



General Assembly

January Session, 2011

Governor's Bill No. 1013

LCO No. 3600

*03600 _____ *

Referred to Committee on Human Services

Introduced by:

SEN. WILLIAMS, 29th Dist.

SEN. LOONEY, 11th Dist.

REP. DONOVAN, 84th Dist.

REP. SHARKEY, 88th Dist.

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

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

1 Section 1. Subdivision (4) of subsection (f) of section 17b-340 of the
2 general statutes is repealed and the following is substituted in lieu
3 thereof (*Effective July 1, 2011*):

4 (4) For the fiscal year ending June 30, 1992, (A) no facility shall
5 receive a rate that is less than the rate it received for the rate year
6 ending June 30, 1991; (B) no facility whose rate, if determined pursuant
7 to this subsection, would exceed one hundred twenty per cent of the
8 state-wide median rate, as determined pursuant to this subsection,
9 shall receive a rate which is five and one-half per cent more than the
10 rate it received for the rate year ending June 30, 1991; and (C) no
11 facility whose rate, if determined pursuant to this subsection, would be
12 less than one hundred twenty per cent of the state-wide median rate,

13 as determined pursuant to this subsection, shall receive a rate which is
14 six and one-half per cent more than the rate it received for the rate year
15 ending June 30, 1991. For the fiscal year ending June 30, 1993, no
16 facility shall receive a rate that is less than the rate it received for the
17 rate year ending June 30, 1992, or six per cent more than the rate it
18 received for the rate year ending June 30, 1992. For the fiscal year
19 ending June 30, 1994, no facility shall receive a rate that is less than the
20 rate it received for the rate year ending June 30, 1993, or six per cent
21 more than the rate it received for the rate year ending June 30, 1993.
22 For the fiscal year ending June 30, 1995, no facility shall receive a rate
23 that is more than five per cent less than the rate it received for the rate
24 year ending June 30, 1994, or six per cent more than the rate it received
25 for the rate year ending June 30, 1994. For the fiscal years ending June
26 30, 1996, and June 30, 1997, no facility shall receive a rate that is more
27 than three per cent more than the rate it received for the prior rate
28 year. For the fiscal year ending June 30, 1998, a facility shall receive a
29 rate increase that is not more than two per cent more than the rate that
30 the facility received in the prior year. For the fiscal year ending June
31 30, 1999, a facility shall receive a rate increase that is not more than
32 three per cent more than the rate that the facility received in the prior
33 year and that is not less than one per cent more than the rate that the
34 facility received in the prior year, exclusive of rate increases associated
35 with a wage, benefit and staffing enhancement rate adjustment added
36 for the period from April 1, 1999, to June 30, 1999, inclusive. For the
37 fiscal year ending June 30, 2000, each facility, except a facility with an
38 interim rate or replaced interim rate for the fiscal year ending June 30,
39 1999, and a facility having a certificate of need or other agreement
40 specifying rate adjustments for the fiscal year ending June 30, 2000,
41 shall receive a rate increase equal to one per cent applied to the rate the
42 facility received for the fiscal year ending June 30, 1999, exclusive of
43 the facility's wage, benefit and staffing enhancement rate adjustment.
44 For the fiscal year ending June 30, 2000, no facility with an interim rate,
45 replaced interim rate or scheduled rate adjustment specified in a
46 certificate of need or other agreement for the fiscal year ending June

47 30, 2000, shall receive a rate increase that is more than one per cent
48 more than the rate the facility received in the fiscal year ending June
49 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a
50 facility with an interim rate or replaced interim rate for the fiscal year
51 ending June 30, 2000, and a facility having a certificate of need or other
52 agreement specifying rate adjustments for the fiscal year ending June
53 30, 2001, shall receive a rate increase equal to two per cent applied to
54 the rate the facility received for the fiscal year ending June 30, 2000,
55 subject to verification of wage enhancement adjustments pursuant to
56 subdivision (15) of this subsection. For the fiscal year ending June 30,
57 2001, no facility with an interim rate, replaced interim rate or
58 scheduled rate adjustment specified in a certificate of need or other
59 agreement for the fiscal year ending June 30, 2001, shall receive a rate
60 increase that is more than two per cent more than the rate the facility
61 received for the fiscal year ending June 30, 2000. For the fiscal year
62 ending June 30, 2002, each facility shall receive a rate that is two and
63 one-half per cent more than the rate the facility received in the prior
64 fiscal year. For the fiscal year ending June 30, 2003, each facility shall
65 receive a rate that is two per cent more than the rate the facility
66 received in the prior fiscal year, except that such increase shall be
67 effective January 1, 2003, and such facility rate in effect for the fiscal
68 year ending June 30, 2002, shall be paid for services provided until
69 December 31, 2002, except any facility that would have been issued a
70 lower rate effective July 1, 2002, than for the fiscal year ending June 30,
71 2002, due to interim rate status or agreement with the department shall
72 be issued such lower rate effective July 1, 2002, and have such rate
73 increased two per cent effective June 1, 2003. For the fiscal year ending
74 June 30, 2004, rates in effect for the period ending June 30, 2003, shall
75 remain in effect, except any facility that would have been issued a
76 lower rate effective July 1, 2003, than for the fiscal year ending June 30,
77 2003, due to interim rate status or agreement with the department shall
78 be issued such lower rate effective July 1, 2003. For the fiscal year
79 ending June 30, 2005, rates in effect for the period ending June 30, 2004,
80 shall remain in effect until December 31, 2004, except any facility that

81 would have been issued a lower rate effective July 1, 2004, than for the
82 fiscal year ending June 30, 2004, due to interim rate status or
83 agreement with the department shall be issued such lower rate
84 effective July 1, 2004. Effective January 1, 2005, each facility shall
85 receive a rate that is one per cent greater than the rate in effect
86 December 31, 2004. Effective upon receipt of all the necessary federal
87 approvals to secure federal financial participation matching funds
88 associated with the rate increase provided in this subdivision, but in
89 no event earlier than July 1, 2005, and provided the user fee imposed
90 under section 17b-320 is required to be collected, for the fiscal year
91 ending June 30, 2006, the department shall compute the rate for each
92 facility based upon its 2003 cost report filing or a subsequent cost year
93 filing for facilities having an interim rate for the period ending June 30,
94 2005, as provided under section 17-311-55 of the regulations of
95 Connecticut state agencies. For each facility not having an interim rate
96 for the period ending June 30, 2005, the rate for the period ending June
97 30, 2006, shall be determined beginning with the higher of the
98 computed rate based upon its 2003 cost report filing or the rate in
99 effect for the period ending June 30, 2005. Such rate shall then be
100 increased by eleven dollars and eighty cents per day except that in no
101 event shall the rate for the period ending June 30, 2006, be thirty-two
102 dollars more than the rate in effect for the period ending June 30, 2005,
103 and for any facility with a rate below one hundred ninety-five dollars
104 per day for the period ending June 30, 2005, such rate for the period
105 ending June 30, 2006, shall not be greater than two hundred seventeen
106 dollars and forty-three cents per day and for any facility with a rate
107 equal to or greater than one hundred ninety-five dollars per day for
108 the period ending June 30, 2005, such rate for the period ending June
109 30, 2006, shall not exceed the rate in effect for the period ending June
110 30, 2005, increased by eleven and one-half per cent. For each facility
111 with an interim rate for the period ending June 30, 2005, the interim
112 replacement rate for the period ending June 30, 2006, shall not exceed
113 the rate in effect for the period ending June 30, 2005, increased by
114 eleven dollars and eighty cents per day plus the per day cost of the

115 user fee payments made pursuant to section 17b-320 divided by
116 annual resident service days, except for any facility with an interim
117 rate below one hundred ninety-five dollars per day for the period
118 ending June 30, 2005, the interim replacement rate for the period
119 ending June 30, 2006, shall not be greater than two hundred seventeen
120 dollars and forty-three cents per day and for any facility with an
121 interim rate equal to or greater than one hundred ninety-five dollars
122 per day for the period ending June 30, 2005, the interim replacement
123 rate for the period ending June 30, 2006, shall not exceed the rate in
124 effect for the period ending June 30, 2005, increased by eleven and one-
125 half per cent. Such July 1, 2005, rate adjustments shall remain in effect
126 unless (i) the federal financial participation matching funds associated
127 with the rate increase are no longer available; or (ii) the user fee
128 created pursuant to section 17b-320 is not in effect. For the fiscal year
129 ending June 30, 2007, each facility shall receive a rate that is three per
130 cent greater than the rate in effect for the period ending June 30, 2006,
131 except any facility that would have been issued a lower rate effective
132 July 1, 2006, than for the rate period ending June 30, 2006, due to
133 interim rate status or agreement with the department, shall be issued
134 such lower rate effective July 1, 2006. For the fiscal year ending June
135 30, 2008, each facility shall receive a rate that is two and nine-tenths
136 per cent greater than the rate in effect for the period ending June 30,
137 2007, except any facility that would have been issued a lower rate
138 effective July 1, 2007, than for the rate period ending June 30, 2007, due
139 to interim rate status or agreement with the department, shall be
140 issued such lower rate effective July 1, 2007. For the fiscal year ending
141 June 30, 2009, rates in effect for the period ending June 30, 2008, shall
142 remain in effect until June 30, 2009, except any facility that would have
143 been issued a lower rate for the fiscal year ending June 30, 2009, due to
144 interim rate status or agreement with the department shall be issued
145 such lower rate. For the fiscal years ending June 30, 2010, and June 30,
146 2011, rates in effect for the period ending June 30, 2009, shall remain in
147 effect until June 30, 2011, except any facility that would have been
148 issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal

149 year ending June 30, 2011, due to interim rate status or agreement with
150 the department, shall be issued such lower rate. For the fiscal years
151 ending June 30, 2012, and June 30, 2013, rates in effect for the period
152 ending June 30, 2011, shall remain in effect until June 30, 2013, except
153 any facility that would have been issued a lower rate for the fiscal year
154 ending June 30, 2012, or the fiscal year ending June 30, 2013, due to
155 interim rate status or agreement with the department, shall be issued
156 such lower rate. The Commissioner of Social Services shall add fair
157 rent increases to any other rate increases established pursuant to this
158 subdivision for a facility which has undergone a material change in
159 circumstances related to fair rent, except for the fiscal [year] years
160 ending June 30, 2010, [and the fiscal year ending] June 30, 2011, June
161 30, 2012, and June 30, 2013, such fair rent increases shall only be
162 provided to facilities with an approved certificate of need pursuant to
163 section 17b-352, 17b-353, 17b-354 or 17b-355. Interim rates may take
164 into account reasonable costs incurred by a facility, including wages
165 and benefits.

166 Sec. 2. Subsection (a) of section 17b-280 of the general statutes is
167 repealed and the following is substituted in lieu thereof (*Effective July*
168 *1, 2011*):

169 (a) The state shall reimburse for all legend drugs provided under
170 [the Medicaid, state-administered general assistance, ConnPACE and
171 Connecticut AIDS drug assistance programs] medical assistance
172 programs administered by the Department of Social Services at the
173 [lower of (1) the rate established by the Centers for Medicare and
174 Medicaid Services as the federal acquisition cost, (2) the average
175 wholesale price minus fourteen per cent, or (3) an equivalent
176 percentage as established under the Medicaid state plan] same rate
177 negotiated by the state for outpatient prescription drugs dispensed to
178 state employees in a retail setting. The [commissioner] state shall [also
179 establish] pay a professional fee [of two dollars and ninety cents] to
180 licensed pharmacies for each prescription [to be paid to licensed
181 pharmacies for dispensing drugs to Medicaid, state-administered

182 general assistance, ConnPACE and Connecticut AIDS drug assistance
183 recipient] dispensed to a recipient of benefits under a medical
184 assistance program administered by the Department of Social Services
185 which shall be the same fee as that negotiated by the state for the
186 dispensing of outpatient prescription drugs to state employees in a
187 retail setting in accordance with federal regulations. [; and on] On and
188 after September 4, 1991, payment for legend and nonlegend drugs
189 provided to Medicaid recipients shall be based upon the actual
190 package size dispensed. Effective October 1, 1991, reimbursement for
191 over-the-counter drugs for such recipients shall be limited to those
192 over-the-counter drugs and products published in the Connecticut
193 Formulary, or the cross reference list, issued by the commissioner. The
194 cost of all over-the-counter drugs and products provided to residents
195 of nursing facilities, chronic disease hospitals, and intermediate care
196 facilities for the mentally retarded shall be included in the facilities' per
197 diem rate. Notwithstanding the provisions of this subsection, no
198 dispensing fee shall be issued for a prescription drug dispensed to a
199 ConnPACE or Medicaid recipient who is a Medicare Part D beneficiary
200 when the prescription drug is a Medicare Part D drug, as defined in
201 Public Law 108-173, the Medicare Prescription Drug, Improvement,
202 and Modernization Act of 2003.

203 Sec. 3. Subsection (b) of section 17b-104 of the general statutes is
204 repealed and the following is substituted in lieu thereof (*Effective July*
205 *1, 2011*):

206 (b) On July 1, 2007, and annually thereafter, the commissioner shall
207 increase the payment standards over those of the previous fiscal year
208 under the temporary family assistance program and the
209 state-administered general assistance program by the percentage
210 increase, if any, in the most recent calendar year average in the
211 consumer price index for urban consumers over the average for the
212 previous calendar year, provided the annual increase, if any, shall not
213 exceed five per cent, except that the payment standards for the fiscal
214 years ending June 30, 2010, [and] June 30, 2011, June 30, 2012, and June

215 30, 2013, shall not be increased.

