



General Assembly

Bill No. 5041

February Session, 2004

LCO No. 518

*00518 _____ *

Referred to Committee on Human Services

Introduced by:

REP. WARD, 86th Dist.

SEN. DELUCA, 32nd Dist.

**AN ACT CONCERNING THE GOVERNOR'S BUDGET
RECOMMENDATIONS REGARDING HUMAN SERVICES STATUTES.**

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

1 Section 1. (NEW) (*Effective July 1, 2004*) The Commissioner of Social
2 Services may contract, through a competitive bidding process, for the
3 most cost-effective long-term care for Medicaid recipients residing in
4 nursing facilities. The commissioner may consider a regional approach
5 that takes into account bed needs in a given geographic area.

6 Sec. 2. (NEW) (*Effective July 1, 2004*) The Commissioner of Social
7 Services may contract with a pharmacy benefits management
8 organization or a single entity qualified to deliver comprehensive
9 health care services, in accordance with section 17b-266 of the general
10 statutes, as amended, to provide prescription drug coverage to medical
11 assistance recipients receiving services in a managed care setting.

12 Sec. 3. (NEW) (*Effective from passage*) The Commissioner of Social
13 Services, to the extent permitted by federal law, shall amend the

14 Medicaid state plan to establish a pilot program serving not more than
15 five hundred elderly or disabled state medical assistance recipients
16 who are also eligible for Medicare and who voluntarily opt to
17 participate in the program. Such program shall demonstrate the
18 feasibility and cost effectiveness of delivering comprehensive health
19 insurance coverage in a managed care setting to such recipients. The
20 commissioner may include medical assistance services in the pilot
21 program not presently covered in the state medical assistance program
22 or other modifications to the state medical assistance program to
23 encourage voluntary participation in the pilot program.

24 Sec. 4. (NEW) (*Effective from passage*) The Commissioner of Social
25 Services, to the extent permitted by federal law, shall amend the
26 Medicaid state plan to limit dental coverage to emergency dental
27 services for medical assistance recipients twenty-one years of age or
28 older. For purposes of this section, "emergency dental services" means
29 a dental condition manifesting itself by acute symptoms of sufficient
30 severity, including severe pain, that a prudent layperson, possessing
31 an average knowledge of health and medicine, would reasonably
32 expect the absence of immediate dental attention to place the health of
33 the individual, or with respect to a pregnant woman, the health of the
34 woman or her unborn child, in serious jeopardy, serious impairment to
35 body functions or serious dysfunction of any body organ or body part.
36 Nonemergency dental services shall continue to be provided for
37 individuals served by the Department of Mental Retardation through
38 said department's home and community-based waiver under Section
39 1915 of the Social Security Act.

40 Sec. 5. Section 17b-492 of the general statutes, as amended by section
41 15 of public act 03-2 and section 58 of public act 03-3 of the June 30
42 special session, is repealed and the following is substituted in lieu
43 thereof (*Effective from passage*):

44 (a) Eligibility for participation in the program shall be limited to any
45 resident (1) who is sixty-five years of age or older or who is disabled,

46 (2) [(A)] whose annual income, if unmarried, [is less than thirteen
47 thousand eight hundred dollars, except after April 1, 2002, such annual
48 income] is less than twenty thousand eight hundred dollars, or whose
49 annual income, if married, when combined with that of the resident's
50 spouse is less than [sixteen thousand six hundred dollars, except after
51 April 1, 2002, such combined annual income is less than twenty-seven]
52 twenty-eight thousand one hundred dollars, [or (B) in the event the
53 program is granted a waiver to be eligible for federal financial
54 participation, then, after July 1, 2002, whose annual income, if
55 unmarried, is less than twenty-five thousand eight hundred dollars, or
56 whose annual income, if married, when combined with that of the
57 resident's spouse is less than thirty-four thousand eight hundred
58 dollars,] (3) who is not insured under a policy which provides full or
59 partial coverage for prescription drugs, except for a Medicare
60 prescription drug discount card endorsed by the Secretary of Health
61 and Human Services in accordance with Public Law 108-173, the
62 Medicare Prescription Drug, Improvement and Modernization Act of
63 2003, once a deductible amount is met, (4) whose available assets are
64 below one hundred thousand dollars if unmarried and one hundred
65 twenty-five thousand dollars if married, (A) the asset limit for a
66 married resident shall be determined by combining the value of assets
67 available to both spouses, and (B) for purposes of this section, available
68 assets are those that are considered available in determining eligibility
69 in the Connecticut Home Care Program for the Elderly, and (5) on and
70 after September 15, 1991, who pays an annual thirty-dollar registration
71 fee to the Department of Social Services. Effective January 1, 2002, the
72 commissioner shall commence accepting applications from individuals
73 who will become eligible to participate in the program as of April 1,
74 2002. On January 1, 1998, and annually thereafter, the commissioner
75 shall increase the income limits established under this subsection over
76 those of the previous fiscal year to reflect the annual inflation
77 adjustment in Social Security income, if any. Each such adjustment
78 shall be determined to the nearest one hundred dollars.

79 (b) Payment for a prescription under the program shall be made

80 only if no other plan of insurance or assistance is available to an
81 eligible person for such prescription at the time of dispensing, except
82 for benefits received from an endorsed Medicare prescription drug
83 discount card. The pharmacy shall make reasonable efforts to ascertain
84 the existence of other insurance or assistance, including the subsidy
85 provided by an endorsed Medicare prescription drug discount card. A
86 Medicare prescription drug discount card beneficiary shall be
87 responsible for the payment of any Medicare prescription drug
88 discount card coinsurance requirements, provided such requirements
89 do not exceed the ConnPACE program copayment requirements. If a
90 Medicare prescription drug discount card beneficiary's coinsurance
91 requirements exceed the ConnPACE copayment requirements, the
92 Department of Social Services shall make payment to the pharmacy to
93 cover costs in excess of the ConnPACE copayment amount. If the cost
94 to such beneficiary exceeds the remaining available Medicare
95 prescription drug discount card subsidy, the beneficiary shall not be
96 responsible for any payment in excess of the amount of the ConnPACE
97 program copayment requirement. In such cases, the Department of
98 Social Services shall make payment to the pharmacy to cover costs in
99 excess of the ConnPACE copayment amount.

