *passage*):

913 (c) The subsidized guardianship program shall provide the
914 following subsidies for the benefit of any child in the care of a relative
915 caregiver who has been appointed the guardian or coguardian of the
916 child by any court of competent jurisdiction: (1) A special-need
917 subsidy, which shall be a lump sum payment for one-time expenses
918 resulting from the assumption of care of the child when no other
919 resource is available to pay for such expense; and (2) a medical subsidy
920 comparable to the medical subsidy to children in the subsidized
921 adoption program if the child lacks private health insurance or does
922 not qualify for coverage under the HUSKY Plan, Part A or Part B, for a
923 reason other than the failure to comply with a procedural requirement
924 necessary to establish or maintain eligibility for such coverage. The
925 subsidized guardianship program shall also provide a monthly
926 subsidy on behalf of the child payable to the relative caregiver that
927 shall be equal to the prevailing foster care rate. The commissioner may
928 establish an asset test for eligibility under the program.

929 Sec. 9. Subsection (b) of section 17a-50 of the general statutes is
930 repealed and the following is substituted in lieu thereof: (*Effective from*
931 *passage*):

932 (b) There shall be established, within existing resources, a Children's
933 Trust Fund Council which shall be within the Department of Children
934 and Families for administrative purposes only. The council shall be
935 composed of sixteen members as follows: (1) The Commissioners of
936 [the Departments of] Social Services, Education, Children and Families
937 and Public Health, or their designees; (2) a representative of the
938 business community with experience in fund-raising, appointed by the
939 president pro tempore of the Senate; (3) a representative of the
940 business community with experience in fund-raising, appointed by the
941 speaker of the House of Representatives; (4) a representative of the
942 business community with experience in fund-raising, appointed by the

943 minority leader of the House of Representatives; (5) a representative of
944 the business community with experience in fund-raising, appointed by
945 the minority leader of the Senate; (6) a parent, appointed by the
946 majority leader of the House of Representatives; (7) a parent,
947 appointed by the majority leader of the Senate; (8) a parent, appointed
948 by the president pro tempore of the Senate; (9) a person with expertise
949 in child abuse prevention, appointed by the speaker of the House of
950 Representatives; (10) a person with expertise in child abuse prevention,
951 appointed by the minority leader of the House of Representatives; (11)
952 a staff member of a child abuse prevention program, appointed by the
953 minority leader of the Senate; (12) a staff member of a child abuse
954 prevention program, appointed by the majority leader of the House of
955 Representatives; and (13) a pediatrician, appointed by the majority
956 leader of the Senate. The council shall solicit and accept funds, on
957 behalf of the Children's Trust Fund, to be used for the prevention of
958 child abuse and neglect and family resource programs, or on behalf of
959 the Parent Trust Fund, to be used for parent community involvement
960 to improve the health, safety and education of children, and shall make
961 grants to programs pursuant to subsections (a) and (c) of this section.
962 The council may, subject to provisions of chapter 67, employ an
963 executive director and any necessary staff within available
964 appropriations.

965 Sec. 10. Section 17b-257 of the general statutes, as amended by
966 section 18 of public act 03-2 and section 43 of public act 03-3 of the June
967 30 special session, is repealed and the following is substituted in lieu
968 thereof (*Effective from passage*):

969 (a) The Commissioner of Social Services shall implement a state
970 medical assistance component of the state-administered general
971 assistance program for persons ineligible for Medicaid. Not later than
972 October 1, 2003, each person eligible for state-administered general
973 assistance shall be entitled to receive medical care through a federally
974 qualified health center or other primary care provider as determined
975 by the commissioner. The Commissioner of Social Services shall

976 determine appropriate service areas and shall, in the commissioner's
977 discretion, contract with community health centers, other similar
978 clinics, and other primary care providers, if necessary, to assure access
979 to primary care services. [for recipients who live farther than a
980 reasonable distance from a federally qualified health center.] The
981 commissioner or the commissioner's agent shall assign and enroll
982 eligible persons in federally qualified health centers and with any
983 other providers contracted for the program because of access needs.
984 Not later than October 1, 2003, each person eligible for state-
985 administered general assistance shall be entitled to receive hospital
986 services. Medical services under the program shall be limited to the
987 services provided by a federally qualified health center, hospital, or
988 other provider contracted for the program at the commissioner's
989 discretion because of access needs. The commissioner shall ensure that
990 ancillary services and specialty services are provided by a federally
991 qualified health center, hospital, or other providers contracted for the
992 program at the commissioner's discretion. Ancillary services include,
993 but are not limited to, radiology, laboratory, and other diagnostic
994 services not available from a recipient's assigned primary-care
995 provider, and durable medical equipment. Specialty services are
996 services provided by a physician with a specialty that are not included
997 in ancillary services. In no event, shall ancillary or specialty services
998 provided under the program exceed such services provided under the
999 state-administered general assistance program on July 1, 2003.
1000 Eligibility criteria concerning income shall be the same as the
1001 medically needy component of the Medicaid program, except that
1002 earned monthly gross income of up to one hundred fifty dollars shall
1003 be disregarded. Unearned income shall not be disregarded. No person
1004 who has family assets exceeding one thousand dollars shall be eligible.
1005 No person eligible for Medicaid shall be eligible to receive medical
1006 care through the state-administered general assistance program.