216 Sec. 4. Subsection (a) of section 17b-106 of the general statutes is
217 repealed and the following is substituted in lieu thereof (*Effective July*
218 *1, 2011*):

219 (a) [On January 1, 2006, and on each January first thereafter, the
220 Commissioner of Social Services shall increase the unearned income
221 disregard for recipients of the state supplement to the federal
222 Supplemental Security Income Program by an amount equal to the
223 federal cost-of-living adjustment, if any, provided to recipients of
224 federal Supplemental Security Income Program benefits for the
225 corresponding calendar year.] On July 1, 1989, and annually thereafter,
226 the commissioner shall increase the adult payment standards over
227 those of the previous fiscal year for the state supplement to the federal
228 Supplemental Security Income Program by the percentage increase, if
229 any, in the most recent calendar year average in the consumer price
230 index for urban consumers over the average for the previous calendar
231 year, provided the annual increase, if any, shall not exceed five per
232 cent, except that the adult payment standards for the fiscal years
233 ending June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June
234 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June
235 30, 2002, June 30, 2003, June 30, 2004, June 30, 2005, June 30, 2006, June
236 30, 2007, June 30, 2008, June 30, 2009, June 30, 2010, [and] June 30, 2011,
237 June 30, 2012, and June 30, 2013, shall not be increased. Effective
238 October 1, 1991, the coverage of excess utility costs for recipients of the
239 state supplement to the federal Supplemental Security Income
240 Program is eliminated. Notwithstanding the provisions of this section,
241 the commissioner may increase the personal needs allowance
242 component of the adult payment standard as necessary to meet federal
243 maintenance of effort requirements.

244 Sec. 5. Section 17b-311 of the general statutes is repealed and the
245 following is substituted in lieu thereof (*Effective July 1, 2011*):

246 (a) There is established the Charter Oak Health Plan for the purpose

247 of providing access to health insurance coverage for state residents
248 who have been uninsured for at least six months, [and] who are
249 ineligible for other publicly funded health insurance plans and who
250 are ineligible for the high-risk pool established pursuant to Section
251 1101 of the Patient Protection and Affordable Care Act, P.L. 111-148.
252 The Commissioner of Social Services may enter into contracts for the
253 provision of comprehensive health care for such uninsured state
254 residents. The commissioner shall conduct outreach to facilitate
255 enrollment in the plan.

256 (b) The commissioner shall impose cost-sharing requirements in
257 connection with services provided under the Charter Oak Health Plan.
258 Such requirements may include, but not be limited to: (1) A monthly
259 premium; (2) an annual deductible not to exceed one thousand dollars;
260 (3) a coinsurance payment not to exceed twenty per cent after the
261 deductible amount is met; (4) tiered copayments for prescription drugs
262 determined by whether the drug is generic or brand name, formulary
263 or nonformulary and whether purchased through mail order; (5) no fee
264 for emergency visits to hospital emergency rooms; (6) a copayment not
265 to exceed one hundred fifty dollars for nonemergency visits to hospital
266 emergency rooms; and (7) a lifetime benefit not to exceed one million
267 dollars.

268 (c) (1) The Commissioner of Social Services shall provide premium
269 assistance to eligible state residents whose gross annual income does
270 not exceed three hundred per cent of the federal poverty level. Such
271 premium assistance shall be limited to: (A) One hundred [seventy-five]
272 fifteen dollars per month for individuals whose gross annual income is
273 below one hundred fifty per cent of the federal poverty level; (B) one
274 hundred [fifty] dollars per month for individuals whose gross annual
275 income is at or above one hundred fifty per cent of the federal poverty
276 level but not more than one hundred eighty-five per cent of the federal
277 poverty level; (C) [seventy-five] fifty dollars per month for individuals
278 whose gross annual income is above one hundred eighty-five per cent
279 of the federal poverty level but not more than two hundred thirty-five

280 per cent of the federal poverty level; and (D) [fifty] thirty-five dollars
281 per month for individuals whose gross annual income is above two
282 hundred thirty-five per cent of the federal poverty level but not more
283 than three hundred per cent of the federal poverty level. Individuals
284 insured under the Charter Oak Health Plan shall pay their share of
285 payment for coverage in the plan directly to the insurer.

286 (2) Notwithstanding the provisions of this subsection, for the fiscal
287 years ending June 30, 2010, [and] June 30, 2011, and each fiscal year
288 thereafter, the Commissioner of Social Services shall only provide
289 premium assistance to state residents who are eligible for such
290 assistance and who are enrolled in the Charter Oak Health Plan on
291 [April 30, 2010] May 31, 2010.

292 (d) The Commissioner of Social Services shall determine minimum
293 requirements on the amount, duration and scope of benefits under the
294 Charter Oak Health Plan, except that there shall be no preexisting
295 condition exclusion. Each participating insurer or administrative
296 services organization shall provide an internal grievance process by
297 which an enrollee in the Charter Oak Health Plan may request and be
298 provided a review of a denial of coverage under the plan.

299 (e) The Commissioner of Social Services shall seek proposals from
300 entities described in subsection (e) of this section based on the cost
301 sharing and benefits described in subsections (b) and (c) of this section.
302 The commissioner may approve an alternative plan in order to make
303 coverage options available to those eligible to be insured under the
304 plan.

305 (f) The Commissioner of Social Services, pursuant to section 17b-10,
306 may implement policies and procedures to administer the provisions
307 of this section while in the process of adopting such policies and
308 procedures as regulation, provided the commissioner prints notice of
309 the intent to adopt the regulation in the Connecticut Law Journal not
310 later than twenty days after the date of implementation. Such policies
311 shall be valid until the time final regulations are adopted and may

312 include: (1) Exceptions to the requirement that a resident be uninsured
313 for at least six months to be eligible for the Charter Oak Health Plan;
314 and (2) requirements for open enrollment and limitations on the ability
315 of enrollees to change plans between such open enrollment periods.

316 Sec. 6. (NEW) (*Effective July 1, 2011*) The Commissioner of Social
317 Services shall limit the extent of adult dental services provided under
318 the Medicaid program to such services that may be provided within
319 available appropriations. The commissioner may implement policies
320 and procedures necessary to administer the provisions of this section
321 while in the process of adopting such policies and procedures in
322 regulation form, provided the commissioner prints notice of intent to
323 adopt regulations in the Connecticut Law Journal not later than twenty
324 days after the date of implementation. Policies and procedures
325 implemented pursuant to this section shall be valid until the time final
326 regulations are adopted.

327 Sec. 7. (NEW) (*Effective July 1, 2011*) The Commissioner of Social
328 Services shall, to the extent permitted by federal law, impose cost-
329 sharing requirements on Medicaid recipients, except copayments shall
330 not be imposed for the following services: (1) Inpatient hospitalization;
331 (2) hospital emergency; (3) home health care; (4) those provided
332 pursuant to a home and community-based services waiver; (5)
333 laboratory; (6) emergency ambulance; and (7) nonemergency medical
334 transportation. The aggregate cost-sharing requirements for
335 prescription drugs shall not exceed twenty dollars per month.

336 Sec. 8. Subsection (a) of section 17b-244 of the general statutes is
337 repealed and the following is substituted in lieu thereof (*Effective July*
338 *1, 2011*):

339 (a) The room and board component of the rates to be paid by the
340 state to private facilities and facilities operated by regional education
341 service centers which are licensed to provide residential care pursuant
342 to section 17a-227, but not certified to participate in the Title XIX
343 Medicaid program as intermediate care facilities for persons with

344 mental retardation, shall be determined annually by the Commissioner
345 of Social Services, except that rates effective April 30, 1989, shall
346 remain in effect through October 31, 1989. Any facility with real
347 property other than land placed in service prior to July 1, 1991, shall,
348 for the fiscal year ending June 30, 1995, receive a rate of return on real
349 property equal to the average of the rates of return applied to real
350 property other than land placed in service for the five years preceding
351 July 1, 1993. For the fiscal year ending June 30, 1996, and any
352 succeeding fiscal year, the rate of return on real property for property
353 items shall be revised every five years. The commissioner shall, upon
354 submission of a request by such facility, allow actual debt service,
355 comprised of principal and interest, on the loan or loans in lieu of
356 property costs allowed pursuant to section 17-313b-5 of the regulations
357 of Connecticut state agencies, whether actual debt service is higher or
358 lower than such allowed property costs, provided such debt service
359 terms and amounts are reasonable in relation to the useful life and the
360 base value of the property. In the case of facilities financed through the
361 Connecticut Housing Finance Authority, the commissioner shall allow
362 actual debt service, comprised of principal, interest and a reasonable
363 repair and replacement reserve on the loan or loans in lieu of property
364 costs allowed pursuant to section 17-313b-5 of the regulations of
365 Connecticut state agencies, whether actual debt service is higher or
366 lower than such allowed property costs, provided such debt service
367 terms and amounts are determined by the commissioner at the time
368 the loan is entered into to be reasonable in relation to the useful life
369 and base value of the property. The commissioner may allow fees
370 associated with mortgage refinancing provided such refinancing will
371 result in state reimbursement savings, after comparing costs over the
372 terms of the existing proposed loans. For the fiscal year ending June 30,
373 1992, the inflation factor used to determine rates shall be one-half of
374 the gross national product percentage increase for the period between
375 the midpoint of the cost year through the midpoint of the rate year. For
376 fiscal year ending June 30, 1993, the inflation factor used to determine
377 rates shall be two-thirds of the gross national product percentage

378 increase from the midpoint of the cost year to the midpoint of the rate
379 year. For the fiscal years ending June 30, 1996, and June 30, 1997, no
380 inflation factor shall be applied in determining rates. The
381 Commissioner of Social Services shall prescribe uniform forms on
382 which such facilities shall report their costs. Such rates shall be
383 determined on the basis of a reasonable payment for necessary
384 services. Any increase in grants, gifts, fund-raising or endowment
385 income used for the payment of operating costs by a private facility in
386 the fiscal year ending June 30, 1992, shall be excluded by the
387 commissioner from the income of the facility in determining the rates
388 to be paid to the facility for the fiscal year ending June 30, 1993,
389 provided any operating costs funded by such increase shall not
390 obligate the state to increase expenditures in subsequent fiscal years.
391 Nothing contained in this section shall authorize a payment by the
392 state to any such facility in excess of the charges made by the facility
393 for comparable services to the general public. The service component
394 of the rates to be paid by the state to private facilities and facilities
395 operated by regional education service centers which are licensed to
396 provide residential care pursuant to section 17a-227, but not certified
397 to participate in the Title XIX Medicaid programs as intermediate care
398 facilities for persons with mental retardation, shall be determined
399 annually by the Commissioner of Developmental Services in
400 accordance with section 17b-244a. For the fiscal year ending June 30,
401 2008, no facility shall receive a rate that is more than two per cent
402 greater than the rate in effect for the facility on June 30, 2007, except
403 any facility that would have been issued a lower rate effective July 1,
404 2007, due to interim rate status or agreement with the department,
405 shall be issued such lower rate effective July 1, 2007. For the fiscal year
406 ending June 30, 2009, no facility shall receive a rate that is more than
407 two per cent greater than the rate in effect for the facility on June 30,
408 2008, except any facility that would have been issued a lower rate
409 effective July 1, 2008, due to interim rate status or agreement with the
410 department, shall be issued such lower rate effective July 1, 2008. For
411 the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect

412 for the period ending June 30, 2009, shall remain in effect until June 30,
413 2011, except that (1) the rate paid to a facility may be higher than the
414 rate paid to the facility for the period ending June 30, 2009, if a capital
415 improvement required by the Commissioner of Developmental
416 Services for the health or safety of the residents was made to the
417 facility during the fiscal years ending June 30, 2010, or June 30, 2011,
418 and (2) any facility that would have been issued a lower rate for the
419 fiscal years ending June 30, 2010, or June 30, 2011, due to interim rate
420 status or agreement with the department, shall be issued such lower
421 rate. For the fiscal years ending June 30, 2012, and June 30, 2013, rates
422 in effect for the period ending June 30, 2011, shall remain in effect until
423 June 30, 2013, except that (1) the rate paid to a facility may be higher
424 than the rate paid to the facility for the period ending June 30, 2011, if a
425 capital improvement required by the Commissioner of Developmental
426 Services for the health or safety of the residents was made to the
427 facility during the fiscal years ending June 30, 2012, or June 30, 2013,
428 and (2) any facility that would have been issued a lower rate for the
429 fiscal years ending June 30, 2012, or June 30, 2013, due to interim rate
430 status or agreement with the department, shall be issued such lower
431 rate.