100 (c) Any eligible resident who (1) is insured under a policy, including
101 an endorsed Medicare prescription drug discount card, which
102 provides full or partial coverage for prescription drugs, and (2) expects
103 to exhaust such coverage, may apply to participate in the program
104 prior to the exhaustion of such coverage. Such application shall be
105 valid for the applicable income year. To be included in the program, on
106 or after the date the applicant exhausts such coverage, the applicant or
107 the applicant's designee shall notify the department that such coverage
108 is exhausted and, if required by the department, shall submit evidence
109 of exhaustion of coverage. Not later than ten days after an eligible
110 resident submits such evidence, such resident shall be included in the
111 program. The program shall, except for those beneficiaries with an
112 endorsed Medicare prescription drug discount card, (A) cover
113 prescriptions that are not covered by any other plan of insurance or

114 assistance available to the eligible resident and that meet the
115 requirements of this chapter, and (B) retroactively cover such
116 prescriptions filled after or concurrently with the exhaustion of such
117 coverage. Nothing in this subsection shall be construed to prevent a
118 resident from applying to participate in the program as otherwise
119 permitted by this chapter and regulations adopted pursuant to this
120 chapter.

121 (d) As a condition of eligibility for participation in the ConnPACE
122 program, a resident with an income at or below one hundred thirty-
123 five per cent of the federal poverty level, who is Medicare Part A or
124 Part B eligible, shall obtain an endorsed Medicare prescription drug
125 discount card. The Commissioner of Social Services may require, as a
126 condition of eligibility for participation in the ConnPACE program,
127 that a resident with an income above one hundred thirty-five per cent
128 of the federal poverty level, who is Medicare Part A or Part B eligible,
129 obtain an endorsed Medicare prescription drug discount card if
130 obtaining such discount card is determined by the commissioner to be
131 cost-effective to the state. In such an event, the commissioner may
132 provide payment for any Medicare prescription drug discount card
133 enrollment fees.

134 ~~[(d)]~~ (e) The Commissioner of Social Services may adopt
135 regulations, in accordance with the provisions of chapter 54, to
136 implement the provisions of subsection (c) of this section. Such
137 regulations may provide for the electronic transmission of relevant
138 coverage information between a pharmacist and the department or
139 between an insurer and the department in order to expedite
140 applications and notice. The commissioner may implement the policies
141 and procedures necessary to carry out the provisions of this section
142 while in the process of adopting such policies and procedures in
143 regulation form, provided notice of intent to adopt the regulations is
144 published not later than twenty days after the date of implementation.
145 Such policies and procedures shall be valid until the time the final
146 regulations are adopted.

147 Sec. 6. Section 17b-95 of the general statutes, as amended by section
148 59 of public act 03-3 of the June 30 special session, is repealed and the
149 following is substituted in lieu thereof (*Effective from passage*):

150 (a) Subject to the provisions of subsection (b) of this section, upon
151 the death of a parent of a child who has, at any time, been a beneficiary
152 under the program of aid to families with dependent children, the
153 temporary family assistance program or the state-administered general
154 assistance program, or upon the death of any person who has at any
155 time been a beneficiary of aid under the state supplement program,
156 medical assistance program, aid to families with dependent children
157 program, temporary family assistance program or state-administered
158 general assistance program, [and, on or after September 1, 2003, the
159 Connecticut Pharmaceutical Assistance Contract to the Elderly and
160 Disabled Program,] except as provided in subsection (b) of section 17b-
161 93, the state shall have a claim against such parent's or person's estate
162 for all amounts paid on behalf of each such child or for the support of
163 either parent or such child or such person under the state supplement
164 program, medical assistance program, aid to families with dependent
165 children program, temporary family assistance program or state-
166 administered general assistance program [and on or after September 1,
167 2003, to a beneficiary of aid under the Connecticut Pharmaceutical
168 Assistance Contract to the Elderly and Disabled Program,] for which
169 the state has not been reimbursed, to the extent that the amount which
170 the surviving spouse, parent or dependent children of the decedent
171 would otherwise take from such estate is not needed for their support.

172 (b) In the case of any person dying after October 1, 1959, the claim
173 for medical payments, even though such payments were made prior
174 thereto, shall be restricted to medical disbursements actually made for
175 care of such deceased beneficiary. [In the case of any person dying
176 after September 1, 2003, the claim for ConnPACE program benefits
177 shall be restricted to benefits actually received on or after July 1, 2003.]

178 (c) Claims pursuant to this section shall have priority over all

179 unsecured claims against such estate, except (1) expenses of last
180 sickness not to exceed three hundred seventy-five dollars, (2) funeral
181 and burial expenses in accordance with section 17b-84, and (3)
182 administrative expenses, including probate fees and taxes, and
183 including fiduciary fees not exceeding the following commissions on
184 the value of the whole estates accounted for by such fiduciaries: On the
185 first two thousand dollars or portion thereof, five per cent; on the next
186 eight thousand dollars or portion thereof, four per cent; on the excess
187 over ten thousand dollars, three per cent. Upon petition by any
188 fiduciary, the Probate Court, after a hearing thereon, may authorize
189 compensation in excess of the above schedule for extraordinary
190 services. Notice of any such petition and hearing shall be given to the
191 Commissioner of Administrative Services in Hartford at least ten days
192 in advance of such hearing. The allowable funeral and burial payment
193 herein shall be reduced by the amount of any prepaid funeral
194 arrangement. Any amount paid from the estate under this section to
195 any person which exceeds the limits provided herein shall be repaid to
196 the estate by such person, and such amount may be recovered in a civil
197 action with interest at six per cent from the date of demand.