1007 (b) Recipients covered by a general assistance program operated by
1008 a town shall be assigned and enrolled in federally qualified health
1009 centers and with any other providers in the same manner as recipients

1010 of medical assistance under the state-administered general assistance
1011 program pursuant to subsection (a) of this section.

1012 (c) On and after October 1, 2003, pharmacy services [shall] may be
1013 provided to recipients of state-administered general assistance through
1014 the federally qualified health center to which they are assigned or
1015 through a pharmacy with which the health center contracts. Prior to
1016 said date, pharmacy services shall be provided as provided under the
1017 Medicaid program. Recipients who are assigned to a community
1018 health center or similar clinic or primary care provider other than a
1019 federally qualified health center or to a federally qualified health
1020 center that does not have a contract for pharmacy services shall receive
1021 pharmacy services at pharmacies designated by the commissioner.

1022 (d) Recipients of state-administered general assistance shall
1023 contribute a copayment of one dollar and fifty cents for each
1024 prescription.

1025 (e) The Commissioner of Social Services shall contract with federally
1026 qualified health centers or other primary care providers as necessary to
1027 provide medical services to eligible state-administered general
1028 assistance recipients pursuant to this section. The commissioner shall,
1029 within available appropriations, make payments to such centers based
1030 on their pro rata share of the cost of services provided or the number
1031 of clients served, or both. The Commissioner of Social Services shall,
1032 within available appropriations, make payments to other providers
1033 based on a methodology determined by the commissioner. The
1034 Commissioner of Social Services may reimburse for extraordinary
1035 medical services, provided such services are documented to the
1036 satisfaction of the commissioner. For purposes of this section, the
1037 commissioner may contract with a managed care organization or other
1038 entity to perform administrative functions, including a grievance
1039 process for recipients to access review of a denial of coverage for a
1040 specific medical service. Provisions of a contract for medical services
1041 entered into by the commissioner pursuant to this section shall

1042 supersede any inconsistent provision in the regulations of Connecticut
1043 state agencies. A recipient who has exhausted the grievance process
1044 established through such contract and wishes to seek further review of
1045 the denial of coverage for a specific medical service may request a
1046 hearing in accordance with the provisions of section 17b-60.

1047 (f) [Each] The Commissioner of Social Services may require each
1048 federally qualified health center participating in the program [shall,
1049 within thirty days of August 20, 2003,] to enroll in the federal Office of
1050 Pharmacy Affairs Section 340B drug discount program established
1051 pursuant to 42 USC 256b to provide pharmacy services to recipients at
1052 Federal Supply Schedule costs. Each such health center may establish
1053 an on-site pharmacy or contract with a commercial pharmacy to
1054 provide such pharmacy services.

1055 (g) The Commissioner of Social Services shall, within available
1056 appropriations, make payments to hospitals for inpatient services
1057 based on their pro rata share of the cost of services provided or the
1058 number of clients served, or both. The Commissioner of Social Services
1059 shall, within available appropriations, make payments for any
1060 ancillary or specialty services provided to state-administered general
1061 assistance recipients under this section based on a methodology
1062 determined by the commissioner.

1063 (h) On or before March 1, 2004, the Commissioner of Social Services
1064 shall seek a waiver of federal law under the Health Insurance
1065 Flexibility and Accountability demonstration initiative for the purpose
1066 of extending health insurance coverage under Medicaid to persons
1067 qualifying for medical assistance under the state-administered general
1068 assistance program. The provisions of section 17b-8 shall apply to this
1069 section.

1070 Sec. 11. Subsection (c) of section 17b-749 of the general statutes is
1071 repealed and the following is substituted in lieu thereof (*Effective from*
1072 *passage*):

1073 (c) The commissioner shall establish eligibility and program
1074 standards including, but not limited to: (1) A priority intake and
1075 eligibility system with preference given to serving recipients of
1076 temporary family assistance who are employed or engaged in
1077 employment activities under the "Reach for Jobs First" program
1078 pursuant to subsection (i) of section 17b-112, as amended, working
1079 families whose temporary family assistance was discontinued not
1080 more than five years prior to the date of application for the child care
1081 subsidy program, teen parents, low-income working families, adoptive
1082 families of children who were adopted from the Department of
1083 Children and Families and who are granted a waiver of income
1084 standards under subdivision (2) of subsection (b), and working
1085 families who are at risk of welfare dependency; (2) health and safety
1086 standards for child care providers not required to be licensed; (3) a
1087 reimbursement system for child care services which account for
1088 differences in the age of the child, number of children in the family, the
1089 geographic region and type of care provided by licensed and
1090 unlicensed caregivers, the cost and type of services provided by
1091 licensed and unlicensed caregivers, successful completion of fifteen
1092 hours of annual in-service training or credentialing of child care
1093 directors and administrators, and program accreditation; (4)
1094 supplemental payment for special needs of the child and extended
1095 nontraditional hours; (5) an annual rate review process which assures
1096 that reimbursement rates are maintained at levels which permit equal
1097 access to a variety of child care settings; (6) a sliding reimbursement
1098 scale for participating families; (7) an administrative appeals process;
1099 (8) an administrative hearing process to adjudicate cases of alleged
1100 fraud and abuse and to impose sanctions and recover overpayments;
1101 and (9) a waiting list for the child care subsidy program that reflects
1102 the priority and eligibility system set forth in subdivision (1) of this
1103 subsection, which is reviewed periodically, with the inclusion of this
1104 information in the annual report required to be issued annually by the
1105 Department of Social Services to the Governor and the General
1106 Assembly in accordance with subdivision (10) of section 17b-733. Such