432 Sec. 9. Subdivision (1) of subsection (h) of section 17b-340 of the
433 general statutes is repealed and the following is substituted in lieu
434 thereof (*Effective July 1, 2011*):

435 (h) (1) For the fiscal year ending June 30, 1993, any residential care
436 home with an operating cost component of its rate in excess of one
437 hundred thirty per cent of the median of operating cost components of
438 rates in effect January 1, 1992, shall not receive an operating cost
439 component increase. For the fiscal year ending June 30, 1993, any
440 residential care home with an operating cost component of its rate that
441 is less than one hundred thirty per cent of the median of operating cost
442 components of rates in effect January 1, 1992, shall have an allowance
443 for real wage growth equal to sixty-five per cent of the increase
444 determined in accordance with subsection (q) of section 17-311-52 of

445 the regulations of Connecticut state agencies, provided such operating
446 cost component shall not exceed one hundred thirty per cent of the
447 median of operating cost components in effect January 1, 1992.
448 Beginning with the fiscal year ending June 30, 1993, for the purpose of
449 determining allowable fair rent, a residential care home with allowable
450 fair rent less than the twenty-fifth percentile of the state-wide
451 allowable fair rent shall be reimbursed as having allowable fair rent
452 equal to the twenty-fifth percentile of the state-wide allowable fair
453 rent. Beginning with the fiscal year ending June 30, 1997, a residential
454 care home with allowable fair rent less than three dollars and ten cents
455 per day shall be reimbursed as having allowable fair rent equal to
456 three dollars and ten cents per day. Property additions placed in
457 service during the cost year ending September 30, 1996, or any
458 succeeding cost year shall receive a fair rent allowance for such
459 additions as an addition to three dollars and ten cents per day if the
460 fair rent for the facility for property placed in service prior to
461 September 30, 1995, is less than or equal to three dollars and ten cents
462 per day. For the fiscal year ending June 30, 1996, and any succeeding
463 fiscal year, the allowance for real wage growth, as determined in
464 accordance with subsection (q) of section 17-311-52 of the regulations
465 of Connecticut state agencies, shall not be applied. For the fiscal year
466 ending June 30, 1996, and any succeeding fiscal year, the inflation
467 adjustment made in accordance with subsection (p) of section
468 17-311-52 of the regulations of Connecticut state agencies shall not be
469 applied to real property costs. Beginning with the fiscal year ending
470 June 30, 1997, minimum allowable patient days for rate computation
471 purposes for a residential care home with twenty-five beds or less shall
472 be eighty-five per cent of licensed capacity. Beginning with the fiscal
473 year ending June 30, 2002, for the purposes of determining the
474 allowable salary of an administrator of a residential care home with
475 sixty beds or less the department shall revise the allowable base salary
476 to thirty-seven thousand dollars to be annually inflated thereafter in
477 accordance with section 17-311-52 of the regulations of Connecticut
478 state agencies. The rates for the fiscal year ending June 30, 2002, shall

479 be based upon the increased allowable salary of an administrator,
480 regardless of whether such amount was expended in the 2000 cost
481 report period upon which the rates are based. Beginning with the fiscal
482 year ending June 30, 2000, the inflation adjustment for rates made in
483 accordance with subsection (p) of section 17-311-52 of the regulations
484 of Connecticut state agencies shall be increased by two per cent, and
485 beginning with the fiscal year ending June 30, 2002, the inflation
486 adjustment for rates made in accordance with subsection (c) of said
487 section shall be increased by one per cent. Beginning with the fiscal
488 year ending June 30, 1999, for the purpose of determining the
489 allowable salary of a related party, the department shall revise the
490 maximum salary to twenty-seven thousand eight hundred fifty-six
491 dollars to be annually inflated thereafter in accordance with section
492 17-311-52 of the regulations of Connecticut state agencies and
493 beginning with the fiscal year ending June 30, 2001, such allowable
494 salary shall be computed on an hourly basis and the maximum
495 number of hours allowed for a related party other than the proprietor
496 shall be increased from forty hours to forty-eight hours per work week.
497 For the fiscal year ending June 30, 2005, each facility shall receive a rate
498 that is two and one-quarter per cent more than the rate the facility
499 received in the prior fiscal year, except any facility that would have
500 been issued a lower rate effective July 1, 2004, than for the fiscal year
501 ending June 30, 2004, due to interim rate status or agreement with the
502 department shall be issued such lower rate effective July 1, 2004.
503 Effective upon receipt of all the necessary federal approvals to secure
504 federal financial participation matching funds associated with the rate
505 increase provided in subdivision (4) of subsection (f) of this section,
506 but in no event earlier than October 1, 2005, and provided the user fee
507 imposed under section 17b-320 is required to be collected, each facility
508 shall receive a rate that is determined in accordance with applicable
509 law and subject to appropriations, except any facility that would have
510 been issued a lower rate effective October 1, 2005, than for the fiscal
511 year ending June 30, 2005, due to interim rate status or agreement with
512 the department, shall be issued such lower rate effective October 1,

513 2005. Such rate increase shall remain in effect unless: (A) The federal
514 financial participation matching funds associated with the rate increase
515 are no longer available; or (B) the user fee created pursuant to section
516 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in
517 effect for the period ending June 30, 2006, shall remain in effect until
518 September 30, 2006, except any facility that would have been issued a
519 lower rate effective July 1, 2006, than for the fiscal year ending June 30,
520 2006, due to interim rate status or agreement with the department,
521 shall be issued such lower rate effective July 1, 2006. Effective October
522 1, 2006, no facility shall receive a rate that is more than four per cent
523 greater than the rate in effect for the facility on September 30, 2006,
524 except for any facility that would have been issued a lower rate
525 effective October 1, 2006, due to interim rate status or agreement with
526 the department, shall be issued such lower rate effective October 1,
527 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates
528 in effect for the period ending June 30, 2009, shall remain in effect until
529 June 30, 2011, except any facility that would have been issued a lower
530 rate for the fiscal year ending June 30, 2010, or the fiscal year ending
531 June 30, 2011, due to interim rate status or agreement with the
532 department, shall be issued such lower rate, except (i) any facility that
533 would have been issued a lower rate for the fiscal year ending June 30,
534 2010, or the fiscal year ending June 30, 2011, due to interim rate status
535 or agreement with the Commissioner of Social Services shall be issued
536 such lower rate; and (ii) the commissioner may increase a facility's rate
537 for reasonable costs associated with such facility's compliance with the
538 provisions of section 19a-495a, as amended by this act, concerning the
539 administration of medication by unlicensed personnel. For the fiscal
540 years ending June 30, 2012, and June 30, 2013, rates in effect for the
541 period ending June 30, 2011, shall remain in effect until June 30, 2013,
542 except any facility that would have been issued a lower rate for the
543 fiscal year ending June 30, 2012, or the fiscal year ending June 30, 2013,
544 due to interim rate status or agreement with the department, shall be
545 issued such lower rate, except (I) any facility that would have been
546 issued a lower rate for the fiscal year ending June 30, 2012, or the fiscal

547 year ending June 30, 2013, due to interim rate status or agreement with
548 the Commissioner of Social Services shall be issued such lower rate;
549 and (II) the commissioner may increase a facility's rate for reasonable
550 costs associated with such facility's compliance with the provisions of
551 section 19a-495a, as amended by this act, concerning the
552 administration of medication by unlicensed personnel.

553 Sec. 10. (NEW) (*Effective July 1, 2011*) (a) The Commissioner of Social
554 Services shall only authorize payment for the mode of transportation
555 service that is medically necessary for a recipient of assistance under a
556 medical assistance program administered by the Department of Social
557 Services. Notwithstanding any provisions of the general statutes or
558 regulations of Connecticut state agencies, a recipient who requires
559 nonemergency transportation and who must be transported in a prone
560 position but who does not require medical services during transport
561 may be transported in a stretcher van. The commissioner shall
562 establish rates for nonemergency transportation provided by stretcher
563 van.

564 (b) Notwithstanding any provision of the general statutes or the
565 regulations of Connecticut state agencies, the Commissioner of
566 Transportation shall adopt regulations, in accordance with chapter 54
567 of the general statutes, to establish oversight of stretcher vans as a
568 livery service for which a permit is required, provided certification
569 issued by the Department of Public Health to provide transportation
570 on a stretcher shall be sufficient qualification to be issued a stretcher
571 van permit by the Commissioner of Transportation.

572 Sec. 11. Subsection (a) of section 19a-180 of the general statutes is
573 repealed and the following is substituted in lieu thereof (*Effective July*
574 *1, 2011*):

575 (a) No person shall operate any ambulance service, rescue service or
576 management service [or otherwise transport in a motor vehicle a
577 patient on a stretcher] without either a license or a certificate issued by
578 the commissioner. No person shall operate a commercial ambulance

579 service or commercial rescue service or a management service without
580 a license issued by the commissioner. A certificate shall be issued to
581 any volunteer or municipal ambulance service which shows proof
582 satisfactory to the commissioner that it meets the minimum standards
583 of the commissioner in the areas of training, equipment and personnel.
584 No license or certificate shall be issued to any volunteer, municipal or
585 commercial ambulance service, rescue service or management service,
586 as defined in subdivision (19) of section 19a-175, as amended by this
587 act, unless it meets the requirements of subsection (e) of section 14-
588 100a. Applicants for a license shall use the forms prescribed by the
589 commissioner and shall submit such application to the commissioner
590 accompanied by an annual fee of two hundred dollars. In considering
591 requests for approval of permits for new or expanded emergency
592 medical services in any region, the commissioner shall consult with the
593 Office of Emergency Medical Services and the emergency medical
594 services council of such region and shall hold a public hearing to
595 determine the necessity for such services. Written notice of such
596 hearing shall be given to current providers in the geographic region
597 where such new or expanded services would be implemented,
598 provided, any volunteer ambulance service which elects not to levy
599 charges for services rendered under this chapter shall be exempt from
600 the provisions concerning requests for approval of permits for new or
601 expanded emergency medical services set forth in this subsection. A
602 primary service area responder that operates in the service area
603 identified in the application shall, upon request, be granted intervenor
604 status with opportunity for cross-examination. Each applicant for
605 licensure shall furnish proof of financial responsibility which the
606 commissioner deems sufficient to satisfy any claim. The commissioner
607 may adopt regulations, in accordance with the provisions of chapter
608 54, to establish satisfactory kinds of coverage and limits of insurance
609 for each applicant for either licensure or certification. Until such
610 regulations are adopted, the following shall be the required limits for
611 licensure: (1) For damages by reason of personal injury to, or the death
612 of, one person on account of any accident, at least five hundred

613 thousand dollars, and more than one person on account of any
614 accident, at least one million dollars, (2) for damage to property at least
615 fifty thousand dollars, and (3) for malpractice in the care of one
616 passenger at least two hundred fifty thousand dollars, and for more
617 than one passenger at least five hundred thousand dollars. In lieu of
618 the limits set forth in subdivisions (1) to (3), inclusive, of this
619 subsection, a single limit of liability shall be allowed as follows: (A) For
620 damages by reason of personal injury to, or death of, one or more
621 persons and damage to property, at least one million dollars; and (B)
622 for malpractice in the care of one or more passengers, at least five
623 hundred thousand dollars. A certificate of such proof shall be filed
624 with the commissioner. Upon determination by the commissioner that
625 an applicant is financially responsible, properly certified and otherwise
626 qualified to operate a commercial ambulance service, rescue service or
627 management service, the commissioner shall issue the appropriate
628 license effective for one year to such applicant. If the commissioner
629 determines that an applicant for either a certificate or license is not so
630 qualified, the commissioner shall notify such applicant of the denial of
631 the application with a statement of the reasons for such denial. Such
632 applicant shall have thirty days to request a hearing on the denial of
633 the application.

634 Sec. 12. Subdivision (11) of section 19a-175 of the general statutes is
635 repealed and the following is substituted in lieu thereof (*Effective July*
636 *1, 2011*):

637 (11) "Invalid coach" means a vehicle used exclusively for the
638 transportation of nonambulatory patients [, who are not confined to
639 stretchers,] to or from either a medical facility or the patient's home in
640 nonemergency situations or utilized in emergency situations as a
641 backup vehicle when insufficient emergency vehicles exist;

642 Sec. 13. Section 17b-28e of the general statutes is repealed and the
643 following is substituted in lieu thereof (*Effective July 1, 2011*):

644 (a) The Commissioner of Social Services shall amend the Medicaid

645 state plan to include, on and after January 1, 2009, hospice services as
646 optional services covered under the Medicaid program. Said state plan
647 amendment shall supersede any regulations of Connecticut state
648 agencies concerning such optional services.

649 (b) [Not later than February 1, 2011] Effective July 1, 2013, the
650 Commissioner of Social Services shall [amend the Medicaid state plan
651 to include] enter into a contract to provide foreign language interpreter
652 services [provided] to any beneficiary with limited English proficiency
653 [as a covered service] under the Medicaid program. [Not later than
654 February 1, 2011, the commissioner shall develop and implement the
655 use of medical billing codes for foreign language interpreter services
656 for the HUSKY Plan, Part A and Part B, and for the fee-for-services
657 Medicaid programs.]

658 [(c) Each care management organization that enters into a contract
659 with the Department of Social Services to provide foreign language
660 interpreter services under the HUSKY Plan, Part A shall report, semi-
661 annually, to the department on the interpreter services provided to
662 recipients of benefits under the program. Such written reports shall be
663 submitted to the department not later than June first and December
664 thirty-first each year. Not later than thirty days after receipt of such
665 report, the department shall submit a copy of the report, in accordance
666 with the provisions of section 11-4a, to the Council on Medicaid Care
667 Management Oversight.]

668 Sec. 14. Subdivisions (1) and (2) of subsection (i) of section 17b-342
669 of the general statutes are repealed and the following is substituted in
670 lieu thereof (*Effective July 1, 2011*):

671 (i) (1) On and after July 1, 1992, the Commissioner of Social Services
672 shall, within available appropriations, administer a state-funded
673 portion of the program for persons (A) who are sixty-five years of age
674 and older; (B) who are inappropriately institutionalized or at risk of
675 inappropriate institutionalization; (C) whose income is less than or
676 equal to the amount allowed under subdivision (3) of subsection (a) of

677 this section; and (D) whose assets, if single, do not exceed the
678 minimum community spouse protected amount pursuant to Section
679 4022.05 of the department's uniform policy manual or, if married, the
680 couple's assets do not exceed one hundred fifty per cent of said
681 community spouse protected amount and on and after April 1, 2007,
682 whose assets, if single, do not exceed one hundred fifty per cent of the
683 minimum community spouse protected amount pursuant to Section
684 4022.05 of the department's uniform policy manual or, if married, the
685 couple's assets do not exceed two hundred per cent of said community
686 spouse protected amount. Notwithstanding any provision of this
687 section, for program applications received by the Department of Social
688 Services on or after July 1, 2011, only persons who require the level of
689 care provided in a nursing home shall be eligible for the state-funded
690 portion of the program.

691 (2) Except for persons residing in affordable housing under the
692 assisted living demonstration project established pursuant to section
693 17b-347e, as provided in subdivision (3) of this subsection, any person
694 whose income is at or below two hundred per cent of the federal
695 poverty level and who is ineligible for Medicaid shall contribute [six]
696 fifteen per cent of the cost of his or her care. Any person whose income
697 exceeds two hundred per cent of the federal poverty level shall
698 contribute [six] fifteen per cent of the cost of his or her care in addition
699 to the amount of applied income determined in accordance with the
700 methodology established by the Department of Social Services for
701 recipients of medical assistance. Any person who does not contribute
702 to the cost of care in accordance with this subdivision, shall be
703 ineligible to receive services under this subsection. Notwithstanding
704 any provision of the general statutes, the department shall not be
705 required to provide an administrative hearing to a person found
706 ineligible for services under this subsection because of a failure to
707 contribute to the cost of care.