198 (d) For purposes of this section, all sums due on or after July 1, 2003,
199 to any individual after the death of a public assistance beneficiary
200 pursuant to the terms of an annuity contract purchased at any time
201 with assets of a public assistance beneficiary, shall be deemed to be
202 part of the estate of the deceased beneficiary and shall be payable to
203 the state by the recipient of such annuity payments to the extent
204 necessary to achieve full reimbursement of any public assistance
205 benefits paid to, or on behalf of, the deceased beneficiary irrespective
206 of any provision of law. The recipient of beneficiary payments from
207 any such annuity contract shall be solely liable to the state of
208 Connecticut for reimbursement of public assistance benefits paid to, or
209 on behalf of, the deceased beneficiary to the extent of any payments
210 received by such recipient pursuant to the annuity contract.

211 Sec. 7. Subsection (a) of section 17b-239 of the general statutes is

212 repealed and the following is substituted in lieu thereof (*Effective July*
213 *1, 2004*):

214 (a) The rate to be paid by the state to hospitals receiving
215 appropriations granted by the General Assembly and to freestanding
216 chronic disease hospitals, providing services to persons aided or cared
217 for by the state for routine services furnished to state patients, shall be
218 based upon reasonable cost to such hospital, or the charge to the
219 general public for ward services or the lowest charge for semiprivate
220 services if the hospital has no ward facilities, imposed by such
221 hospital, whichever is lowest, except to the extent, if any, that the
222 commissioner determines that a greater amount is appropriate in the
223 case of hospitals serving a disproportionate share of indigent patients.
224 Such rate shall be promulgated annually by the Commissioner of
225 Social Services. Nothing contained herein shall authorize a payment by
226 the state for such services to any such hospital in excess of the charges
227 made by such hospital for comparable services to the general public.
228 Notwithstanding the provisions of this section, for the rate period
229 beginning July 1, 2000, rates paid to freestanding chronic disease
230 hospitals and freestanding psychiatric hospitals shall be increased by
231 three per cent. For the rate period beginning July 1, 2001, a
232 freestanding chronic disease hospital or freestanding psychiatric
233 hospital shall receive a rate that is two and one-half per cent more than
234 the rate it received in the prior fiscal year and such rate shall remain
235 effective until December 31, 2002. Effective January 1, 2003, a
236 freestanding chronic disease hospital or freestanding psychiatric
237 hospital shall receive a rate that is two per cent more than the rate it
238 received in the prior fiscal year. Notwithstanding the provisions of this
239 subsection, for the period commencing July 1, 2001, and ending June
240 30, 2003, the commissioner may pay an additional total of no more
241 than three hundred thousand dollars annually for services provided to
242 long-term ventilator patients. For purposes of this subsection, "long-
243 term ventilator patient" means any patient at a freestanding chronic
244 disease hospital on a ventilator for a total of sixty days or more in any
245 consecutive twelve-month period. Effective July 1, 2004, each

246 freestanding chronic disease hospital shall receive a rate that is two per
247 cent more than the rate it received in the prior fiscal year.

248 Sec. 8. Subsection (g) of section 17b-239 of the general statutes, as
249 amended by section 68 of public act 03-3 of the June 30 special session,
250 is repealed and the following is substituted in lieu thereof (*Effective July*
251 *1, 2004*):

252 (g) Effective June 1, 2001, the commissioner shall establish inpatient
253 hospital rates in accordance with the method specified in regulations
254 adopted pursuant to this section and applied for the rate period
255 beginning October 1, 2000, except that the commissioner shall update
256 each hospital's target amount per discharge to the actual allowable cost
257 per discharge based upon the 1999 cost report filing multiplied by
258 sixty-two and one-half per cent if such amount is higher than the target
259 amount per discharge for the rate period beginning October 1, 2000, as
260 adjusted for the ten per cent incentive identified in Section 4005 of
261 Public Law 101-508. If a hospital's rate is increased pursuant to this
262 subsection, the hospital shall not receive the ten per cent incentive
263 identified in Section 4005 of Public Law 101-508. For rate periods
264 beginning October 1, 2001, through September 30, [2005] 2004, the
265 commissioner shall not apply an annual adjustment factor to the target
266 amount per discharge. Effective October 1, 2004, the revised target
267 amount per discharge for each hospital with a target amount per
268 discharge less than three thousand seven hundred fifty dollars shall be
269 three thousand seven hundred fifty dollars. Effective October 1, 2005,
270 the revised target amount per discharge for each hospital with a target
271 amount per discharge less than four thousand dollars shall be four
272 thousand dollars. Effective October 1, 2006, the revised target amount
273 per discharge for each hospital with a target amount per discharge less
274 than four thousand two hundred fifty dollars shall be four thousand
275 two hundred fifty dollars.

276 Sec. 9. Subsection (a) of section 17b-244 of the general statutes, as
277 amended by section 81 of public act 03-3 of the June 30 special session,

278 is repealed and the following is substituted in lieu thereof (*Effective July*
279 *1, 2004*):

280 (a) The room and board component of the rates to be paid by the
281 state to private facilities and facilities operated by regional education
282 service centers which are licensed to provide residential care pursuant
283 to section 17a-227, as amended, but not certified to participate in the
284 Title XIX Medicaid program as intermediate care facilities for persons
285 with mental retardation, shall be determined annually by the
286 Commissioner of Social Services, except that rates effective April 30,
287 1989, shall remain in effect through October 31, 1989. Any facility with
288 real property other than land placed in service prior to July 1, 1991,
289 shall, for the fiscal year ending June 30, 1995, receive a rate of return on
290 real property equal to the average of the rates of return applied to real
291 property other than land placed in service for the five years preceding
292 July 1, 1993. For the fiscal year ending June 30, 1996, and any
293 succeeding fiscal year, the rate of return on real property for property
294 items shall be revised every five years. The commissioner shall, upon
295 submission of a request by such facility, allow actual debt service,
296 comprised of principal and interest, on the loan or loans in lieu of
297 property costs allowed pursuant to section 17-313b-5 of the regulations
298 of Connecticut state agencies, whether actual debt service is higher or
299 lower than such allowed property costs, provided such debt service
300 terms and amounts are reasonable in relation to the useful life and the
301 base value of the property. In the case of facilities financed through the
302 Connecticut Housing Finance Authority, the commissioner shall allow
303 actual debt service, comprised of principal, interest and a reasonable
304 repair and replacement reserve on the loan or loans in lieu of property
305 costs allowed pursuant to section 17-313b-5 of the regulations of
306 Connecticut state agencies, whether actual debt service is higher or
307 lower than such allowed property costs, provided such debt service
308 terms and amounts are determined by the commissioner at the time
309 the loan is entered into to be reasonable in relation to the useful life
310 and base value of the property. The commissioner may allow fees
311 associated with mortgage refinancing provided such refinancing will