1107 action will include, but not be limited to, family income, age of child,
1108 region of state and length of time on such waiting list. The
1109 commissioner may establish additional priority intake provisions,
1110 including provisions to set aside child care subsidies for children for
1111 whom foster care, subsidized guardianship, or subsidized adoption
1112 payments are being made by the Department of Children and Families.

1113 Sec. 12. Section 17b-261 of the general statutes, as amended by
1114 section 10 of public act 03-2, section 2 of public act 03-28, section 7 of
1115 public act 03-268 and section 63 of public act 03-3 of the June 30 special
1116 session, is repealed and the following is substituted in lieu thereof
1117 (*Effective from passage*):

1118 (a) Medical assistance shall be provided for any otherwise eligible
1119 person whose income, including any available support from legally
1120 liable relatives and the income of the person's spouse or dependent
1121 child, is not more than one hundred forty-three per cent, pending
1122 approval of a federal waiver applied for pursuant to subsection (d) of
1123 this section, of the benefit amount paid to a person with no income
1124 under the temporary family assistance program in the appropriate
1125 region of residence and if such person is an institutionalized
1126 individual as defined in Section 1917(c) of the Social Security Act, 42
1127 USC 1396p(c), and has not made an assignment or transfer or other
1128 disposition of property for less than fair market value for the purpose
1129 of establishing eligibility for benefits or assistance under this section.
1130 Any such disposition shall be treated in accordance with Section
1131 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
1132 property made on behalf of an applicant or recipient or the spouse of
1133 an applicant or recipient by a guardian, conservator, person
1134 authorized to make such disposition pursuant to a power of attorney
1135 or other person so authorized by law shall be attributed to such
1136 applicant, recipient or spouse. A disposition of property ordered by a
1137 court shall be evaluated in accordance with the standards applied to
1138 any other such disposition for the purpose of determining eligibility.
1139 The commissioner shall establish the standards for eligibility for

1140 medical assistance at one hundred forty-three per cent of the benefit
1141 amount paid to a family unit of equal size with no income under the
1142 temporary family assistance program in the appropriate region of
1143 residence, pending federal approval, except that the medical assistance
1144 program shall provide coverage to persons under the age of nineteen
1145 up to one hundred eighty-five per cent of the federal poverty level
1146 without an asset limit. Said medical assistance program shall also
1147 provide coverage to persons under the age of nineteen and their
1148 parents and needy caretaker relatives who qualify for coverage under
1149 Section 1931 of the Social Security Act with family income up to one
1150 hundred per cent of the federal poverty level without an asset limit. [,
1151 upon the request of such a person or upon a redetermination of
1152 eligibility.] Such levels shall be based on the regional differences in
1153 such benefit amount, if applicable, unless such levels based on regional
1154 differences are not in conformance with federal law. Any income in
1155 excess of the applicable amounts shall be applied as may be required
1156 by said federal law, and assistance shall be granted for the balance of
1157 the cost of authorized medical assistance. All contracts entered into on
1158 and after July 1, 1997, pursuant to this section shall include provisions
1159 for collaboration of managed care organizations with the Healthy
1160 Families Connecticut Program established pursuant to section 17a-56.
1161 The Commissioner of Social Services shall provide applicants for
1162 assistance under this section, at the time of application, with a written
1163 statement advising them of the effect of an assignment or transfer or
1164 other disposition of property on eligibility for benefits or assistance.

1165 (b) For the purposes of the Medicaid program, the Commissioner of
1166 Social Services shall consider parental income and resources as
1167 available to a child under eighteen years of age who is living with his
1168 or her parents and is blind or disabled for purposes of the Medicaid
1169 program, or to any other child under twenty-one years of age who is
1170 living with his or her parents.

1171 (c) For the purposes of determining eligibility for the Medicaid
1172 program, an available asset is one that is actually available to the

1173 applicant or one that the applicant has the legal right, authority or
1174 power to obtain or to have applied for the applicant's general or
1175 medical support. If the terms of a trust provide for the support of an
1176 applicant, the refusal of a trustee to make a distribution from the trust
1177 does not render the trust an unavailable asset. Notwithstanding the
1178 provisions of this subsection, the availability of funds in a trust or
1179 similar instrument funded in whole or in part by the applicant or the
1180 applicant's spouse shall be determined pursuant to the Omnibus
1181 Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of
1182 this subsection shall not apply to special needs trust, as defined in 42
1183 USC 1396p(d)(4)(A).