708 Sec. 15. Section 19a-495a of the general statutes is repealed and the
709 following is substituted in lieu thereof (*Effective July 1, 2011*):

710 (a) (1) The Commissioner of Public Health shall adopt regulations,
711 as provided in subsection (d) of this section, to require each residential
712 care home, as defined in section 19a-490, as amended by this act, that
713 admits residents requiring assistance with medication administration,
714 and each home health care agency, as defined in section 19a-490, as
715 amended by this act, that serves clients requiring assistance with
716 medication administration to (A) designate unlicensed personnel to
717 obtain certification for the administration of medication, and (B) to
718 ensure that such unlicensed personnel receive such certification.

719 (2) The regulations shall establish criteria to be used by such homes
720 and agencies in determining (A) the appropriate number of unlicensed
721 personnel who shall obtain such certification, and (B) training
722 requirements, including on-going training requirements for such
723 certification. Training requirements shall include, but shall not be
724 limited to: Initial orientation, resident rights, identification of the types
725 of medication that may be administered by unlicensed personnel,
726 behavioral management, personal care, nutrition and food safety, and
727 health and safety in general.

728 (b) Each residential care home, as defined in section 19a-490, as
729 amended by this act, shall ensure that, on or before January 1, 2010, an
730 appropriate number of unlicensed personnel, as determined by the
731 residential care home, obtain certification for the administration of
732 medication. Each home health care agency, as defined in section 19a-
733 490, as amended by this act, shall ensure that, on or before January 1,
734 2012, an appropriate number of unlicensed personnel, as determined
735 by the home health care agency, obtain certification for the
736 administration of medication. Certification of such personnel shall be
737 in accordance with regulations adopted pursuant to this section.
738 Unlicensed personnel obtaining such certification may administer
739 medications that are not administered by injection to residents of such
740 homes or clients of such home health care agencies, unless a resident's
741 physician specifies that a medication only be administered by licensed
742 personnel.

743 (c) On and after October 1, 2007, unlicensed assistive personnel
744 employed in residential care homes, as defined in section 19a-490, may
745 (1) obtain and document residents' blood pressures and temperatures
746 with digital medical instruments that (A) contain internal decision-
747 making electronics, microcomputers or special software that allow the
748 instruments to interpret physiologic signals, and (B) do not require the
749 user to employ any discretion or judgment in their use; (2) obtain and
750 document residents' weight; and (3) assist residents in the use of
751 glucose monitors to obtain and document their blood glucose levels.

752 (d) The Commissioner of Public Health may implement policies and
753 procedures necessary to administer the provisions of this section while
754 in the process of adopting such policies and procedures as regulation,
755 provided the commissioner prints notice of intent to adopt regulations
756 in the Connecticut Law Journal not later than twenty days after the
757 date of implementation. Policies and procedures implemented
758 pursuant to this section shall be valid until the time final regulations
759 are adopted.

760 Sec. 16. Section 17b-490 of the general statutes is repealed and the
761 following is substituted in lieu thereof (*Effective July 1, 2011*):

762 As used in sections 17b-490 to 17b-498, inclusive, as amended by
763 this act:

764 (a) "Pharmacy" means a pharmacy licensed under section 20-594 or
765 a pharmacy located in a health care institution, as defined in
766 subsection (a) of section 19a-490, as amended by this act, which elects
767 to participate in the program;

768 (b) "Prescription drugs" means (1) legend drugs, as defined in
769 section 20-571, (2) any other drugs which by state law or regulation
770 require the prescription of a licensed practitioner for dispensing,
771 except: (A) Products prescribed for cosmetic purposes as specified in
772 regulations adopted pursuant to section 17b-494; (B) on and after
773 September 15, 1991, diet pills, smoking cessation gum, contraceptives,

774 multivitamin combinations, cough preparations and antihistamines;
775 (C) drugs for the treatment of erectile dysfunction, unless such drug is
776 prescribed to treat a condition other than sexual or erectile
777 dysfunction, for which the drug has been approved by the Food and
778 Drug Administration; and (D) drugs for the treatment of erectile
779 dysfunction for persons who have been convicted of a sexual offense
780 who are required to register with the Commissioner of Public Safety
781 pursuant to chapter 969, and (3) insulin and insulin syringes;

782 (c) "Reasonable cost" means the cost of the prescription drug
783 determined in accordance with the formula adopted by the
784 Commissioner of Social Services in regulations for medical assistance
785 purposes plus a dispensing fee equal to the fee determined by said
786 commissioner for medical assistance purposes;

787 (d) "Resident" means a person legally domiciled within the state for
788 a period of not less than one hundred eighty-three days immediately
789 preceding the date of application for inclusion in the program. Mere
790 seasonal or temporary residences within the state, of whatever
791 duration, shall not constitute domicile;

792 (e) "Disabled" means a person over eighteen years of age who is
793 receiving disability payments pursuant to either Title 2 or Title 16 of
794 the Social Security Act of 1935, as amended;

795 (f) "Commissioner" means the Commissioner of Social Services;

796 (g) "Income" means adjusted gross income as determined for
797 purposes of the federal income tax plus any other income of such
798 person not included in such adjusted gross income, [minus Medicare
799 Part B premium payments.] The amount of any Medicaid payments
800 made on behalf of such person or the spouse of such person shall not
801 constitute income;

802 (h) "Program" means the Connecticut Pharmaceutical Assistance
803 Contract to the Elderly and the Disabled Program otherwise known as

804 ConnPACE;

805 (i) "Pharmaceutical manufacturer" means any entity holding legal
806 title to or possession of a national drug code number issued by the
807 federal Food and Drug Administration;

808 (j) "Average manufacturer price" means the average price paid by a
809 wholesaler to a pharmaceutical manufacturer, after the deduction of
810 any customary prompt payment discounts, for a product distributed
811 for retail sale. [j]

812 [(k) "Assets" means a person's resources, as defined by Public Law
813 108-173, the Medicare Prescription Drug, Improvement, and
814 Modernization Act of 2003;

815 (l) "Low income subsidy" means a premium and cost-sharing
816 subsidy for low-income individuals, as defined by Public Law 108-173,
817 the Medicare Prescription Drug, Improvement, and Modernization Act
818 of 2003;

819 (m) "Medicare Part D covered prescription drugs" means drugs that
820 are included in Medicare Part D plan's formulary or are treated as
821 being included in a Medicare Part D plan's formulary, as defined by
822 Public Law 108-173, the Medicare Prescription Drug, Improvement
823 and Modernization Act of 2003;

824 (n) "Medicare Part D plan" means a Medicare Part D plan, as
825 defined by Public Law 108-173, the Medicare Prescription Drug,
826 Improvement, and Modernization Act of 2003;

827 (o) "Gap in standard Medicare Part D coverage" means a drug
828 obtained after a Medicare Part D beneficiary's initial coverage limit has
829 been exceeded but before the beneficiary's annual out-of-pocket
830 threshold has been met, as defined by Public Law 108-173, the
831 Medicare Prescription Drug, Improvement, and Modernization Act of
832 2003.]

833 Sec. 17. Section 17b-492 of the general statutes is repealed and the
834 following is substituted in lieu thereof (*Effective July 1, 2011*):

835 (a) Eligibility for participation in the program shall be limited to any
836 resident (1) who is sixty-five years of age or older or who is disabled,
837 (2) whose current annual income at the time of application or
838 redetermination, if unmarried, is less than twenty thousand eight
839 hundred dollars or whose annual income, if married, when combined
840 with that of the resident's spouse is less than twenty-eight thousand
841 one hundred dollars, (3) who is not eligible for Medicare or insured
842 under a policy which provides full or partial coverage for prescription
843 drugs once a deductible is met, [except for a Medicare prescription
844 drug discount card endorsed by the Secretary of Health and Human
845 Services in accordance with Public Law 108-173, the Medicare
846 Prescription Drug, Improvement, and Modernization Act of 2003, or
847 coverage under Medicare Part D pursuant to said act, and] (4) on and
848 after September 15, 1991, who pays an annual forty-five-dollar
849 registration fee to the Department of Social Services, and (5) who is
850 enrolled in the program on or before June 30, 2011. On January 1, 2012,
851 and annually thereafter, the commissioner shall increase the income
852 limits established under this subsection over those of the previous
853 fiscal year to reflect the annual inflation adjustment in Social Security
854 income, if any. Each such adjustment shall be determined to the
855 nearest one hundred dollars. On and after October 1, 2009, new
856 applications to participate in the ConnPACE program may be accepted
857 only from the fifteenth day of November through the thirty-first day of
858 December each year, except that individuals may apply within thirty-
859 one days of (A) reaching sixty-five years of age, or (B) becoming
860 eligible for Social Security Disability Income or Supplemental Security
861 Income.

862 (b) (1) Payment for a prescription under the program shall be made
863 only if no other plan of insurance or assistance is available to an
864 eligible person for such prescription at the time of dispensing. [, except
865 for benefits received from an endorsed Medicare prescription drug

866 discount card or benefits provided under Medicare Part D.] The
867 pharmacy shall make reasonable efforts to ascertain the existence of
868 other insurance or assistance, [including the subsidy provided by an
869 endorsed Medicare prescription drug discount card or benefits
870 provided under Medicare Part D. A Medicare prescription drug
871 discount card beneficiary shall be responsible for the payment of any
872 Medicare prescription drug discount card coinsurance requirements,
873 provided such requirements do not exceed the ConnPACE program
874 copayment requirements. If a Medicare prescription drug discount
875 card beneficiary's coinsurance requirements exceed the ConnPACE
876 copayment requirements, the Department of Social Services shall make
877 payment to the pharmacy to cover costs in excess of the ConnPACE
878 copayment amount. If the cost to such beneficiary exceeds the
879 remaining available Medicare prescription drug discount card subsidy,
880 the beneficiary shall not be responsible for any payment in excess of
881 the amount of the ConnPACE program copayment requirement. In
882 such cases, the Department of Social Services shall make payment to
883 the pharmacy to cover costs in excess of the ConnPACE copayment
884 amount.]

885 [(2) A Medicare Part D beneficiary shall be responsible for the
886 payment of Medicare Part D copayments, coinsurance and deductible
887 requirements for Medicare-Part-D-covered prescription drugs, as
888 defined in Public Law 108-173, the Medicare Prescription Drug,
889 Improvement, and Modernization Act of 2003, to the extent such
890 requirements do not exceed the ConnPACE program copayment
891 requirements. The Department of Social Services shall pay Medicare
892 Part D monthly beneficiary premiums on behalf of the beneficiary. If a
893 Medicare Part D beneficiary's out-of-pocket copayment, coinsurance or
894 deductible requirements exceed the ConnPACE copayment
895 requirements, the department shall make payment to the pharmacy to
896 cover costs in excess of the ConnPACE copayment amount. The
897 department shall be responsible for payment of a Medicare-Part-D-
898 covered prescription drug obtained during the gap in standard
899 Medicare Part D coverage. To the extent permitted under said act, such

900 payment may be made by the department for a prescription at (A) the
901 lower of the price that would be paid under the ConnPACE program
902 or the negotiated price established by the beneficiary's Medicare Part D
903 plan pursuant to Public Law 108-173, the Medicare Prescription Drug,
904 Improvement, and Modernization Act of 2003, or (B) in consultation
905 with the Secretary of the Office of Policy and Management, at the price
906 that would be paid under the ConnPACE program. Payment shall be
907 made under the ConnPACE program for prescription drugs that are
908 not Medicare Part D drugs, as defined in said act.]

909 [(3)] (2) Payment for a replacement prescription under the program
910 shall be made only if the eligible person signs a statement, on such
911 form as the commissioner prescribes and subject to penalty under
912 section 17b-497, that the prescription drug is lost or was stolen or
913 destroyed and the person has made a good faith effort to recover the
914 prescription drug, except that payment for a replacement prescription
915 shall not be made on behalf of a person more than twice in a calendar
916 year.

917 (c) Any eligible resident who (1) is insured under a policy,
918 [including an endorsed Medicare prescription drug discount card,
919 which provides full or partial coverage for prescription drugs,] and (2)
920 expects to exhaust such coverage, may apply to participate in the
921 program prior to the exhaustion of such coverage. Such application
922 shall be valid for the applicable income year. To be included in the
923 program, on or after the date the applicant exhausts such coverage, the
924 applicant or the applicant's designee shall notify the department that
925 such coverage is exhausted and, if required by the department, shall
926 submit evidence of exhaustion of coverage. Not later than ten days
927 after an eligible resident submits such evidence, such resident shall be
928 included in the program. The program shall [, except for those
929 beneficiaries with an endorsed Medicare prescription drug discount
930 card,] (A) cover prescriptions that are not covered by any other plan of
931 insurance or assistance available to the eligible resident and that meet
932 the requirements of this chapter, and (B) retroactively cover such

933 prescriptions filled after or concurrently with the exhaustion of such
934 coverage. Nothing in this subsection shall be construed to prevent a
935 resident from applying to participate in the program as otherwise
936 permitted by this chapter and regulations adopted pursuant to this
937 chapter.