312 result in state reimbursement savings, after comparing costs over the
313 terms of the existing proposed loans. For the fiscal year ending June 30,
314 1992, the inflation factor used to determine rates shall be one-half of
315 the gross national product percentage increase for the period between
316 the midpoint of the cost year through the midpoint of the rate year. For
317 fiscal year ending June 30, 1993, the inflation factor used to determine
318 rates shall be two-thirds of the gross national product percentage
319 increase from the midpoint of the cost year to the midpoint of the rate
320 year. For the fiscal years ending June 30, 1996, and June 30, 1997, no
321 inflation factor shall be applied in determining rates. The
322 Commissioner of Social Services shall prescribe uniform forms on
323 which such facilities shall report their costs. Such rates shall be
324 determined on the basis of a reasonable payment for necessary
325 services. Any increase in grants, gifts, fund-raising or endowment
326 income used for the payment of operating costs by a private facility in
327 the fiscal year ending June 30, 1992, shall be excluded by the
328 commissioner from the income of the facility in determining the rates
329 to be paid to the facility for the fiscal year ending June 30, 1993,
330 provided any operating costs funded by such increase shall not
331 obligate the state to increase expenditures in subsequent fiscal years.
332 For the fiscal year ending June 30, 2005, rates in effect for the period
333 ending June 30, 2004, shall remain in effect, except any facility that
334 would have received a lower rate effective July 1, 2004, than for the
335 fiscal year ending June 30, 2004, due to interim rate status or
336 agreement with the department shall be issued such lower rate
337 effective July 1, 2004. Nothing contained in this section shall authorize
338 a payment by the state to any such facility in excess of the charges
339 made by the facility for comparable services to the general public. The
340 service component of the rates to be paid by the state to private
341 facilities and facilities operated by regional education service centers
342 which are licensed to provide residential care pursuant to section 17a-
343 227, as amended, but not certified to participate in the Title XIX
344 Medicaid programs as intermediate care facilities for persons with
345 mental retardation, shall be determined annually by the Commissioner

346 of Mental Retardation.

347 Sec. 10. Section 17b-257 of the general statutes, as amended by
348 section 18 of public act 03-2 and section 43 of public act 03-3 of the June
349 30 special session, is repealed and the following is substituted in lieu
350 thereof (*Effective July 1, 2004*):

351 (a) The Commissioner of Social Services shall implement a state
352 medical assistance component of the state-administered general
353 assistance program for persons ineligible for Medicaid. Not later than
354 October 1, 2003, each person eligible for state-administered general
355 assistance shall be entitled to receive medical care through a federally
356 qualified health center or other primary care provider as determined
357 by the commissioner. The Commissioner of Social Services shall
358 determine appropriate service areas and shall, in the commissioner's
359 discretion, contract with community health centers, other similar
360 clinics, and other primary care providers, if necessary, to assure access
361 to primary care services for recipients who live farther than a
362 reasonable distance from a federally qualified health center. The
363 commissioner shall assign and enroll eligible persons in federally
364 qualified health centers and with any other providers contracted for
365 the program because of access needs. Not later than October 1, 2003,
366 each person eligible for state-administered general assistance shall be
367 entitled to receive hospital services. Medical services under the
368 program shall be limited to the services provided by a federally
369 qualified health center, hospital, or other provider contracted for the
370 program at the commissioner's discretion because of access needs. The
371 commissioner shall ensure that ancillary services and specialty services
372 are provided by a federally qualified health center, hospital, or other
373 providers contracted for the program at the commissioner's discretion.
374 Ancillary services include, but are not limited to, radiology, laboratory,
375 and other diagnostic services not available from a recipient's assigned
376 primary-care provider, and durable medical equipment. Specialty
377 services are services provided by a physician with a specialty that are
378 not included in ancillary services. In no event, shall ancillary or

379 specialty services provided under the program exceed such services
380 provided under the state-administered general assistance program on
381 July 1, 2003. Eligibility criteria concerning income shall be the same as
382 the medically needy component of the Medicaid program, except that
383 earned monthly gross income of up to one hundred fifty dollars shall
384 be disregarded. Unearned income shall not be disregarded. No person
385 who has family assets exceeding one thousand dollars shall be eligible.
386 No person eligible for Medicaid shall be eligible to receive medical
387 care through the state-administered general assistance program. No
388 person shall be eligible for assistance under this section if such person
389 made, during the three months prior to the month of application, an
390 assignment or transfer or other disposition of property for less than
391 fair market value. The number of months of ineligibility due to such
392 disposition shall be determined by dividing the fair market value of
393 such property, less any consideration received in exchange for its
394 disposition, by five hundred dollars. Such period of ineligibility shall
395 commence in the month in which the person is otherwise eligible for
396 benefits. Any assignment, transfer or other disposition of property, on
397 the part of the transferor, shall be presumed to have been made for the
398 purpose of establishing eligibility for benefits or services unless such
399 person provides convincing evidence to establish that the transaction
400 was exclusively for some other purpose.

401 (b) Recipients covered by a general assistance program operated by
402 a town shall be assigned and enrolled in federally qualified health
403 centers and with any other providers in the same manner as recipients
404 of medical assistance under the state-administered general assistance
405 program pursuant to subsection (a) of this section.