1184 (d) The transfer of an asset in exchange for other valuable
1185 consideration shall be allowable to the extent the value of the other
1186 valuable consideration is equal to or greater than the value of the asset
1187 transferred.

1188 (e) The Commissioner of Social Services shall [seek a waiver from
1189 federal law] make provision in the Medicaid state plan to permit
1190 federal financial participation for Medicaid expenditures for families
1191 with incomes of one hundred forty-three per cent of the temporary
1192 family assistance program payment standard.

1193 (f) Notwithstanding the provisions of subsection (a) of this section,
1194 on or after April 1, 2003, all parent and needy caretaker relatives with
1195 incomes exceeding one hundred per cent of the federal poverty level,
1196 who are receiving medical assistance pursuant to this section, shall be
1197 ineligible for such medical assistance. On and after February 28, 2003,
1198 the Department of Social Services shall not accept applications for
1199 medical assistance program coverage under Section 1931 of the Social
1200 Security Act from parent and needy caretaker relatives with incomes
1201 exceeding one hundred per cent of the federal poverty level until on or
1202 after July 1, 2005.

1203 (g) To the extent permitted by federal law, Medicaid eligibility shall
1204 be extended for two years to a family who becomes ineligible for

1205 medical assistance under Section 1931 of the Social Security Act [while
1206 employed] because of income from employment or due to receipt of
1207 child support income. [or a family with an adult who, within six
1208 months of becoming ineligible under Section 1931 of the Social
1209 Security Act becomes employed.]

1210 (h) An institutionalized spouse applying for Medicaid and having a
1211 spouse living in the community shall be required, to the maximum
1212 extent permitted by law, to divert income to such community spouse
1213 in order to raise the community spouse's income to the level of the
1214 minimum monthly needs allowance, as described in Section 1924 of
1215 the Social Security Act. Such diversion of income shall occur before the
1216 community spouse is allowed to retain assets in excess of the
1217 community spouse protected amount described in Section 1924 of the
1218 Social Security Act. The Commissioner of Social Services, pursuant to
1219 section 17b-10, may implement the provisions of this subsection while
1220 in the process of adopting regulations, provided the commissioner
1221 prints notice of intent to adopt the regulations in the Connecticut Law
1222 Journal within twenty days of adopting such policy. Such policy shall
1223 be valid until the time final regulations are effective.

1224 Sec. 13. Section 1 of public act 03-1 of the September 8 special
1225 session is repealed and the following is substituted in lieu thereof
1226 (*Effective from passage*):

1227 (a) For purposes of funding (1) the deficit in the General Fund
1228 arising from the operations of the General Fund for the fiscal year
1229 ending June 30, 2003, as reported by the Comptroller to the Governor
1230 in accordance with section 3-115 of the general statutes, and (2) the
1231 amount of funding required to pay any remaining retrospective
1232 reimbursements billed by hospitals for inpatient and outpatient
1233 services or other providers of medical services for services rendered to
1234 recipients of medical assistance in the State Administered General
1235 Assistance and General Assistance programs prior to the conversion of
1236 such program pursuant to section 43 of public act 03-3 of the June 30

1237 special session, the Treasurer is authorized to issue notes of the state in
1238 an amount not to exceed the amount of such deficit and retrospective
1239 reimbursements, and such additional amounts as may be required in
1240 connection with the costs of issuance of such notes, and to deposit the
1241 proceeds thereof in the General Fund.

1242 (b) (1) The Comptroller is hereby authorized and directed to certify
1243 to the Treasurer the amount of such deficit and the amount so certified
1244 shall be conclusive evidence for the purpose of determining at the time
1245 of issuance the amount of obligations which the Treasurer shall issue
1246 pursuant to this section. (2) The Secretary of the Office of Policy and
1247 Management is hereby authorized and directed to certify to the State
1248 Treasurer the estimate of the amount of funding required to pay any
1249 remaining retrospective reimbursements billed by hospitals for
1250 inpatient and outpatient services or other providers of medical services
1251 for services rendered to recipients of medical assistance in the State
1252 Administered General Assistance and General Assistance programs
1253 prior to the conversion of such program pursuant to section 43 of
1254 public act 03-3 of the June 30 special session and the amount so
1255 certified shall be conclusive evidence for the purpose of determining at
1256 the time of issuance the amount of obligations which the Treasurer
1257 shall issue pursuant to this section.

1258 (c) The notes shall be designated economic recovery notes and shall
1259 be issued on or after the effective date of this section, whenever the
1260 Treasurer determines that the cash requirements of the General Fund
1261 must be met by such borrowing and shall be scheduled so as to
1262 minimize the need for additional temporary borrowing pursuant to
1263 section 3-16 of the general statutes.