938 [(d) (1) As a condition of eligibility for participation in the
939 ConnPACE program, a resident with an income at or below one
940 hundred thirty-five per cent of the federal poverty level, who is
941 Medicare Part A or Part B eligible, shall obtain annually an endorsed
942 Medicare prescription drug discount card designated by the
943 Commissioner of Social Services for use in conjunction with the
944 ConnPACE program. The commissioner shall be the authorized
945 representative of such resident for the purpose of enrolling a resident
946 in the transitional assistance program of Public Law 108-173, the
947 Medicare Prescription Drug, Improvement, and Modernization Act of
948 2003. As the authorized representative for this purpose, the
949 commissioner may sign required forms and enroll such resident in an
950 endorsed Medicare prescription drug discount card on the resident's
951 behalf. Such resident shall have the opportunity to select an endorsed
952 Medicare prescription drug discount card designated by the
953 commissioner for use in conjunction with the ConnPACE program,
954 and shall be notified of such opportunity by the commissioner. In the
955 event that such resident does not select an endorsed Medicare
956 prescription drug discount card designated by the commissioner for
957 use in conjunction with the ConnPACE program within a reasonable
958 period of time, as determined by the commissioner, the department
959 shall enroll the resident in an endorsed Medicare prescription drug
960 discount card designated by the commissioner. The provisions of this
961 subdivision shall remain in effect until the effective date of the
962 Medicare Part D program pursuant to Public Law 108-173, the
963 Medicare Prescription Drug, Improvement, and Modernization Act of
964 2003.

965 (2) The commissioner may require, as a condition of eligibility for

966 participation in the ConnPACE program, that a resident with an
967 income above one hundred thirty-five per cent of the federal poverty
968 level, who is Medicare Part A or Part B eligible, obtain an endorsed
969 Medicare prescription drug discount card designated by the
970 commissioner for use in conjunction with the ConnPACE program if
971 obtaining such discount card is determined by the commissioner to be
972 cost-effective to the state. In such an event, the commissioner may
973 provide payment for any Medicare prescription drug discount card
974 enrollment fees. The provisions of this subdivision shall remain in
975 effect until the effective date of the Medicare Part D program pursuant
976 to Public Law 108-173, the Medicare Prescription Drug, Improvement,
977 and Modernization Act of 2003.

978 (e) On and after the effective date of the Medicare Part D program
979 pursuant to Public Law 108-173, the Medicare Prescription Drug,
980 Improvement, and Modernization Act of 2003, enrollment in the
981 Medicare Part D program, for individuals eligible for such program in
982 accordance with said act, shall be a condition of eligibility for the
983 ConnPACE program. The ConnPACE program shall cover the
984 financial costs of Medicare Part D participation for ConnPACE
985 recipients enrolled in Medicare Part D in accordance with subsection
986 (b) of this section. Effective July 1, 2005, a ConnPACE recipient shall, as
987 a condition of eligibility, provide information regarding the recipient's
988 assets and income, as defined by said act, and that of the recipient's
989 spouse, provided said spouse resides in the same household, as
990 required by the Department of Social Services in order to determine
991 the extent of benefits for which the recipient is eligible under Medicare
992 Part D.

993 (f) Each ConnPACE applicant or recipient who is eligible for
994 Medicare Part D shall enroll in a Medicare Part D benchmark plan. The
995 Commissioner of Social Services may be the authorized representative
996 of a ConnPACE applicant or recipient for purposes of: (1) Enrolling in
997 a Medicare Part D benchmark plan, (2) submitting an application to
998 the Social Security Administration to obtain the low income subsidy

999 benefit provided under Public Law 108-173, the Medicare Prescription
1000 Drug, Improvement, and Modernization Act of 2003, or (3) facilitating
1001 the enrollment in a Medicare savings program of any such applicant or
1002 recipient who elects to participate in such program. The applicant or
1003 recipient shall have the opportunity to select a Medicare Part D
1004 benchmark plan and shall be notified of such opportunity by the
1005 commissioner. The applicant or recipient, prior to selecting a Medicare
1006 Part D benchmark plan, shall have the opportunity to consult with the
1007 commissioner, or the commissioner's designated agent, concerning the
1008 selection of a Medicare Part D benchmark plan that best meets the
1009 prescription drug needs of such applicant or recipient. In the event that
1010 such applicant or recipient does not select a Medicare Part D
1011 benchmark plan within a reasonable period of time, as determined by
1012 the commissioner, the commissioner shall enroll the applicant or
1013 recipient in a Medicare Part D benchmark plan designated by the
1014 commissioner in accordance with said act. The applicant or recipient
1015 shall appoint the commissioner as such applicant's or recipient's
1016 representative for the purpose of appealing any denial of Medicare
1017 Part D benefits and for any other purpose allowed under said act and
1018 deemed necessary by the commissioner.]

1019 [(g)] (d) The Commissioner of Social Services may adopt
1020 regulations, in accordance with the provisions of chapter 54, to
1021 implement the provisions of subsection (c) of this section. Such
1022 regulations may provide for the electronic transmission of relevant
1023 coverage information between a pharmacist and the department or
1024 between an insurer and the department in order to expedite
1025 applications and notice. The commissioner may implement the policies
1026 and procedures necessary to carry out the provisions of this section
1027 while in the process of adopting such policies and procedures in
1028 regulation form, provided notice of intent to adopt the regulations is
1029 published not later than twenty days after the date of implementation.
1030 Such policies and procedures shall be valid until the time the final
1031 regulations are adopted.

1032 Sec. 18. Section 17b-265f of the general statutes is repealed and the
1033 following is substituted in lieu thereof (*Effective July 1, 2011*):

1034 No pharmacy shall claim payment from the Department of Social
1035 Services under a medical assistance program administered by the
1036 department [or the Medicare Part D Supplemental Needs Fund,
1037 established pursuant to section 17b-265e,] for prescription drugs
1038 dispensed to individuals who have other prescription drug insurance
1039 coverage unless such coverage has been exhausted and the individual
1040 is otherwise eligible for such a medical assistance program. [or
1041 assistance from the Medicare Part D Supplemental Needs Fund.] The
1042 department shall recoup from the submitting pharmacy any claims
1043 submitted to and paid by the department when other insurance
1044 coverage is available. The department shall investigate a pharmacy
1045 that consistently submits ineligible claims for payment to determine
1046 whether the pharmacy is in violation of its medical assistance provider
1047 agreement or is committing fraud or abuse in the program and based
1048 on the findings of such investigation, may take action against such
1049 pharmacy, in accordance with state and federal law.

1050 Sec. 19. Subsection (g) of section 17b-340 of the general statutes is
1051 repealed and the following is substituted in lieu thereof (*Effective July*
1052 *1, 2011*):

1053 (g) For the fiscal year ending June 30, 1993, any intermediate care
1054 facility for the mentally retarded with an operating cost component of
1055 its rate in excess of one hundred forty per cent of the median of
1056 operating cost components of rates in effect January 1, 1992, shall not
1057 receive an operating cost component increase. For the fiscal year
1058 ending June 30, 1993, any intermediate care facility for the mentally
1059 retarded with an operating cost component of its rate that is less than
1060 one hundred forty per cent of the median of operating cost
1061 components of rates in effect January 1, 1992, shall have an allowance
1062 for real wage growth equal to thirty per cent of the increase
1063 determined in accordance with subsection (q) of section 17-311-52 of

1064 the regulations of Connecticut state agencies, provided such operating
1065 cost component shall not exceed one hundred forty per cent of the
1066 median of operating cost components in effect January 1, 1992. Any
1067 facility with real property other than land placed in service prior to
1068 October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a
1069 rate of return on real property equal to the average of the rates of
1070 return applied to real property other than land placed in service for the
1071 five years preceding October 1, 1993. For the fiscal year ending June 30,
1072 1996, and any succeeding fiscal year, the rate of return on real property
1073 for property items shall be revised every five years. The commissioner
1074 shall, upon submission of a request, allow actual debt service,
1075 comprised of principal and interest, in excess of property costs allowed
1076 pursuant to section 17-311-52 of the regulations of Connecticut state
1077 agencies, provided such debt service terms and amounts are
1078 reasonable in relation to the useful life and the base value of the
1079 property. For the fiscal year ending June 30, 1995, and any succeeding
1080 fiscal year, the inflation adjustment made in accordance with
1081 subsection (p) of section 17-311-52 of the regulations of Connecticut
1082 state agencies shall not be applied to real property costs. For the fiscal
1083 year ending June 30, 1996, and any succeeding fiscal year, the
1084 allowance for real wage growth, as determined in accordance with
1085 subsection (q) of section 17-311-52 of the regulations of Connecticut
1086 state agencies, shall not be applied. For the fiscal year ending June 30,
1087 1996, and any succeeding fiscal year, no rate shall exceed three
1088 hundred seventy-five dollars per day unless the commissioner, in
1089 consultation with the Commissioner of Developmental Services,
1090 determines after a review of program and management costs, that a
1091 rate in excess of this amount is necessary for care and treatment of
1092 facility residents. For the fiscal year ending June 30, 2002, rate period,
1093 the Commissioner of Social Services shall increase the inflation
1094 adjustment for rates made in accordance with subsection (p) of section
1095 17-311-52 of the regulations of Connecticut state agencies to update
1096 allowable fiscal year 2000 costs to include a three and one-half per cent
1097 inflation factor. For the fiscal year ending June 30, 2003, rate period, the

1098 commissioner shall increase the inflation adjustment for rates made in
1099 accordance with subsection (p) of section 17-311-52 of the regulations
1100 of Connecticut state agencies to update allowable fiscal year 2001 costs
1101 to include a one and one-half per cent inflation factor, except that such
1102 increase shall be effective November 1, 2002, and such facility rate in
1103 effect for the fiscal year ending June 30, 2002, shall be paid for services
1104 provided until October 31, 2002, except any facility that would have
1105 been issued a lower rate effective July 1, 2002, than for the fiscal year
1106 ending June 30, 2002, due to interim rate status or agreement with the
1107 department shall be issued such lower rate effective July 1, 2002, and
1108 have such rate updated effective November 1, 2002, in accordance with
1109 applicable statutes and regulations. For the fiscal year ending June 30,
1110 2004, rates in effect for the period ending June 30, 2003, shall remain in
1111 effect, except any facility that would have been issued a lower rate
1112 effective July 1, 2003, than for the fiscal year ending June 30, 2003, due
1113 to interim rate status or agreement with the department shall be issued
1114 such lower rate effective July 1, 2003. For the fiscal year ending June
1115 30, 2005, rates in effect for the period ending June 30, 2004, shall
1116 remain in effect until September 30, 2004. Effective October 1, 2004,
1117 each facility shall receive a rate that is five per cent greater than the
1118 rate in effect September 30, 2004. Effective upon receipt of all the
1119 necessary federal approvals to secure federal financial participation
1120 matching funds associated with the rate increase provided in
1121 subdivision (4) of subsection (f) of this section, but in no event earlier
1122 than October 1, 2005, and provided the user fee imposed under section
1123 17b-320 is required to be collected, each facility shall receive a rate that
1124 is four per cent more than the rate the facility received in the prior
1125 fiscal year, except any facility that would have been issued a lower rate
1126 effective October 1, 2005, than for the fiscal year ending June 30, 2005,
1127 due to interim rate status or agreement with the department, shall be
1128 issued such lower rate effective October 1, 2005. Such rate increase
1129 shall remain in effect unless: (A) The federal financial participation
1130 matching funds associated with the rate increase are no longer
1131 available; or (B) the user fee created pursuant to section 17b-320 is not

1132 in effect. For the fiscal year ending June 30, 2007, rates in effect for the
1133 period ending June 30, 2006, shall remain in effect until September 30,
1134 2006, except any facility that would have been issued a lower rate
1135 effective July 1, 2006, than for the fiscal year ending June 30, 2006, due
1136 to interim rate status or agreement with the department, shall be
1137 issued such lower rate effective July 1, 2006. Effective October 1, 2006,
1138 no facility shall receive a rate that is more than three per cent greater
1139 than the rate in effect for the facility on September 30, 2006, except any
1140 facility that would have been issued a lower rate effective October 1,
1141 2006, due to interim rate status or agreement with the department,
1142 shall be issued such lower rate effective October 1, 2006. For the fiscal
1143 year ending June 30, 2008, each facility shall receive a rate that is two
1144 and nine-tenths per cent greater than the rate in effect for the period
1145 ending June 30, 2007, except any facility that would have been issued a
1146 lower rate effective July 1, 2007, than for the rate period ending June
1147 30, 2007, due to interim rate status, or agreement with the department,
1148 shall be issued such lower rate effective July 1, 2007. For the fiscal year
1149 ending June 30, 2009, rates in effect for the period ending June 30, 2008,
1150 shall remain in effect until June 30, 2009, except any facility that would
1151 have been issued a lower rate for the fiscal year ending June 30, 2009,
1152 due to interim rate status or agreement with the department, shall be
1153 issued such lower rate. For the fiscal years ending June 30, 2010, and
1154 June 30, 2011, rates in effect for the period ending June 30, 2009, shall
1155 remain in effect until June 30, 2011, except any facility that would have
1156 been issued a lower rate for the fiscal year ending June 30, 2010, or the
1157 fiscal year ending June 30, 2011, due to interim rate status or
1158 agreement with the department, shall be issued such lower rate. For
1159 the fiscal years ending June 30, 2012, and June 30, 2013, rates in effect
1160 for the period ending June 30, 2011, shall remain in effect until June 30,
1161 2013, except any facility that would have been issued a lower rate for
1162 the fiscal year ending June 30, 2012, or the fiscal year ending June 30,
1163 2013, due to interim rate status or agreement with the department,
1164 shall be issued such lower rate.

1165 Sec. 20. (NEW) (Effective July 1, 2011) The Commissioner of Social

1166 Services may establish a fee schedule for the payment of any
1167 outpatient hospital services under the Medicaid program.

1168 Sec. 21. Subsection (c) of section 17b-265d of the general statutes is
1169 repealed and the following is substituted in lieu thereof (*Effective July*
1170 *1, 2011*):

1171 (c) A full benefit dually eligible Medicare Part D beneficiary shall be
1172 responsible for any Medicare Part D prescription drug copayments
1173 imposed pursuant to Public Law 108-173, the Medicare Prescription
1174 Drug, Improvement, and Modernization Act of 2003, in amounts not to
1175 exceed fifteen dollars per month. The department shall be responsible
1176 for payment, on behalf of such beneficiary, of any Medicare Part D
1177 prescription drug copayments in any month in which such copayment
1178 amounts exceed [~~fifteen~~] twenty-five dollars in the aggregate.