406 (c) On and after October 1, 2003, pharmacy services shall be
407 provided to recipients of state-administered general assistance through
408 the federally qualified health center to which they are assigned or
409 through a pharmacy with which the health center contracts. Prior to
410 said date, pharmacy services shall be provided as provided under the
411 Medicaid program. Recipients who are assigned to a community

412 health center or similar clinic or primary care provider other than a
413 federally qualified health center or to a federally qualified health
414 center that does not have a contract for pharmacy services shall receive
415 pharmacy services at pharmacies designated by the commissioner.

416 (d) Recipients of state-administered general assistance shall
417 contribute a copayment of one dollar and fifty cents for each
418 prescription.

419 (e) The Commissioner of Social Services shall contract with federally
420 qualified health centers or other primary care providers as necessary to
421 provide medical services to eligible state-administered general
422 assistance recipients pursuant to this section. The commissioner shall,
423 within available appropriations, make payments to such centers based
424 on their pro rata share of the cost of services provided or the number
425 of clients served, or both. The Commissioner of Social Services shall,
426 within available appropriations, make payments to other providers
427 based on a methodology determined by the commissioner. The
428 Commissioner of Social Services may reimburse for extraordinary
429 medical services, provided such services are documented to the
430 satisfaction of the commissioner. For purposes of this section, the
431 commissioner may contract with a managed care organization or other
432 entity to perform administrative functions. Provisions of a contract for
433 medical services entered into by the commissioner pursuant to this
434 section shall supersede any inconsistent provision in the regulations of
435 Connecticut state agencies.

436 (f) Each federally qualified health center participating in the
437 program shall, within thirty days of August 20, 2003, enroll in the
438 federal Office of Pharmacy Affairs Section 340B drug discount
439 program established pursuant to 42 USC 256b to provide pharmacy
440 services to recipients at Federal Supply Schedule costs. Each such
441 health center may establish an on-site pharmacy or contract with a
442 commercial pharmacy to provide such pharmacy services.

443 (g) The Commissioner of Social Services shall, within available

444 appropriations, make payments to hospitals for inpatient services
445 based on their pro rata share of the cost of services provided or the
446 number of clients served, or both. The Commissioner of Social Services
447 shall, within available appropriations, make payments for any
448 ancillary or specialty services provided to state-administered general
449 assistance recipients under this section based on a methodology
450 determined by the commissioner.

451 (h) On or before March 1, 2004, the Commissioner of Social Services
452 shall seek a waiver of federal law under the Health Insurance
453 Flexibility and Accountability demonstration initiative for the purpose
454 of extending health insurance coverage under Medicaid to persons
455 qualifying for medical assistance under the state-administered general
456 assistance program. The provisions of section 17b-8 shall apply to this
457 section.

458 (i) The commissioner may implement policies and procedures to
459 administer the provisions of this section while in the process of
460 adopting such policies and procedures in regulation form, provided
461 the commissioner prints notice of the intent to adopt the regulations in
462 the Connecticut Law Journal not later than twenty days after the date
463 of implementation. Such policy shall be valid until the time final
464 regulations are adopted.

465 Sec. 11. Section 11 of public act 03-1 of the September 8 special
466 session is repealed and the following is substituted in lieu thereof
467 (*Effective July 1, 2004*):

468 [On and after August 20, 2003, the] The Commissioner of Social
469 Services may impose cost-sharing requirements on recipients of
470 medical assistance, including a deductible, coinsurance or similar
471 charge up to the maximum permitted under 42 CFR 447.54. The
472 Commissioner of Social Services shall impose cost-sharing
473 requirements on recipients of medical assistance, as follows: (1) A
474 [one-dollar] copayment not to exceed three dollars for each outpatient
475 medical service delivered by an enrolled Medicaid provider to a

476 medical assistance recipient as permitted under federal law; [, and] (2)
477 a one-dollar and fifty cent copayment for each drug prescription at the
478 time the prescription is filled; and (3) a two-dollar copayment for each
479 nonemergency medical transportation service provided to a medical
480 assistance recipient not enrolled in a managed care plan, as permitted
481 under federal law, except that such copayments shall not apply to
482 medical assistance recipients residing in nursing facilities. [On and
483 after October 1, 2003, the copayment for prescription drugs shall be
484 one dollar and fifty cents per prescription and the copayment for
485 outpatient medical services shall not exceed three dollars per service in
486 accordance with 42 CFR 447.54.] To the degree permitted under federal
487 law, the commissioner may make modifications to the prescription
488 cost-sharing requirements imposed pursuant to this section for certain
489 individuals who have drugs dispensed in less than a thirty-day supply
490 and may exempt residents in certain institutional settings from such
491 requirements. Such cost-sharing requirements shall be implemented in
492 accordance with the conditions specified in federal regulations.

493 Sec. 12. Subsection (g) of section 17b-261 of the general statutes, as
494 amended by section 2 of public act 03-28, is repealed and the following
495 is substituted in lieu thereof (*Effective July 1, 2004*):

496 (g) To the extent permitted by federal law, Medicaid eligibility shall
497 be extended for [two years] one year to a family who becomes
498 ineligible for medical assistance under Section 1931 of the Social
499 Security Act while employed or due to receipt of child support income
500 or a family with an adult who, within six months of becoming
501 ineligible under Section 1931 of the Social Security Act becomes
502 employed. A family receiving extended benefits on July 1, 2004, shall
503 receive the balance of such extended benefits, but in no case shall such
504 a family receive more than twelve additional months of such benefits.