1264 (d) All such notes shall be general obligations of the state and the
1265 full faith and credit of the state of Connecticut are pledged for the
1266 payment of the principal of and interest on said notes as the same shall
1267 become due, and accordingly and as part of the contract of the state
1268 with the holders of said notes, appropriation of all amounts necessary

1269 for punctual payment of such principal and interest is hereby made,
1270 and the Treasurer shall pay such principal and interest as the same
1271 become due. All such notes shall be sold at not less than par and
1272 accrued interest in such manner and on such terms as the Treasurer
1273 may determine, in the best interest of the state, and shall be signed in
1274 the name of the state and on its behalf by the Treasurer. All such notes
1275 shall mature no later than five years after the date of issuance, in such
1276 principal amounts and at such times, bear such date or dates, be
1277 payable at such place or places, bear interest at such rate or different or
1278 varying rates, payable at such time or times, be in such denominations,
1279 be in such form with or without interest coupons attached, carry such
1280 registration and transfer privileges, be payable in such medium of
1281 payment, be subject to such terms of redemption with or without
1282 premium and have such additional security, covenant or contract
1283 provisions, including credit facilities which may include a letter of
1284 credit or insurance policy from a commercial bank or insurance
1285 company authorized to do business within or without the state, and
1286 the necessary or appropriate provisions to ensure the exclusion of
1287 interest on the notes from taxation under the Internal Revenue Code of
1288 1986, or any subsequent corresponding internal revenue code of the
1289 United States, as from time to time amended, as appropriate or
1290 necessary to improve their marketability, as the Treasurer shall
1291 determine prior to their issuance. Such notes shall be issued with only
1292 interest payable in the state fiscal year of issuance. In connection with
1293 any such credit facility, the Treasurer may enter into any
1294 reimbursement agreements, remarketing agreements, standby
1295 purchase agreements or any other necessary or appropriate
1296 agreements securing or insuring such notes, on such terms and
1297 conditions as the Treasurer determines to be in the best interest of the
1298 state. In the event the credit facility is drawn upon to pay the principal
1299 of or interest on such notes, the full faith and credit of the state is
1300 pledged to the repayment of the amount so drawn and the Treasurer is
1301 authorized to include such pledge in any such agreement as part of the
1302 contract with the provider of such credit facility. The Treasurer shall

1303 apply any appropriation for the payment of such notes to such
1304 reimbursement repayment if such credit facility is drawn upon. Any
1305 expense incurred in connection with the initial issuance of the
1306 economic recovery notes shall be paid from the accrued interest and
1307 premiums or otherwise from the General Fund. All such notes, their
1308 transfer and the income therefrom, including any profit on the sale or
1309 transfer thereof, shall at all times be exempt from all taxation by the
1310 state or under its authority except for estate or succession taxes but the
1311 interest on such notes shall be included in the computation of any
1312 excise or franchise tax and are hereby made and declared to be (1) legal
1313 investments for savings banks and trustees unless otherwise provided
1314 in the instrument creating the trust, (2) securities in which all public
1315 officers and bodies, all insurance companies and associations and
1316 persons carrying on an insurance business, all banks, bankers, trust
1317 companies, savings banks and savings associations, including savings
1318 and loan associations, building and loan associations, investment
1319 companies and persons carrying on a banking or investment business,
1320 all administrators, guardians, executors, trustees and other fiduciaries
1321 and all persons whatsoever who are or may be authorized to invest in
1322 notes of the state, may properly and legally invest funds including
1323 capital in their control or belonging to them, and (3) securities which
1324 may be deposited with and shall be received by all public officers and
1325 bodies for any purpose for which the deposit of notes of the state is or
1326 may be authorized.

1327 (e) Notwithstanding any provision of law, for the purpose of
1328 determining at any time or times the position of the General Fund as of
1329 June 30, 2004, the Comptroller is authorized and directed to give effect
1330 to and to show the funding of the General Fund deficit as of June 30,
1331 2003, as certified and provided for in this section in an amount equal to
1332 the principal amount of the notes issued and deposited in the General
1333 Fund, provided the notes authorized in this section have been so
1334 issued prior to such time or times of determination, it being hereby
1335 declared to be the intent and purpose of this section to provide for the
1336 General Fund deficit as of June 30, 2003, by the funding thereof

1337 through the issuance of the notes.

1338 (f) An amount equal to the amount certified by the Secretary of the
1339 Office of Policy and Management for retrospective reimbursements
1340 shall be credited to the State Administered General Assistance account
1341 in the Department of Social Services for the fiscal [year] years ending
1342 June 30, 2004, and June 30, 2005. Such amount shall be available to the
1343 department to pay such retrospective reimbursement claims received
1344 during the fiscal [year] years ending June 30, 2004, and June 30, 2005.

1345 Sec. 14. Section 17b-289 of the general statutes is repealed and the
1346 following is substituted in lieu thereof (*Effective from passage*):

1347 (a) Sections 17b-289 to 17b-303, inclusive, as amended by this act,
1348 and section 16 of public act 97-1 of the October 29 special session* shall
1349 be known as the "HUSKY and HUSKY Plus Act".

1350 (b) [Children] Medicaid recipients who are pregnant women or
1351 newborns or other children and their eligible parents or caretaker
1352 relatives receiving assistance under section 17b-261, as amended by
1353 this act, shall be participants in the HUSKY Plan, Part A. [and children]
1354 Children receiving assistance under sections 17b-289 to 17b-303,
1355 inclusive, as amended by this act, and section 16 of public act 97-1 of
1356 the October 29 special session* shall be participants in the HUSKY
1357 Plan, Part B. For purposes of marketing and outreach, both parts shall
1358 be known as the HUSKY Plan.