1179 Sec. 22. Section 17b-260d of the general statutes is repealed and the
1180 following is substituted in lieu thereof (*Effective July 1, 2011*):

1181 [(a)] The Commissioner of Social Services shall apply for a home
1182 and community-based services waiver pursuant to Section 1915(c) of
1183 the Social Security Act that will allow the commissioner to develop
1184 and implement a program for the provision of home or community-
1185 based services, as defined in 42 CFR 440.180, to not more than [~~one~~
1186 ~~hundred~~] fifty persons currently receiving services under the Medicaid
1187 program who (1) have tested positive for human immunodeficiency
1188 virus or have acquired immune deficiency syndrome, and (2) would
1189 remain eligible for Medicaid if admitted to a hospital, nursing facility
1190 or intermediate care facility for the mentally retarded, or in the absence
1191 of the services that are requested under such waiver, would require the
1192 Medicaid covered level of care provided in such facilities. [In
1193 accordance with 42 CFR 440.180, such persons shall be eligible to
1194 receive services that are deemed necessary by the commissioner to
1195 meet their unique needs in order to avoid institutionalization.]

1196 [(b) If the commissioner fails to submit the application for the

1197 waiver to the joint standing committees of the General Assembly
1198 having cognizance of matters relating to human services and
1199 appropriations by February 1, 2010, the commissioner shall submit a
1200 written report to said committees not later than February 2, 2010. The
1201 report shall include, but not be limited to: (1) An explanation of the
1202 reasons for failing to seek the waiver; and (2) an estimate of the fiscal
1203 impact that would result from the approval of the waiver in one
1204 calendar year.]

1205 Sec. 23. Subsection (b) of section 17b-106 of the general statutes is
1206 repealed and the following is substituted in lieu thereof (*Effective July*
1207 *1, 2011*):

1208 (b) Effective July 1, [1998] 2011, the commissioner shall provide a
1209 state supplement payment for recipients of Medicaid and the federal
1210 Supplemental Security Income Program who reside in long-term care
1211 facilities sufficient to increase their personal needs allowance to [fifty]
1212 sixty dollars per month. Such state supplement payment shall be made
1213 to the long-term care facility to be deposited into the personal fund
1214 account of each such recipient. [Effective July 1, 1999, and annually
1215 thereafter, the commissioner shall increase such allowance to reflect
1216 the annual inflation adjustment in Social Security income, if any.] For
1217 the purposes of this subsection, "long-term care facility" means a
1218 licensed chronic and convalescent nursing home, a chronic disease
1219 hospital, a rest home with nursing supervision, an intermediate care
1220 facility for the mentally retarded or a state humane institution.

1221 Sec. 24. Subsection (a) of section 17b-278g of the general statutes is
1222 repealed and the following is substituted in lieu thereof (*Effective July*
1223 *1, 2011*):

1224 (a) To the extent permitted by federal law, no payment shall be
1225 provided by the Department of Social Services under the Medicaid
1226 program for more than one pair of eyeglasses [per year] every two
1227 years. Said department shall administer the payment for eyeglasses
1228 and contact lenses as cost effectively as possible.

1229 Sec. 25. Subsection (e) of section 17b-372 of the general statutes is
1230 repealed and the following is substituted in lieu thereof (*Effective July*
1231 *1, 2011*):

1232 (e) Notwithstanding the provisions of subsection (d) of this section,
1233 the commissioner shall approve no more than one project. [through
1234 June 30, 2011.] The total number of beds under such project shall not
1235 exceed two hundred eighty beds.

1236 Sec. 26. Subsection (b) of section 17b-790a of the general statutes is
1237 repealed and the following is substituted in lieu thereof (*Effective July*
1238 *1, 2011*):

1239 (b) The commissioner shall provide assistance to an individual
1240 under this section in an amount equal to [seventy-five] fifty per cent of
1241 the amount the individual would be eligible to receive under the
1242 federal Food and Nutrition Act of 2008, as amended.

1243 Sec. 27. Section 17b-802 of the general statutes is repealed and the
1244 following is substituted in lieu thereof (*Effective July 1, 2011*):

1245 (a) The Commissioner of Social Services shall establish, within
1246 available appropriations, and administer a security deposit guarantee
1247 program for persons who (1) (A) are recipients of temporary family
1248 assistance, aid under the state supplement program, or state-
1249 administered general assistance, or (B) have a documented showing of
1250 financial need, and (2) (A) are residing in emergency shelters or other
1251 emergency housing, cannot remain in permanent housing due to any
1252 reason specified in subsection (a) of section 17b-808, or are served a
1253 [notice to quit] writ, summons and complaint in a summary process
1254 action instituted pursuant to chapter 832, or (B) have a rental assistance
1255 program or federal Section 8 certificate or voucher. Under such
1256 program, the Commissioner of Social Services may provide security
1257 deposit guarantees for use by such persons in lieu of a security deposit
1258 on a rental dwelling unit. Eligible persons may receive a security
1259 deposit guarantee in an amount not to exceed the equivalent of two

1260 months' rent on such rental unit. No person may apply for and receive
1261 a security deposit guarantee more than once in any [eighteen-month]
1262 five-year period without the express authorization of the
1263 Commissioner of Social Services, except as provided in subsection (b)
1264 of this section. The Commissioner of Social Services may deny
1265 eligibility for the security deposit guarantee program to an applicant
1266 for whom the commissioner has paid two or more claims by landlords,
1267 [during the immediately preceding five-year period.] The
1268 Commissioner of Social Services may establish priorities for providing
1269 security deposit guarantees to eligible persons described in
1270 subparagraphs (A) and (B) of subdivision (2) of this subsection in order
1271 to administer the program within available appropriations.

1272 (b) In the case of any person who qualifies for a guarantee, the
1273 Commissioner of Social Services, or any emergency shelter under
1274 contract with the Department of Social Services to assist in the
1275 administration of the security deposit guarantee program established
1276 pursuant to subsection (a) of this section, may execute a written
1277 agreement to pay the landlord for any damages suffered by the
1278 landlord due to the tenant's failure to comply with such tenant's
1279 obligations as defined in section 47a-21, provided the amount of any
1280 such payment shall not exceed the amount of the requested security
1281 deposit. Notwithstanding the provisions of subsection (a) of this
1282 section, if a person who has previously received a grant for a security
1283 deposit or a security deposit guarantee becomes eligible for a
1284 subsequent security deposit guarantee within [eighteen months] five
1285 years after a claim has been paid on a prior security deposit guarantee,
1286 such person may receive a security deposit guarantee. The amount of
1287 the subsequent security deposit guarantee for which such person
1288 would otherwise have been eligible shall be reduced by (1) any
1289 amount of a previous grant which has not been returned to the
1290 department pursuant to section 47a-21, or (2) the amount of any
1291 payment made to the landlord for damages pursuant to this
1292 subsection.

1293 (c) Any payment made pursuant to this section to any person
1294 receiving temporary family assistance, aid under the state supplement
1295 program or state-administered general assistance shall not be deducted
1296 from the amount of assistance to which the recipient would otherwise
1297 be entitled.

1298 (d) On and after July 1, 2000, no special need or special benefit
1299 payments shall be made by the commissioner for security deposits
1300 from the temporary family assistance, state supplement, or state-
1301 administered general assistance programs.

1302 (e) The Commissioner of Social Services may, within available
1303 appropriations, on a case-by-case basis, provide a security deposit
1304 grant to a person eligible for the security deposit guarantee program
1305 established under subsection (a) of this section, in an amount not to
1306 exceed the equivalent of one month's rent on such rental unit provided
1307 the commissioner determines that emergency circumstances exist
1308 which threaten the health, safety or welfare of a child who resides with
1309 such person. Such person shall not be eligible for more than one such
1310 grant without the authorization of said commissioner. Nothing in this
1311 section shall preclude the approval of such one-month security deposit
1312 grant in conjunction with a one-month security deposit guarantee.

1313 (f) The Commissioner of Social Services may provide a security
1314 deposit grant to a person receiving such grant through any emergency
1315 shelter under an existing contract with the Department of Social
1316 Services to assist in the administration of the security deposit program,
1317 but in no event shall a payment be authorized after October 1, 2000.
1318 Nothing in this section shall preclude the commissioner from entering
1319 into a contract with one or more emergency shelters for the purpose of
1320 issuing security deposit guarantees.

1321 (g) A landlord may submit a claim for damages not later than forty-
1322 five days after the date of termination of the tenancy. Payment shall be
1323 made only for a claim that includes receipts for repairs made. No claim
1324 shall be paid for an apartment from which a tenant vacated because

1325 substandard conditions made the apartment uninhabitable, as
1326 determined by a local, state or federal regulatory agency.

1327 (h) Any person with income exceeding one hundred fifty per cent of
1328 the federal poverty level who is found eligible to receive a security
1329 deposit guarantee under this section shall contribute ten per cent of
1330 one month's rent to the payment of the security deposit. The
1331 commissioner may waive such payment for good cause.

1332 [(g)] (i) The Commissioner of Social Services shall adopt regulations,
1333 in accordance with the provisions of chapter 54, to administer the
1334 program established pursuant to this section and to set eligibility
1335 criteria for the program, but may implement the program until June 30,
1336 2003, while in the process of adopting such regulations provided
1337 notice of intent to adopt the regulations is published in the Connecticut
1338 Law Journal within twenty days after implementation.

1339 Sec. 28. Section 17b-749a of the general statutes is repealed and the
1340 following is substituted in lieu thereof (*Effective July 1, 2011*):

1341 (a) The [Commissioner of Social Services, in consultation with the]
1342 Commissioner of Education [.] shall establish, within available
1343 appropriations, a program to (1) purchase directly or provide subsidies
1344 to parents to purchase child day care services provided by any
1345 elementary or secondary school, nursery school, preschool, day care
1346 center, group day care home, family day care home, family resource
1347 center, Head Start program, or local or regional board of education,
1348 provided, if the commissioner purchases such services directly, he
1349 shall give preference to purchasing from providers of full-day and
1350 year-round programs; and (2) award grants to providers of school
1351 readiness programs, as defined in section 10-16p, to increase the hours
1352 of operation of their programs in order to provide child care for
1353 children attending such programs. The commissioner, for purposes of
1354 subdivision (1) of this subsection, [shall] may model the program on
1355 the program established pursuant to section 17b-749.

1356 (b) No funds received by a provider pursuant to this section shall be
1357 used to supplant federal funding received for early childhood
1358 education on behalf of children in an early childhood education
1359 program.

1360 (c) The [Commissioners of Social Services and] Commissioner of
1361 Education shall: (1) Coordinate the development of a range of
1362 alternative programs to meet the needs of all children; (2) foster
1363 partnerships between school districts and private organizations; (3)
1364 provide information and assistance to parents in selecting an
1365 appropriate school readiness program; and (4) work to ensure, to the
1366 extent possible, that school readiness programs allow open enrollment
1367 for all children and allow families receiving benefits for such a
1368 program to choose a public or accredited private program.

1369 Sec. 29. Subsection (a) of section 17b-749c of the general statutes is
1370 repealed and the following is substituted in lieu thereof (*Effective July*
1371 *1, 2011*):

1372 (a) The [Commissioner of Social Services, in consultation with the]
1373 Commissioner of Education [,] shall establish a program, within
1374 available appropriations, to provide, on a competitive basis,
1375 supplemental quality enhancement grants to providers of child day
1376 care services or providers of school readiness programs pursuant to
1377 section 10-16p and section 10-16u. Child day care providers and school
1378 readiness programs may apply for a supplemental quality
1379 enhancement grant at such time and on such form as the
1380 Commissioner of [Social Services] Education prescribes.

1381 Sec. 30. Section 12-263a of the general statutes is repealed and the
1382 following is substituted in lieu thereof (*Effective July 1, 2011, and*
1383 *applicable to calendar quarters commencing on or after July 1, 2011*):

1384 As used in sections 12-263a to 12-263e, inclusive, as amended by this
1385 act:

1386 (1) "Hospital" means any health care facility or institution, as
1387 defined in section 19a-630, which is licensed as a short-term general
1388 hospital by the Department of Public Health but does not include (A)
1389 any hospital which, on October 1, 1997, is within the class of hospitals
1390 licensed by the department as children's general hospitals, or (B) a
1391 short-term acute hospital operated exclusively by the state other than a
1392 short-term acute hospital operated by the state as a receiver pursuant
1393 to chapter 920;

1394 [(2) "Gross revenue" means the amount of a hospital's total charges
1395 for all patient care services minus any refunds resulting from errors or
1396 overcharges;

1397 (3) "Contractual allowance" means the percentage amount of
1398 discounts that are provided to nongovernmental payers pursuant to
1399 subsections (c), (d) and (e) of section 19a-646;

1400 (4) "Uncompensated care" means the cost of care that is written off
1401 as a bad debt or provided free under a free care policy that has been
1402 approved by the Office of Health Care Access division of the
1403 Department of Public Health;

1404 (5) "Other allowances" means any financial requirements, as
1405 authorized by the Office of Health Care Access division of the
1406 Department of Public Health, of a hospital resulting from
1407 circumstances including, but not limited to, an insurance settlement of
1408 a liability case or satisfaction of a lien or encumbrance, any difference
1409 between charges for employee self-insurance and related expenses. For
1410 fiscal years commencing on and after October 1, 1994, "other
1411 allowances" means the amount of any difference between charges for
1412 employee self-insurance and related expenses determined using the
1413 hospital's overall relationship of costs to charges as determined by the
1414 Office of Health Care Access division of the Department of Public
1415 Health;

1416 (6) "Net revenue" means the amount of a hospital's gross revenue

1417 minus the hospital's (A) contractual allowances, (B) the difference
1418 between government charges and government payments, (C)
1419 uncompensated care and (D) other allowances;

1420 (7) "Hospital gross earnings" means the amount of a hospital's net
1421 revenue minus (A) the amount that is projected to be received by the
1422 hospital from the federal government for Medicare patients, based on
1423 the hospital's budget authorization, and (B) the amount that is
1424 projected to be received by the hospital from the Department of Social
1425 Services, based on the hospital's budget authorization;

1426 (8) "Patient care services" means therapeutic and diagnostic medical
1427 services provided by the hospital to inpatients and outpatients,
1428 including tangible personal property transferred in connection with
1429 such services.]