505 Sec. 13. Section 17b-280 of the general statutes, as amended by
506 section 11 of public act 03-2 and section 52 of public act 03-3 of the June
507 30 special session, is repealed and the following is substituted in lieu

508 thereof (*Effective July 1, 2004*):

509 (a) The state shall reimburse for all legend drugs provided under
510 the Medicaid, state-administered general assistance, general assistance,
511 ConnPACE and Connecticut AIDS drug assistance programs at the
512 lower of: (1) The rate established by the Health Care Finance
513 Administration as the federal acquisition cost, or [, if no such rate is
514 established, the commissioner shall establish and periodically revise
515 the estimated acquisition cost in accordance with federal regulations]
516 (2) the average wholesale price minus fourteen per cent. Effective
517 [October 1, 2003] July 1, 2004, the commissioner shall also establish a
518 professional fee of three dollars [and thirty cents] for each prescription
519 to be paid to licensed pharmacies for dispensing drugs to Medicaid,
520 state-administered general assistance, general assistance, ConnPACE
521 and Connecticut AIDS drug assistance recipients in accordance with
522 federal regulations; and on and after September 4, 1991, payment for
523 legend and nonlegend drugs provided to Medicaid recipients shall be
524 based upon the actual package size dispensed. Effective October 1,
525 1991, reimbursement for over-the-counter drugs for such recipients
526 shall be limited to those over-the-counter drugs and products
527 published in the Connecticut Formulary, or the cross reference list,
528 issued by the commissioner. The cost of all over-the-counter drugs and
529 products provided to residents of nursing facilities, chronic disease
530 hospitals, and intermediate care facilities for the mentally retarded
531 shall be included in the facilities' per diem rate.

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

537 Sec. 14. Subsection (g) of section 17b-340 of the general statutes, as
538 amended by section 45 of public act 03-19 and section 50 of public act
539 03-3 of the June 30 special session, is repealed and the following is

540 substituted in lieu thereof (*Effective July 1, 2004*):

541 (g) For the fiscal year ending June 30, 1993, any intermediate care
542 facility for the mentally retarded with an operating cost component of
543 its rate in excess of one hundred forty per cent of the median of
544 operating cost components of rates in effect January 1, 1992, shall not
545 receive an operating cost component increase. For the fiscal year
546 ending June 30, 1993, any intermediate care facility for the mentally
547 retarded with an operating cost component of its rate that is less than
548 one hundred forty per cent of the median of operating cost
549 components of rates in effect January 1, 1992, shall have an allowance
550 for real wage growth equal to thirty per cent of the increase
551 determined in accordance with subsection (q) of section 17-311-52 of
552 the regulations of Connecticut state agencies, provided such operating
553 cost component shall not exceed one hundred forty per cent of the
554 median of operating cost components in effect January 1, 1992. Any
555 facility with real property other than land placed in service prior to
556 October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a
557 rate of return on real property equal to the average of the rates of
558 return applied to real property other than land placed in service for the
559 five years preceding October 1, 1993. For the fiscal year ending June 30,
560 1996, and any succeeding fiscal year, the rate of return on real property
561 for property items shall be revised every five years. The commissioner
562 shall, upon submission of a request, allow actual debt service,
563 comprised of principal and interest, in excess of property costs allowed
564 pursuant to section 17-311-52 of the regulations of Connecticut state
565 agencies, provided such debt service terms and amounts are
566 reasonable in relation to the useful life and the base value of the
567 property. For the fiscal year ending June 30, 1995, and any succeeding
568 fiscal year, the inflation adjustment made in accordance with
569 subsection (p) of section 17-311-52 of the regulations of Connecticut
570 state agencies shall not be applied to real property costs. For the fiscal
571 year ending June 30, 1996, and any succeeding fiscal year, the
572 allowance for real wage growth, as determined in accordance with
573 subsection (q) of section 17-311-52 of the regulations of Connecticut

574 state agencies, shall not be applied. For the fiscal year ending June 30,
575 1996, and any succeeding fiscal year, no rate shall exceed three
576 hundred seventy-five dollars per day unless the commissioner, in
577 consultation with the Commissioner of Mental Retardation,
578 determines after a review of program and management costs, that a
579 rate in excess of this amount is necessary for care and treatment of
580 facility residents. For the fiscal year ending June 30, 2002, rate period,
581 the Commissioner of Social Services shall increase the inflation
582 adjustment for rates made in accordance with subsection (p) of section
583 17-311-52 of the regulations of Connecticut state agencies to update
584 allowable fiscal year 2000 costs to include a three and one-half per cent
585 inflation factor. For the fiscal year ending June 30, 2003, rate period, the
586 commissioner shall increase the inflation adjustment for rates made in
587 accordance with subsection (p) of section 17-311-52 of the regulations
588 of Connecticut state agencies to update allowable fiscal year 2001 costs
589 to include a one and one-half per cent inflation factor, except that such
590 increase shall be effective November 1, 2002, and such facility rate in
591 effect for the fiscal year ending June 30, 2002, shall be paid for services
592 provided until October 31, 2002, except any facility that would have
593 been issued a lower rate effective July 1, 2002, than for the fiscal year
594 ending June 30, 2002, due to interim rate status or agreement with the
595 department shall be issued such lower rate effective July 1, 2002, and
596 have such rate updated effective November 1, 2002, in accordance with
597 applicable statutes and regulations. For the fiscal year ending June 30,
598 2004, rates in effect for the period ending June 30, 2003, shall remain in
599 effect, except any facility that would have been issued a lower rate
600 effective July 1, 2003, than for the fiscal year ending June 30, 2003, due
601 to interim rate status or agreement with the department shall be issued
602 such lower rate effective July 1, 2003. [Effective July 1, 2004, each
603 facility shall receive a rate that is three-quarters of one per cent greater
604 than the rate in effect June 30, 2004.] For the fiscal year ending June 30,
605 2005, rates in effect for the period ending June 30, 2004, shall remain in
606 effect until September 30, 2004. Effective October 1, 2004, each facility
607 shall receive a rate that is five per cent greater than the rate in effect

608 September 30, 2004.

609 Sec. 15. Subsection (h) of section 17b-340 of the general statutes, as
610 amended by section 45 of public act 03-19 and section 50 of public act
611 03-3 of the June 30 special session, is repealed and the following is
612 substituted in lieu thereof (*Effective July 1, 2004*):