1359 Sec. 15. Section 17b-290 of the general statutes, as amended by
1360 section 73 of public act 03-3 of the June 30 special session, is repealed
1361 and the following is substituted in lieu thereof (*Effective from passage*):

1362 As used in sections 17b-289 to 17b-303, inclusive, as amended by
1363 this act, section 72 of [this act] public act 03-3 of the June 30 special
1364 session, as amended by this act, and section 16 of public act 97-1 of the
1365 October 29 special session*:

1366 (1) "Applicant" means an individual over the age of eighteen years

1367 who is a natural or adoptive parent or a legal guardian; a caretaker
1368 relative, foster parent or stepparent with whom the child resides; or a
1369 noncustodial parent under order of a court or family support
1370 magistrate to provide health insurance, who applies for coverage
1371 under the HUSKY Plan, Part B on behalf of a child and shall include a
1372 child who is eighteen years of age or emancipated in accordance with
1373 the provisions of sections 46b-150 to 46b-150e, inclusive, and who is
1374 applying on his own behalf or on behalf of a minor dependent for
1375 coverage under such plan;

1376 (2) "Child" means an individual under nineteen years of age;

1377 (3) "Coinsurance" means the sharing of health care expenses by the
1378 insured and an insurer in a specified ratio;

1379 (4) "Commissioner" means the Commissioner of Social Services;

1380 (5) "Copayment" means a payment made on behalf of an enrollee for
1381 a specified service under the HUSKY Plan, Part B;

1382 (6) "Cost sharing" means arrangements made on behalf of an
1383 enrollee whereby an applicant pays a portion of the cost of health
1384 services, sharing costs with the state and includes copayments,
1385 premiums, deductibles and coinsurance;

1386 (7) "Deductible" means the amount of out-of-pocket expenses that
1387 would be paid for health services on behalf of an enrollee before
1388 becoming payable by the insurer;

1389 (8) "Department" means the Department of Social Services;

1390 (9) "Durable medical equipment" means durable medical
1391 equipment, as defined in Section 1395x(n) of the Social Security Act;

1392 (10) "Eligible beneficiary" means a child who meets the
1393 requirements specified in section 17b-292, as amended by this act,
1394 except a child excluded under the provisions of Subtitle J of Public

1395 Law 105-33 or a child of any municipal employee eligible for
1396 employer-sponsored insurance on or after October 30, 1997, provided a
1397 child of such a municipal employee may be eligible for coverage under
1398 the HUSKY Plan, Part B if dependent coverage was terminated due to
1399 an extreme economic hardship on the part of the employee, as
1400 determined by the commissioner;

1401 (11) "Enrollee" means an eligible beneficiary who receives services
1402 from a managed care plan under the HUSKY Plan, Part B;

1403 (12) "Family" means any combination of the following: (A) An
1404 individual; (B) the individual's spouse; (C) any child of the individual
1405 or such spouse; or (D) the legal guardian of any such child if the
1406 guardian resides with the child;

1407 (13) "HUSKY Plan, Part A" means assistance provided to pregnant
1408 women, newborns and other children and their eligible parents and
1409 caretaker relatives pursuant to section 17b-261, as amended by this act,
1410 who are enrolled in a managed care organization for receipt of
1411 Medicaid services;

1412 (14) "HUSKY Plan, Part B" means the health insurance plan for
1413 children established pursuant to the provisions of sections 17b-289 to
1414 17b-303, inclusive, as amended by this act, and section 16 of public act
1415 97-1 of the October 29 special session*;

1416 (15) "HUSKY Plus programs" means two supplemental health
1417 insurance programs established pursuant to section 17b-294 for
1418 medically eligible enrollees of the HUSKY Plan, Part B whose medical
1419 needs cannot be accommodated within the basic benefit package
1420 offered to enrollees. One program shall supplement coverage for those
1421 medically eligible enrollees with intensive physical health needs and
1422 the other program shall supplement coverage for those medically
1423 eligible enrollees with intensive behavioral health needs;

1424 (16) "Income" means income as calculated in the same manner as

1425 under the Medicaid program pursuant to section 17b-261, as amended
1426 by this act;

1427 (17) "Managed care plan" means a plan offered by an entity that
1428 contracts with the department to provide benefits to enrollees on a
1429 prepaid basis;

1430 (18) "Parent" means a natural parent, stepparent, adoptive parent,
1431 guardian or custodian of a child;

1432 (19) "Premium" means any required payment made by an
1433 individual to offset or pay in full the capitation rate under the HUSKY
1434 Plan, Part B;

1435 (20) "Preventive care and services" means: (A) Child preventive
1436 care, including periodic and interperiodic well-child visits, routine
1437 immunizations, health screenings and routine laboratory tests; (B)
1438 prenatal care, including care of all complications of pregnancy; (C) care
1439 of newborn infants, including attendance at high-risk deliveries and
1440 normal newborn care; (D) WIC evaluations; (E) child abuse assessment
1441 required under sections 17a-106a and 46b-129a; (F) preventive dental
1442 care for children; and (G) periodicity schedules and reporting based on
1443 the standards specified by the American Academy of Pediatrics;