1430 (2) "Net patient revenue" means the amount of a hospital's gross
1431 revenue excluding the amount received by the hospital from the
1432 federal government for Medicare patients;

1433 (3) "Commissioner" means the Commissioner of Revenue Services;

1434 (4) "Department" means the Department of Revenue Services.

1435 Sec. 31. Section 12-263b of the general statutes is repealed and the
1436 following is substituted in lieu thereof (*Effective July 1, 2011, and*
1437 *applicable to calendar quarters commencing on or after July 1, 2011*):

1438 [There is hereby imposed on the hospital gross earnings of each
1439 hospital in this state a tax (1) at the rate of eleven per cent of its
1440 hospital gross earnings in each taxable quarter for taxable quarters
1441 commencing prior to October 1, 1996; (2) at the rate of nine and
1442 one-fourth per cent of its hospital gross earnings in each taxable
1443 quarter commencing on or after October 1, 1996, and prior to October
1444 1, 1997; (3) at the rate of eight and one-fourth per cent of its hospital
1445 gross earnings in each taxable quarter commencing on or after October
1446 1, 1997, and prior to October 1, 1998; (4) at the rate of seven and

1447 one-fourth per cent of its hospital gross earnings in each taxable
1448 quarter commencing on or after October 1, 1998, and prior to October
1449 1, 1999; and (5) at the rate of four and one-half per cent of its hospital
1450 gross earnings in each taxable quarter commencing on or after October
1451 1, 1999, and prior to April 1, 2000. The hospital gross earnings of each
1452 hospital in this state shall not be subject to the provisions of this
1453 chapter with respect to calendar quarters commencing on or after
1454 April 1, 2000.]

1455 (a) For each calendar quarter commencing on or after July 1, 2011,
1456 there is hereby imposed a tax on the net patient revenue of each
1457 hospital in this state to be paid each calendar quarter at the maximum
1458 rate allowed under federal law.

1459 (b) Each hospital shall, on or before the last day of January, April,
1460 July and October of each year, render to the Commissioner of Revenue
1461 Services a return, on forms prescribed or furnished by the
1462 Commissioner of Revenue Services and signed by one of its principal
1463 officers, stating specifically the name and location of such hospital, and
1464 the [amounts of its hospital gross earnings, its net revenue and its
1465 gross revenue] amount of its net patient revenue for the calendar
1466 quarter ending the last day of the preceding month. Payment shall be
1467 made with such return. Each hospital shall file such return
1468 electronically with the department and make such payment by
1469 electronic funds transfer in the manner provided by chapter 228g,
1470 irrespective of whether the hospital would otherwise have been
1471 required to file such return electronically or to make such payment by
1472 electronic funds transfer under the provisions of chapter 228g.

1473 Sec. 32. Section 12-263c of the general statutes is repealed and the
1474 following is substituted in lieu thereof (*Effective July 1, 2011, and*
1475 *applicable to calendar quarters commencing on or after July 1, 2011*):

1476 (a) If any hospital fails to pay the amount of tax reported to be due
1477 on its return within the time specified under the provisions of section
1478 12-263b, as amended by this act, there shall be imposed a penalty equal

1479 to ten per cent of such amount due and unpaid, or fifty dollars,
1480 whichever is greater. The tax shall bear interest at the rate of one per
1481 cent per month or fraction thereof, from the due date of such tax until
1482 the date of payment.

1483 (b) If any hospital has not made its return within one month after
1484 the time specified in section 12-263b, as amended by this act, the
1485 Commissioner of Revenue Services may make such return at any time
1486 thereafter, according to the best information obtainable and according
1487 to the form prescribed. To the tax imposed upon the basis of such
1488 return, there shall be added an amount equal to ten per cent of such
1489 tax, or fifty dollars, whichever is greater. The tax shall bear interest at
1490 the rate of one per cent per month or fraction thereof, from the due
1491 date of such tax until the date of payment.

1492 (c) Subject to the provisions of section 12-3a, the commissioner may
1493 waive all or part of the penalties provided under this section when it is
1494 proven to his satisfaction that the failure to pay any tax on time was
1495 due to reasonable cause and was not intentional or due to neglect.

1496 (d) The commissioner shall notify the Commissioner of Social
1497 Services of any amount delinquent under sections 12-263a to 12-263e,
1498 inclusive, as amended by this act, and, upon receipt of such notice, the
1499 Commissioner of Social Services shall deduct and withhold such
1500 amount from amounts otherwise payable by the Department of Social
1501 Services to the delinquent hospital.

1502 Sec. 33. Section 12-263d of the general statutes is amended by
1503 adding subsection (c) as follows (*Effective July 1, 2011, and applicable to*
1504 *calendar quarters commencing on or after July 1, 2011*):

1505 (NEW) (c) The commissioner may enter into an agreement with the
1506 Commissioner of Social Services delegating to the Commissioner of
1507 Social Services the authority to examine the records and returns of any
1508 hospital subject to the tax imposed under section 12-263b of the
1509 general statutes, as amended by this act, and to determine whether

1510 such tax has been underpaid or overpaid. If such authority is so
1511 delegated, examinations of such records and returns by the
1512 Commissioner of Social Services and determinations by the
1513 Commissioner of Social Services that such tax has been underpaid or
1514 overpaid shall have the same effect as similar examinations or
1515 determinations made by the Commissioner of Revenue Services.

1516 Sec. 34. (NEW) (*Effective July 1, 2011, and applicable to calendar quarters*
1517 *commencing on or after July 1, 2011*) At the close of each fiscal year
1518 commencing with the fiscal year ending June 30, 2012, the Comptroller
1519 is authorized to record as revenue for such fiscal year the amount of
1520 tax imposed under the provisions of section 12-263b of the general
1521 statutes, as amended by this act, that is received by the Commissioner
1522 of Revenue Services not later than five business days after the last day
1523 of July immediately following the end of such fiscal year.

1524 Sec. 35. Section 17b-321 of the general statutes is repealed and the
1525 following is substituted in lieu thereof (*Effective July 1, 2011*):

1526 (a) On or before July 1, 2005, and on or before July first biennially
1527 thereafter, the Commissioner of Social Services shall determine the
1528 amount of the user fee and promptly notify the commissioner and
1529 nursing homes of such amount. The user fee shall be (1) the sum of
1530 each nursing home's anticipated nursing home net revenue, including,
1531 but not limited to, its estimated net revenue from any increases in
1532 Medicaid payments, during the twelve-month period ending on June
1533 thirtieth of the succeeding calendar year, (2) which sum shall be
1534 multiplied by a percentage as determined by the Secretary of the Office
1535 of Policy and Management, in consultation with the Commissioner of
1536 Social Services, provided before January 1, 2008, such percentage shall
1537 not exceed six per cent, [and] on and after January 1, 2008, and prior to
1538 October 1, 2011, such percentage shall not exceed five and one-half per
1539 cent, and on and after October 1, 2011, such percentage shall not
1540 exceed the maximum allowed under federal law, and (3) which
1541 product shall be divided by the sum of each nursing home's

1542 anticipated resident days during the twelve-month period ending on
1543 June thirtieth of the succeeding calendar year. The Commissioner of
1544 Social Services, in anticipating nursing home net revenue and resident
1545 days, shall use the most recently available nursing home net revenue
1546 and resident day information. [On or before July 1, 2007, the
1547 Commissioner of Social Services shall report, in accordance with
1548 section 11-4a, to the joint standing committees of the General
1549 Assembly having cognizance of matters relating to appropriations and
1550 the budgets of state agencies and human services on the detrimental
1551 effects, if any, that a biennial determination of the user fee may have
1552 on private payors.]

1553 (b) Upon approval of the waiver of federal requirements for
1554 uniform and broad-based user fees in accordance with 42 CFR 433.68
1555 pursuant to section 17b-323, the Commissioner of Social Services shall
1556 redetermine the amount of the user fee and promptly notify the
1557 commissioner and nursing homes of such amount. The user fee shall
1558 be (1) the sum of each nursing home's anticipated nursing home net
1559 revenue, including, but not limited to, its estimated net revenue from
1560 any increases in Medicaid payments, during the twelve-month period
1561 ending on June thirtieth of the succeeding calendar year but not
1562 including any such anticipated net revenue of any nursing home
1563 exempted from such user fee due to waiver of federal requirements
1564 pursuant to section 17b-323, (2) which sum shall be multiplied by a
1565 percentage as determined by the Secretary of the Office of Policy and
1566 Management, in consultation with the Commissioner of Social
1567 Services, provided before January 1, 2008, such percentage shall not
1568 exceed six per cent, [and] on and after January 1, 2008, and prior to
1569 October 1, 2011, such percentage shall not exceed five and one-half per
1570 cent, and on and after October 1, 2011, such percentage shall not
1571 exceed the maximum allowed under federal law, and (3) which
1572 product shall be divided by the sum of each nursing home's
1573 anticipated resident days, but not including the anticipated resident
1574 days of any nursing home exempted from such user fee due to waiver
1575 of federal requirements pursuant to section 17b-323. Notwithstanding

1576 the provisions of this subsection, the amount of the user fee for each
1577 nursing home licensed for more than two hundred thirty beds or
1578 owned by a municipality shall be equal to the amount necessary to
1579 comply with federal provider tax uniformity waiver requirements as
1580 determined by the Commissioner of Social Services. The
1581 Commissioner of Social Services may increase retroactively the user fee
1582 for nursing homes not licensed for more than two hundred thirty beds
1583 and not owned by a municipality to the effective date of waiver of said
1584 federal requirements to offset user fee reductions necessary to meet the
1585 federal waiver requirements. On or before July 1, 2005, and biennially
1586 thereafter, the Commissioner of Social Services shall determine the
1587 amount of the user fee in accordance with this subsection. The
1588 Commissioner of Social Services, in anticipating nursing home net
1589 revenue and resident days, shall use the most recently available
1590 nursing home net revenue and resident day information. [On or before
1591 July 1, 2007, the Commissioner of Social Services shall report, in
1592 accordance with section 11-4a, to the joint standing committees of the
1593 General Assembly having cognizance of matters relating to
1594 appropriations and the budgets of state agencies and human services
1595 on the detrimental effects, if any, that a biennial determination of the
1596 user fee may have on private payors.]

1597 (c) (1) Following a redetermination of the resident day user fee by
1598 the Commissioner of Social Services pursuant to subsection (b) of this
1599 section, the Commissioner of Social Services shall notify the
1600 commissioner of the identity of (A) any nursing home subsequently
1601 exempted from the resident day user fee due to the waiver of federal
1602 requirements pursuant to section 17b-323 and the effective date of such
1603 waiver, (B) any nursing home licensed for more than two hundred
1604 thirty beds or owned by a municipality and the effective date of any
1605 change in its user fee, and (C) any nursing home for which the user fee
1606 is retroactively increased pursuant to subsection (b) of this section and
1607 the effective date of such increase. The Commissioner of Social
1608 Services shall provide notice of any such retroactive user fee increase
1609 to each nursing home so affected.

1610 (2) Upon being notified by the Commissioner of Social Services, the
1611 commissioner shall refund or credit to any nursing home subsequently
1612 exempted from the resident day user fee due to the waiver of federal
1613 requirements pursuant to section 17b-323 any resident day user fee
1614 collected from such home. No interest shall be payable on the amount
1615 of such refund or credit. Any such nursing home shall refund any fees
1616 paid by or on behalf of any resident to the party making such
1617 payment.

1618 (3) Upon being notified by the Commissioner of Social Services, the
1619 commissioner shall refund or credit to any nursing home licensed for
1620 more than two hundred thirty beds or owned by a municipality any
1621 resident day user fee collected from such home in excess of the
1622 resident day user fee that would have been payable had the user fee, as
1623 redetermined by the Commissioner of Social Services, been used in
1624 calculating the nursing home's resident day user fee. No interest shall
1625 be payable on the amount of such refund or credit.

1626 (4) Upon being notified by the Commissioner of Social Services, the
1627 commissioner shall notify any nursing home for which the user fee is
1628 retroactively increased pursuant to subsection (b) of this section of the
1629 additional amount of resident day user fee due and owing from such
1630 nursing home. Such a notice of additional amount due and owing to
1631 the commissioner shall not be treated as a notice of deficiency
1632 assessment by the commissioner nor shall the nursing home have,
1633 based on such notice of additional amount due, any right of protest or
1634 appeal to the commissioner as in the case of such a deficiency
1635 assessment. No interest shall be payable on such additional amount to
1636 the extent such additional amount is paid on or before the last day of
1637 the month next succeeding the month during which the Commissioner
1638 of Social Services provided notice of such retroactive user fee increase
1639 to such nursing home.

1640 Sec. 36. (NEW) (*Effective July 1, 2011*) (a) For purposes of this section
1641 and section 37 of this act:

1642 (1) "Commissioner" means the Commissioner of Revenue Services;

1643 (2) "Department" means the Department of Revenue Services;

1644 (3) "Intermediate care facility for the mentally retarded" or
1645 "intermediate care facility" means a residential facility for the mentally
1646 retarded which is certified to meet the requirements of 42 CFR 442,
1647 Subpart C and, in the case of a private facility, licensed pursuant to
1648 section 17a-227 of the general statutes;

1649 (4) "Resident day" means a day of intermediate care facility
1650 residential care provided to an individual and includes the day a
1651 resident is admitted and any day for which the intermediate care
1652 facility is eligible for payment for reserving a resident's bed due to
1653 hospitalization or temporary leave and for the date of death. For
1654 purposes of this subdivision, a day of care shall be the period of time
1655 between the census-taking hour in a facility on two successive calendar
1656 days. "Resident day" does not include the day a resident is discharged;

1657 (5) "Intermediate care facility for the mentally retarded net revenue"
1658 means amounts billed by an intermediate care facility for all services
1659 provided, including room, board and ancillary services, minus (A)
1660 contractual allowances, (B) payer discounts, (C) charity care, and (D)
1661 bad debts; and

1662 (6) "Contractual allowances" means the amount of discounts
1663 allowed by an intermediate care facility to certain payers from
1664 amounts billed for room, board and ancillary services.