613 (h) (1) For the fiscal year ending June 30, 1993, any residential care
614 home with an operating cost component of its rate in excess of one
615 hundred thirty per cent of the median of operating cost components of
616 rates in effect January 1, 1992, shall not receive an operating cost
617 component increase. For the fiscal year ending June 30, 1993, any
618 residential care home with an operating cost component of its rate that
619 is less than one hundred thirty per cent of the median of operating cost
620 components of rates in effect January 1, 1992, shall have an allowance
621 for real wage growth equal to sixty-five per cent of the increase
622 determined in accordance with subsection (q) of section 17-311-52 of
623 the regulations of Connecticut state agencies, provided such operating
624 cost component shall not exceed one hundred thirty per cent of the
625 median of operating cost components in effect January 1, 1992.
626 Beginning with the fiscal year ending June 30, 1993, for the purpose of
627 determining allowable fair rent, a residential care home with allowable
628 fair rent less than the twenty-fifth percentile of the state-wide
629 allowable fair rent shall be reimbursed as having allowable fair rent
630 equal to the twenty-fifth percentile of the state-wide allowable fair
631 rent. Beginning with the fiscal year ending June 30, 1997, a residential
632 care home with allowable fair rent less than three dollars and ten cents
633 per day shall be reimbursed as having allowable fair rent equal to
634 three dollars and ten cents per day. Property additions placed in
635 service during the cost year ending September 30, 1996, or any
636 succeeding cost year shall receive a fair rent allowance for such
637 additions as an addition to three dollars and ten cents per day if the
638 fair rent for the facility for property placed in service prior to
639 September 30, 1995, is less than or equal to three dollars and ten cents
640 per day. For the fiscal year ending June 30, 1996, and any succeeding

641 fiscal year, the allowance for real wage growth, as determined in
642 accordance with subsection (q) of section 17-311-52 of the regulations
643 of Connecticut state agencies, shall not be applied. For the fiscal year
644 ending June 30, 1996, and any succeeding fiscal year, the inflation
645 adjustment made in accordance with subsection (p) of section
646 17-311-52 of the regulations of Connecticut state agencies shall not be
647 applied to real property costs. Beginning with the fiscal year ending
648 June 30, 1997, minimum allowable patient days for rate computation
649 purposes for a residential care home with twenty-five beds or less shall
650 be eighty-five per cent of licensed capacity. Beginning with the fiscal
651 year ending June 30, 2002, for the purposes of determining the
652 allowable salary of an administrator of a residential care home with
653 sixty beds or less the department shall revise the allowable base salary
654 to thirty-seven thousand dollars to be annually inflated thereafter in
655 accordance with section 17-311-52 of the regulations of Connecticut
656 state agencies. The rates for the fiscal year ending June 30, 2002, shall
657 be based upon the increased allowable salary of an administrator,
658 regardless of whether such amount was expended in the 2000 cost
659 report period upon which the rates are based. Beginning with the fiscal
660 year ending June 30, 2000, the inflation adjustment for rates made in
661 accordance with subsection (p) of section 17-311-52 of the regulations
662 of Connecticut state agencies shall be increased by two per cent, and
663 beginning with the fiscal year ending June 30, 2002, the inflation
664 adjustment for rates made in accordance with subsection (c) of said
665 section shall be increased by one per cent. Beginning with the fiscal
666 year ending June 30, 1999, for the purpose of determining the
667 allowable salary of a related party, the department shall revise the
668 maximum salary to twenty-seven thousand eight hundred fifty-six
669 dollars to be annually inflated thereafter in accordance with section
670 17-311-52 of the regulations of Connecticut state agencies and
671 beginning with the fiscal year ending June 30, 2001, such allowable
672 salary shall be computed on an hourly basis and the maximum
673 number of hours allowed for a related party other than the proprietor
674 shall be increased from forty hours to forty-eight hours per work week.

675 For the fiscal year ending June 30, 2005, rates in effect for the period
676 ending June 30, 2004, shall remain in effect, except any facility that
677 would have been issued a lower rate effective July 1, 2004, than for the
678 fiscal year ending June 30, 2004, due to interim rate status or
679 agreement with the department shall be issued such lower rate
680 effective July 1, 2004.

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

689 Sec. 16. Subsection (a) of section 17b-365 of the general statutes is
690 repealed and the following is substituted in lieu thereof (*Effective from*
691 *passage*):

692 (a) The Commissioner of Social Services may, within available
693 appropriations, establish and operate a pilot program to allow [not
694 more than fifty persons] individuals to receive assisted living services,
695 provided by an assisted living services agency licensed by the
696 Department of Public Health in accordance with chapter 368v. In order
697 to be eligible for the program, a person shall: (1) Reside in a managed
698 residential community, as defined by the regulations of the
699 Department of Public Health; (2) be ineligible to receive assisted living
700 services under any other assisted living pilot program established by
701 the General Assembly; and (3) be eligible for services under the
702 Medicaid waiver portion of the Connecticut home-care program for
703 the elderly established under section 17b-342. The total number of
704 individuals enrolled in said pilot program, when combined with the
705 total number of individuals enrolled in the pilot program established
706 pursuant to section 17b-366, as amended by this act, shall not exceed

707 seventy-five individuals. The Commissioner of Social Services shall
708 use the current Medicaid rules under 42 USC 1396p(c), as from time to
709 time amended.

710 Sec. 17. Subsection (a) of section 17b-366 of the general statutes is
711 repealed and the following is substituted in lieu thereof (*Effective from*
712 *passage*):

713 (a) The Commissioner of Social Services may, within available
714 appropriations, establish and operate a pilot program to allow [not
715 more than twenty-five persons] individuals to receive assisted living
716 services, provided by an assisted living services agency licensed by the
717 Department of Public Health, in accordance with chapter 368v. In
718 order to be eligible for the pilot program, a person shall: (1) Reside in a
719 managed residential community, as defined by the regulations of the
720 Department of Public Health; (2) be ineligible to receive assisted living
721 services under any other assisted living pilot program established by
722 the General Assembly; and (3) be eligible for services under the state-
723 funded portion of the Connecticut home-care program for the elderly
724 established under section 17b-342. The total number of individuals
725 enrolled in said pilot program, when combined with the total number
726 of individuals enrolled in the pilot program established pursuant to
727 section 17b-365, as amended by this act, shall not exceed seventy-five
728 individuals. The Commissioner of Social Services shall use the current
729 Medicaid rules under 42 USC 1396p(c), as from time to time amended.