1444 (21) "Primary and preventive health care services" means the
1445 services of licensed physicians, optometrists, nurses, nurse
1446 practitioners, midwives and other related health care professionals
1447 which are provided on an outpatient basis, including routine well-
1448 child visits, diagnosis and treatment of illness and injury, laboratory
1449 tests, diagnostic x-rays, prescription drugs, radiation therapy,
1450 chemotherapy, hemodialysis, emergency room services, and outpatient
1451 alcohol and substance abuse services, as defined by the commissioner;

1452 (22) "Qualified entity" means any entity: (A) Eligible for payments
1453 under a state plan approved under Medicaid and which provides
1454 medical services under the HUSKY Plan, Part A, or (B) that is a

1455 qualified entity, as defined in 42 USC 1396r-1a, as amended by Section
1456 708 of Public Law 106-554 and that is determined by the commissioner
1457 to be capable of making the determination of eligibility. The
1458 commissioner shall provide qualified entities with such forms as are
1459 necessary for an application to be made on behalf of a child under the
1460 HUSKY Plan, Part A and information on how to assist parents,
1461 guardians and other persons in completing and filing such forms;

1462 (23) "WIC" means the federal Special Supplemental Food Program
1463 for Women, Infants and Children administered by the Department of
1464 Public Health pursuant to section 19a-59c.

1465 Sec. 16. Section 72 of public act 03-3 of the June 30 special session is
1466 repealed and the following is substituted in lieu thereof (*Effective from*
1467 *passage*):

1468 (a) Notwithstanding any provision of the general statutes or the
1469 regulations of Connecticut state agencies, the Commissioner of Social
1470 Services, in consultation with the Office of Policy and Management,
1471 shall enter into contracts with managed care organizations to provide
1472 services for eligible individuals enrolled in a managed care plan under
1473 the HUSKY Plan, Part A. The managed care plan shall be substantially
1474 similar to the State Employee Non-Gatekeeper POE Plan as of October
1475 1, 2003, and shall comply with all Medicaid federal law and
1476 regulations. For the fiscal years ending June 30, 2004, and June 30,
1477 2005, the copayment requirements shall not exceed three dollars per
1478 medical service and one dollar and fifty cents per prescription drug.
1479 The [commissioner shall require] department or the managed care
1480 organizations [to] shall assess a monthly [cost sharing] premium
1481 requirement for eligible individuals enrolled in a managed care plan as
1482 follows: (1) For a family with an income that is at or above fifty per
1483 cent of the federal poverty level but below one hundred per cent of the
1484 federal poverty level, an amount of ten dollars per person with a
1485 family share not to exceed twenty-five dollars per month; and (2) for a
1486 family with an income that is at or above one hundred per cent of the

1487 federal poverty level, [but does not exceed one hundred eighty-five per
1488 cent of the federal poverty level,] an amount of twenty dollars per
1489 person with a family share not to exceed fifty dollars per month.

1490 (b) Individuals participating in [HUSKY Plan, Part A] Medicaid, not
1491 enrolled in managed care, shall be assessed similar copayments and
1492 [cost sharing] premium requirements as described under subsection (a)
1493 of this section.

1494 (c) The commissioner may deny coverage or discontinue eligibility
1495 for any recipient who is two months in arrears on premium
1496 requirements. Termination shall not occur until thirty days after the
1497 recipient is notified.

1498 [(c)] (d) The commissioner shall amend the state Medicaid plan and
1499 seek any federal waivers necessary to implement the provisions of this
1500 section.

1501 [(d)] (e) The commissioner shall implement the changes pursuant to
1502 this section while in the process of adopting necessary policies and
1503 procedures in regulation form in accordance with the provisions of
1504 section 17b-10.

1505 Sec. 17. Section 17b-131 of the general statutes, as amended by
1506 section 48 of public act 03-3 of the June 30 special session, is repealed
1507 and the following is substituted in lieu thereof (*Effective from passage*):

1508 When a person in any town, or sent from such town to any licensed
1509 institution or state humane institution, dies or is found dead therein
1510 and does not leave sufficient estate or has no legally liable relative able
1511 to pay the cost of a proper funeral and burial, the [chief executive
1512 officer of such town,] Commissioner of Social Services shall give to
1513 such person a proper funeral and burial, and shall pay a sum not
1514 exceeding twelve hundred dollars as an allowance toward the funeral
1515 expenses of such deceased, said sum to be paid, upon submission of a
1516 proper bill, to the funeral director, cemetery or crematory, as the case

1517 may be. [The Commissioner of Social Services shall reimburse such
1518 town for such burial.] Such payment for funeral and burial expenses
1519 shall be reduced by (1) the amount in any revocable or irrevocable
1520 funeral fund, (2) any prepaid funeral contract, (3) the face value of any
1521 life insurance policy owned by the decedent, and (4) contributions in
1522 excess of two thousand eight hundred dollars toward such funeral and
1523 burial expenses from all other sources including friends, relatives and
1524 all other persons, organizations, veterans and other benefit programs
1525 and other agencies.