1665 (b) (1) For each calendar quarter commencing on or after July 1,
1666 2011, there is hereby imposed a resident day user fee on each
1667 intermediate care facility for the mentally retarded in this state, which
1668 fee shall be the product of the facility's total resident days during the
1669 calendar quarter multiplied by the user fee, as determined by the
1670 Commissioner of Social Services pursuant to section 37 of this act.

1671 (2) Each intermediate care facility for the mentally retarded shall, on

1672 or before the last day of January, April, July and October of each year,
1673 render to the commissioner a return, on forms prescribed or furnished
1674 by the commissioner, stating the intermediate care facility's total
1675 resident days during the calendar quarter ending on the last day of the
1676 preceding month and stating such other information as the
1677 commissioner deems necessary for the proper administration of the
1678 provisions of this section. The resident day user fee imposed under
1679 this section shall be due and payable on the due date of such return.
1680 Each intermediate care facility shall be required to file such return
1681 electronically with the department and to make such payment by
1682 electronic funds transfer in the manner provided by chapter 228g of
1683 the general statutes, irrespective of whether such facility would have
1684 otherwise been required to file such return electronically or to make
1685 such payment by electronic funds transfer under the provisions of
1686 chapter 228g of the general statutes.

1687 (c) Whenever such resident day user fee is not paid when due, a
1688 penalty of ten per cent of the amount due or fifty dollars, whichever is
1689 greater, shall be imposed, and interest at the rate of one per cent per
1690 month or a fraction thereof shall accrue on such user fee from the due
1691 date of such user fee until the date of payment.

1692 (d) The commissioner shall notify the Commissioner of Social
1693 Services of any amount delinquent under section 37 of this act and,
1694 upon receipt of such notice, the Commissioner of Social Services shall
1695 deduct and withhold such amount from amounts otherwise payable
1696 by the Department of Social Services to the delinquent facility.

1697 (e) The provisions of section 12-548 of the general statutes, sections
1698 12-550 to 12-554, inclusive, of the general statutes and section 12-555a
1699 of the general statutes shall apply to the provisions of this section in
1700 the same manner and with the same force and effect as if the language
1701 of said sections had been incorporated in full into this section and had
1702 expressly referred to the user fee imposed under this section, except to
1703 the extent that any provision is inconsistent with a provision in this

1704 section. For purposes of section 12-39g of the general statutes, the
1705 resident day user fee shall be treated as a tax.

1706 (f) The commissioner may enter into an agreement with the
1707 Commissioner of Social Services delegating to the Commissioner of
1708 Social Services the authority to examine the records and returns of any
1709 intermediate care facility for the mentally retarded in this state subject
1710 to the resident day user fee imposed under this section and to
1711 determine whether such user fee has been underpaid or overpaid. If
1712 such authority is so delegated, examinations of such records and
1713 returns by the Commissioner of Social Services and determinations by
1714 the Commissioner of Social Services that such user fee has been
1715 underpaid or overpaid shall have the same effect as similar
1716 examinations or determinations made by the Commissioner of
1717 Revenue Services.

1718 (g) (1) The commissioner shall not collect the resident day user fee
1719 pursuant to this section until the Commissioner of Social Services
1720 informs the commissioner that all the necessary federal approvals are
1721 in effect to secure federal financial participation matching funds
1722 associated with any authorized facility rate increases.

1723 (2) The commissioner shall cease to collect the resident day user fee
1724 pursuant to this section if the Commissioner of Social Services informs
1725 the commissioner that the federal approvals described in subdivision
1726 (1) of this subsection are withheld or withdrawn.

1727 Sec. 37. (NEW) (*Effective July 1, 2011*) On or before July 1, 2011, and
1728 on or before July first biennially thereafter, the Commissioner of Social
1729 Services shall determine the amount of the user fee and promptly
1730 notify the commissioner and the intermediate care facilities for the
1731 mentally retarded of such amount. The user fee shall be (1) the sum of
1732 each facility's anticipated net revenue, including, but not limited to, its
1733 estimated net revenue from any increases in Medicaid payments
1734 during the twelve-month period ending on June thirtieth of the
1735 succeeding calendar year, (2) which sum shall be multiplied by a

1736 percentage as determined by the Secretary of the Office of Policy and
1737 Management, in consultation with the Commissioner of Social
1738 Services, provided, before October 1, 2011, such percentage shall not
1739 exceed five and one-half per cent and, on and after October 1, 2011,
1740 such percentage shall not exceed the maximum amount allowed under
1741 federal law, and (3) which product shall be divided by the sum of each
1742 facility's anticipated resident days during the twelve-month period
1743 ending on June thirtieth of the succeeding calendar year. The
1744 Commissioner of Social Services, in anticipating facility net revenue
1745 and resident days, shall use the most recently available facility net
1746 revenue and resident day information.

1747 Sec. 38. (NEW) (*Effective July 1, 2011*) At the close of each fiscal year
1748 commencing with the fiscal year ending June 30, 2012, the Comptroller
1749 is authorized to record as revenue for such fiscal year the amount of
1750 the user fee imposed under the provisions of section 36 of this act that
1751 is received by the Commissioner of Revenue Services not later than
1752 five business days after the last day of July immediately following the
1753 end of such fiscal year.

1754 Sec. 39. (NEW) (*Effective July 1, 2011*) The Commissioner of Social
1755 Services, pursuant to section 17b-10 of the general statutes, may
1756 implement policies and procedures necessary to administer the
1757 provisions of this act, while in the process of adopting such policies
1758 and procedures in regulation form, provided the commissioner prints
1759 notice of intent to adopt regulations in the Connecticut Law Journal
1760 not later than twenty days after the date of implementation. Policies
1761 and procedures implemented pursuant to this section shall be valid
1762 until the time final regulations are adopted.

1763 Sec. 40. Section 17b-261a of the general statutes is repealed and the
1764 following is substituted in lieu thereof (*Effective from passage*):

1765 (a) Any transfer or assignment of assets resulting in the imposition
1766 of a penalty period shall be presumed to be made with the intent, on
1767 the part of the transferor or the transferee, to enable the transferor to

1768 obtain or maintain eligibility for medical assistance. This presumption
1769 may be rebutted only by clear and convincing evidence that the
1770 transferor's eligibility or potential eligibility for medical assistance was
1771 not a basis for the transfer or assignment.

1772 (b) Any transfer or assignment of assets resulting in the
1773 establishment or imposition of a penalty period shall create a debt, as
1774 defined in section 36a-645, that shall be due and owing by the
1775 transferor or transferee to the Department of Social Services in an
1776 amount equal to the amount of the medical assistance provided to or
1777 on behalf of the transferor on or after the date of the transfer of assets,
1778 but said amount shall not exceed the fair market value of the assets at
1779 the time of transfer. The Commissioner of Social Services, the
1780 Commissioner of Administrative Services and the Attorney General
1781 shall have the power or authority to seek administrative, legal or
1782 equitable relief as provided by other statutes or by common law.

1783 (c) The Commissioner of Social Services may waive the imposition
1784 of a penalty period when the transferor (1) in accordance with the
1785 provisions of section 3025.25 of the department's Uniform Policy
1786 Manual, suffers from dementia at the time of application for medical
1787 assistance and cannot explain transfers that would otherwise result in
1788 the imposition of a penalty period; or (2) suffered from dementia at the
1789 time of the transfer; or (3) was exploited into making such a transfer
1790 due to dementia. Waiver of the imposition of a penalty period does not
1791 prohibit the establishment of a debt in accordance with subsection (b)
1792 of this section.

1793 (d) An institutionalized individual shall not be penalized for the
1794 transfer of an asset if the entire amount of the transferred asset is
1795 returned to the institutionalized individual. The partial return of a
1796 transferred asset shall not result in a reduced penalty period.

1797 (1) If there are multiple transfers of assets by the institutionalized
1798 individual to the same or different transferees, a return of anything
1799 less than the total amount of the transferred assets from all of the

1800 separate transferees shall not constitute a return of the entire amount
1801 of the transferred assets.

1802 (2) If the circumstances surrounding the transfer of an asset and
1803 return of the entire amount of the asset to the institutionalized
1804 individual indicates to the Department of Social Services that such
1805 individual, such individual's spouse or such individual's authorized
1806 representative intended, from the time the asset was transferred, that
1807 the transferee would subsequently return the asset to such individual,
1808 such individual's spouse or such individual's authorized
1809 representative for the purpose of altering the start of the penalty
1810 period or shifting nursing facility costs, that may have been borne by
1811 such individual, to the Medicaid program, the entire amount of the
1812 returned asset shall be considered available to such individual from
1813 the date of transfer. If such individual demonstrates to the department
1814 that the purpose of the transfer and its subsequent return was not to
1815 alter the penalty period or qualify such individual for Medicaid
1816 eligibility, the entire amount of the returned asset is considered
1817 available to the individual from the date of the return of the
1818 transferred asset.

1819 (3) The conveyance and subsequent return of an asset for the
1820 purpose of shifting costs to the Medicaid program shall be regarded as
1821 a trust-like device. Such asset shall be considered available for the
1822 purpose of determining Medicaid eligibility.

1823 [(d)] (e) The Commissioner of Social Services, pursuant to section
1824 17b-10, shall implement the policies and procedures necessary to carry
1825 out the provisions of this section while in the process of adopting such
1826 policies and procedures in regulation form, provided notice of intent to
1827 adopt regulations is published in the Connecticut Law Journal not later
1828 than twenty days after implementation. Such policies and procedures
1829 shall be valid until the time final regulations are effective.

1830 Sec. 41. Section 17b-28d of the general statutes is repealed and the
1831 following is substituted in lieu thereof (*Effective from passage*):

1832 The Commissioner of Social Services, in consultation with the
 1833 Commissioner of Education, shall submit to the Centers for Medicare
 1834 and Medicaid Services an amendment to the state Medicaid plan
 1835 [required by Title XIX of the Social Security Act to enhance federal
 1836 financial participation for Medicaid] concerning school-based child
 1837 health services provided to Medicaid enrolled children requiring
 1838 special education pursuant to an individualized education plan. [The
 1839 amendment shall propose (1) the establishment of either a simplified
 1840 cost-based or fixed fee method of determining state expenditures for
 1841 eligible Medicaid services provided to such children, and (2) the
 1842 replacement of the annual activity cost reports for all school-based
 1843 child health services provided to such children. Any fixed fee
 1844 established by the Department of Social Services shall be a per diem or
 1845 monthly rate per child and shall reflect reimbursable administrative
 1846 expenses.] Such amendment to the Medicaid plan shall maintain and
 1847 enhance, to the extent permitted, federal financial participation
 1848 associated with such costs through a service-specific rate method.

1849 Sec. 42. Sections 17b-239a, 17b-261k, 17b-371, 17b-265e, 17b-424 and
 1850 17b-492a of the general statutes are repealed. (*Effective July 1, 2011*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2011</i>	17b-340(f)(4)
Sec. 2	<i>July 1, 2011</i>	17b-280(a)
Sec. 3	<i>July 1, 2011</i>	17b-104(b)
Sec. 4	<i>July 1, 2011</i>	17b-106(a)
Sec. 5	<i>July 1, 2011</i>	17b-311
Sec. 6	<i>July 1, 2011</i>	New section
Sec. 7	<i>July 1, 2011</i>	New section
Sec. 8	<i>July 1, 2011</i>	17b-244(a)
Sec. 9	<i>July 1, 2011</i>	17b-340(h)(1)
Sec. 10	<i>July 1, 2011</i>	New section
Sec. 11	<i>July 1, 2011</i>	19a-180(a)
Sec. 12	<i>July 1, 2011</i>	19a-175(11)
Sec. 13	<i>July 1, 2011</i>	17b-28e

Sec. 14	July 1, 2011	17b-342(i)(1) and (2)
Sec. 15	July 1, 2011	19a-495a
Sec. 16	July 1, 2011	17b-490
Sec. 17	July 1, 2011	17b-492
Sec. 18	July 1, 2011	17b-265f
Sec. 19	July 1, 2011	17b-340(g)
Sec. 20	July 1, 2011	New section
Sec. 21	July 1, 2011	17b-265d(c)
Sec. 22	July 1, 2011	17b-260d
Sec. 23	July 1, 2011	17b-106(b)
Sec. 24	July 1, 2011	17b-278g(a)
Sec. 25	July 1, 2011	17b-372(e)
Sec. 26	July 1, 2011	17b-790a(b)
Sec. 27	July 1, 2011	17b-802
Sec. 28	July 1, 2011	17b-749a
Sec. 29	July 1, 2011	17b-749c(a)
Sec. 30	July 1, 2011, and applicable to calendar quarters commencing on or after July 1, 2011	12-263a
Sec. 31	July 1, 2011, and applicable to calendar quarters commencing on or after July 1, 2011	12-263b
Sec. 32	July 1, 2011, and applicable to calendar quarters commencing on or after July 1, 2011	12-263c
Sec. 33	July 1, 2011, and applicable to calendar quarters commencing on or after July 1, 2011	12-263d
Sec. 34	July 1, 2011, and applicable to calendar quarters commencing on or after July 1, 2011	New section
Sec. 35	July 1, 2011	17b-321
Sec. 36	July 1, 2011	New section
Sec. 37	July 1, 2011	New section
Sec. 38	July 1, 2011	New section
Sec. 39	July 1, 2011	New section

Sec. 40	<i>from passage</i>	17b-261a
Sec. 41	<i>from passage</i>	17b-28d
Sec. 42	<i>July 1, 2011</i>	Repealer section

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.]