730 Sec. 18. Subsection (b) of section 17b-688c of the general statutes is
731 repealed and the following is substituted in lieu thereof (*Effective July*
732 *1, 2004*):

733 (b) In no event shall temporary family assistance be granted to an
734 applicant for such assistance, who is not exempt from participation in
735 the employment services program, prior to the applicant's attendance
736 at a scheduled employment services assessment interview and
737 completion of an employment services plan. The Department of Social
738 Services shall reduce the benefits awarded to a family under the

739 temporary family assistance program when a member of the family
740 who is required to participate in employment services fails to comply
741 with an employment services requirement without good cause. The
742 first instance of noncompliance with an employment services
743 requirement shall result in a twenty-five per cent reduction of such
744 benefits for three consecutive months. The second instance of
745 noncompliance with such requirement shall result in a thirty-five per
746 cent reduction of such benefits for three consecutive months. A third or
747 subsequent instance of noncompliance with such requirement shall
748 result in the termination of such benefits for three consecutive months.
749 If only one member of a family is eligible for temporary family
750 assistance and such member fails to comply with an employment
751 services requirement, the department shall terminate all benefits of
752 such family for three consecutive months. Notwithstanding the
753 provisions of this subsection, the department shall terminate the
754 benefits awarded to a family under the temporary family assistance
755 program if a member of the family who is not exempt from the twenty-
756 one-month time limit specified in subsection (a) of section 17b-112, as
757 amended, fails, without good cause, to: (1) Attend any scheduled
758 assessment appointment or interview relating to the establishment of
759 an employment services plan, except that such individual's benefits
760 shall be reinstated if the individual attends a subsequently scheduled
761 appointment or interview within thirty days of the date on which the
762 department has issued notification to the individual that benefits have
763 been terminated, or (2) comply with an employment services
764 requirement during a six-month extension of benefits. Any individual
765 who fails to comply with the provisions of subdivision (1) of this
766 subsection may submit a new application for such benefits at any time
767 after termination of benefits.

768 Sec. 19. (NEW) (*Effective from passage*) (a) Notwithstanding any
769 provision of the general statutes or any special act, the Commissioner
770 of Veterans' Affairs, on behalf of any facility operated by the
771 commissioner and established by the state for the care of veterans, may
772 apply to the Department of Public Health for: (1) A license for a

773 chronic and convalescent nursing home, as defined in section 19a-521
774 of the general statutes; (2) a license for a rest home with nursing
775 supervision, as defined in section 19a-521 of the general statutes; or (3)
776 a license for an assisted living services agency, as defined in section
777 19a-490 of the general statutes, as amended.

778 (b) Notwithstanding any provision of the general statutes or any
779 special act, in the event the commissioner applies for a license under
780 subsection (a) of this section, the Veterans Home and Hospital may
781 retain such home and hospital's chronic disease hospital license.

782 (c) The Department of Public Health shall process an application for
783 any license submitted under subsection (a) of this section in an
784 expedited manner.

785 (d) Notwithstanding the provisions of chapter 319y of the general
786 statutes and the regulations of Connecticut state agencies, any
787 Veterans' Home and Hospital project undertaken pursuant to a license
788 application as provided in subsection (a) of this section shall not be
789 subject to certificate of need application and approval requirements
790 applicable to nursing home services, including beds, additions and
791 capital expenditures.

792 (e) Notwithstanding any provision of the general statutes or any
793 special act, the Veterans' Home and Hospital project undertaken
794 pursuant to a license application as provided in subsection (a) of this
795 section shall be exempt from the requirements for approval of a
796 request or application provided for in section 19a-638 of the general
797 statutes, as amended.

798 Sec. 20. (NEW) (*Effective July 1, 2004*) The Commissioner of Children
799 and Families, in collaboration with the Commissioners of Economic
800 and Community Development, Social Services, Mental Retardation
801 and Public Health, the Secretary of the Office of Policy and
802 Management and the executive director of the Connecticut Housing
803 Finance Authority, shall establish a pilot project to provide affordable

804 housing and support services to families with children who have one
805 or more serious, chronic medical conditions and have ongoing,
806 significant health care service needs.

807 Sec. 21. Section 65 of public act 03-3 of the June 30 special session is
808 amended to read as follows (*Effective from passage*):

809 [For the fiscal year ending June 30, 2004, the sum of two hundred
810 eighty-three thousand dollars shall be disbursed from the nonlapsing
811 account maintained pursuant to subsection (c) of section 10-303 of the
812 general statutes, as amended by this act, for the purpose of retiring
813 obligations associated with the contract for tee shirts manufactured by
814 the Industries program, and not] Not more than five hundred
815 thousand dollars shall be disbursed from [said account] the nonlapsing
816 account maintained pursuant to subsection (c) of section 10-303, as
817 amended, for the purpose of funding competitive employment or
818 sheltered employment of blind and visually impaired adults.

This act shall take effect as follows:	
Section 1	<i>July 1, 2004</i>
Sec. 2	<i>July 1, 2004</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>July 1, 2004</i>
Sec. 8	<i>July 1, 2004</i>
Sec. 9	<i>July 1, 2004</i>
Sec. 10	<i>July 1, 2004</i>
Sec. 11	<i>July 1, 2004</i>
Sec. 12	<i>July 1, 2004</i>
Sec. 13	<i>July 1, 2004</i>
Sec. 14	<i>July 1, 2004</i>
Sec. 15	<i>July 1, 2004</i>
Sec. 16	<i>from passage</i>
Sec. 17	<i>from passage</i>
Sec. 18	<i>July 1, 2004</i>

Sec. 19	<i>from passage</i>
Sec. 20	<i>July 1, 2004</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.]