1526 Sec. 18. Section 17b-78 of the general statutes, as amended by section
1527 45 of public act 03-3 of the June 30 special session, is repealed and the
1528 following is substituted in lieu thereof (*Effective from passage*):

1529 The Commissioner of Social Services shall adopt regulations, in
1530 accordance with the provisions of chapter 54, to implement policies
1531 and procedures necessary to carry out the purposes of [sections 42 and
1532 44 of this act] section 42 of public act 03-3 of the June 30 special session
1533 and sections 17b-119, as amended, 17b-131, as amended by this act,
1534 17b-257, as amended by this act, and 17b-689, as amended by this act.
1535 The Commissioner of Social Services shall implement such policies and
1536 procedures while in the process of adopting such policies and
1537 procedures as regulations, or amending existing regulations provided
1538 notice of intent to adopt or amend the regulations is published in the
1539 Connecticut Law Journal within twenty days of implementation, and
1540 such policies and procedures shall be valid until the time final
1541 regulations are effective. The commissioner shall also amend any
1542 regulations in existence on August 20, 2003, to conform to the
1543 provisions of [sections 42 and 44 of this act and section 17b-78,] section
1544 42 of public act 03-3 of the June 30 special session, this section, as
1545 amended, sections 17b-119, as amended, 17b-131, as amended by this
1546 act, 17b-257, as amended by this act, and 17b-689, as amended by this
1547 act.

1548 Sec. 19. Subsection (a) of section 17b-689 of the general statutes, as

1549 amended by section 46 of public act 03-3 of the June 30 special session,
1550 is repealed and the following is substituted in lieu thereof (*Effective*
1551 *from passage*):

1552 (a) For the purposes of this section, [sections 42 and 44 of this act]
1553 section 42 of public act 03-3 of the June 30 special session and sections
1554 17b-78, as amended by this act, 17b-118, as amended, 17b-119, as
1555 amended, 17b-131, as amended by this act, and 17b-257, as amended
1556 by this act, (1) an "employable person" means one (A) who is sixteen
1557 years of age or older but less than sixty-five years of age; and (B) who
1558 has no documented physical or mental impairment prohibiting such
1559 person from working or participating in an education, training or other
1560 work readiness program, or who has such an impairment which is
1561 expected to last less than two months, as determined by the
1562 commissioner; (2) an "unemployable person" means a person who (A)
1563 is under sixteen years of age or sixty-five years of age or older or fifty-
1564 five years of age or older with a history of chronic unemployment; (B)
1565 has a physical or mental impairment prohibiting such person from
1566 working or participating in an education, training or other work-
1567 readiness program, which is expected to last at least six months, as
1568 determined by the commissioner; (C) is pending receipt of
1569 supplemental security income, Social Security income or financial
1570 assistance through another program administered by the Department
1571 of Social Services; (D) is needed to care for a child under two years of
1572 age or to care for an incapacitated child or spouse; (E) is a full-time
1573 high school student in good standing; or (F) is a VISTA volunteer; and
1574 (3) a "transitional individual" means a person (A) who has a
1575 documented physical or mental impairment which prevents
1576 employment and is expected to last at least two months, but less than
1577 six months, as determined by the commissioner, and who has a recent
1578 connection to the labor market, unless circumstances precluded
1579 participation in the labor force, as determined by the commissioner; or
1580 (B) whose determination of unemployability or disability, as defined
1581 by the commissioner, is pending and who provides medical
1582 documentation of a severe physical or mental impairment which is

1583 expected to last at least six months. A person who is a substance
1584 abuser shall be required to participate in treatment, including
1585 counseling, and shall be eligible for assistance while waiting for
1586 treatment.

1587 Sec. 20. Subsection (a) of section 42 of public act 03-3 of the June 30
1588 special session is repealed and the following is substituted in lieu
1589 thereof (*Effective from passage*):

1590 (a) Notwithstanding the provisions of sections 17b-7, 17b-111, 17b-
1591 111b, 17b-118, as amended, 17b-118a, 17b-118b and 17b-221, as
1592 amended, the Commissioner of Social Services shall operate a state-
1593 administered general assistance program in accordance with this
1594 section [and section 44 of this act] and sections 17b-78, as amended by
1595 this act, 17b-119, as amended, 17b-131, as amended, 17b-257, as
1596 amended by this act, and 17b-689, as amended by this act.
1597 Notwithstanding any provision of the general statutes, on and after
1598 October 1, 2003, no town shall be reimbursed by the state for any
1599 general assistance medical benefits incurred after September 30, 2003,
1600 and on and after March 1, 2004, no town shall be reimbursed by the
1601 state for any general assistance cash benefits or general assistance
1602 program administrative costs incurred after February 29, 2004.

1603 Sec. 21. (*Effective from passage*) Section 44 of public act 03-3 of the
1604 June 30 special session is repealed.

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| 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>from passage</i> |
| Sec. 19 | <i>from passage</i> |
| Sec. 20 | <i>from passage</i> |
| Sec. 21 | <i>from passage</i> |

Statement of Purpose:

To implement the Governor's budget recommendations.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]