STATE OF CONNECTICUT

EMERGENCY CERTIFICATION

General Assembly

Bill No. 703

February Session, 2006

LCO No. **5180**

* 0 5 1 8 0 *

Referred to Committee on

EMERGENCY CERTIFICATION

Introduced by:

SEN. WILLIAMS, 29th Dist.

REP. AMANN, 118th Dist.

AN ACT REQUIRING A STUDY OF STATE SOCIAL SERVICES INSTITUTIONS AND DEPARTMENTS WITH RESPECT TO THE EXPENDITURES OF SUCH INSTITUTIONS AND DEPARTMENTS AND THE PROGRAMS ADMINISTERED OR SERVICES PROVIDED BY SUCH INSTITUTIONS AND DEPARTMENTS.

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

Section 1. (NEW) (*Effective July 1, 2006*) The Commissioner of Social Services shall annually review the programs and services administered or provided by state social services institutions and departments in order to evaluate the cost-effectiveness and benefits of such functions and activities and assign priority for their continued funding. The commissioner shall submit findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies not later than January 1, 2007, and annually thereafter.

This act shall take effect as follows and shall amend the following sections:

[1067

Bill No. [7037

Section 1	*July 1, 2006*	New section

EMERGENCY CERTIFICATION

703

General Assembly

(SENATE) **Amendment** [A. 7

February Session, 2006

LCO No. **5589**

SB007030558 9SD0

Offered by:

SEN. HARP, 10th Dist.
SEN. HANDLEY, 4th Dist.
SEN. MURPHY, 16th Dist.

REP. MERRILL, 54th Dist.
REP. VILLANO, 91st Dist.
REP. SAYERS, 60th Dist.

To: Senate Bill No. **703** File No. Cal. No. 512

"AN ACT REQUIRING A STUDY OF STATE SOCIAL SERVICES INSTITUTIONS AND DEPARTMENTS WITH RESPECT TO THE EXPENDITURES OF SUCH INSTITUTIONS AND DEPARTMENTS AND THE PROGRAMS ADMINISTERED OR SERVICES PROVIDED BY SUCH INSTITUTIONS AND DEPARTMENTS."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. Subsection (a) of section 17b-340 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) The rates to be paid by or for persons aided or cared for by the state or any town in this state to licensed chronic and convalescent nursing homes, to chronic disease hospitals associated with chronic and convalescent nursing homes, to rest homes with nursing supervision, to licensed residential care homes, as defined by section 19a-490, as amended, and to residential facilities for the mentally

retarded which are licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as intermediate care facilities for the mentally retarded, for room, board and services specified in licensing regulations issued by the licensing agency shall be determined annually, except as otherwise provided in this subsection, after a public hearing, by the Commissioner of Social Services, to be effective July first of each year except as otherwise provided in this subsection. Such rates shall be determined on a basis of a reasonable payment for such necessary services, which basis shall take into account as a factor the costs of such services. Cost of such services shall include reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons employed as managers or chief administrators or required to be licensed as nursing home administrators, and compensation for services rendered by proprietors at prevailing wage rates, as determined by application of principles of accounting as prescribed by said commissioner. Cost of such services shall not include amounts paid by the facilities to employees as salary, or to attorneys or consultants as fees, where the responsibility of the employees, attorneys, or consultants is to persuade or seek to persuade the other employees of the facility to support or oppose unionization. Nothing in this subsection shall prohibit inclusion of amounts paid for legal counsel related to the negotiation of collective bargaining agreements, the settlement of grievances or normal administration of labor relations. The commissioner may, in his discretion, allow the inclusion of extraordinary and unanticipated costs of providing services which were incurred to avoid an immediate negative impact on the health and safety of patients. The commissioner may, in his discretion, based upon review of a facility's costs, direct care staff to patient ratio and any other related information, revise a facility's rate for any increases or decreases to total licensed capacity of more than ten beds or changes to its number of licensed rest home with nursing supervision beds and chronic and convalescent nursing home beds. The commissioner may so revise a facility's rate established for the

fiscal year ending June 30, 1993, and thereafter for any bed increases, decreases or changes in licensure effective after October 1, 1989. Effective July 1, 1991, in facilities which have both a chronic and convalescent nursing home and a rest home with nursing supervision, the rate for the rest home with nursing supervision shall not exceed such facility's rate for its chronic and convalescent nursing home. All such facilities for which rates are determined under this subsection shall report on a fiscal year basis ending on the thirtieth day of September. Such report shall be submitted to the commissioner by the thirty-first day of December. The commissioner may reduce the rate in effect for a facility which fails to report on or before such date by an amount not to exceed ten per cent of such rate. The commissioner shall annually, on or before the fifteenth day of February, report the data contained in the reports of such facilities to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations. For the cost reporting year commencing October 1, 1985, and for subsequent cost reporting years, facilities shall report the cost of using the services of any nursing pool employee by separating said cost into two categories, the portion of the cost equal to the salary of the employee for whom the nursing pool employee is substituting shall be considered a nursing cost and any cost in excess of such salary shall be further divided so that seventy-five per cent of the excess cost shall be considered an administrative or general cost and twenty-five per cent of the excess cost shall be considered a nursing cost, provided if the total nursing pool costs of a facility for any cost year are equal to or exceed fifteen per cent of the total nursing expenditures of the facility for such cost year, no portion of nursing pool costs in excess of fifteen per cent shall be classified as administrative or general costs. The commissioner, in determining such rates, shall also take into account the classification of patients or boarders according to special care requirements or classification of the facility according to such factors as facilities and services and such other factors as he deems reasonable, including anticipated fluctuations in the cost of providing such services. The commissioner may establish a separate rate for a facility or a portion of a facility for

traumatic brain injury patients who require extensive care but not acute general hospital care. Such separate rate shall reflect the special care requirements of such patients. If changes in federal or state laws, regulations or standards adopted subsequent to June 30, 1985, result in increased costs or expenditures in an amount exceeding one-half of one per cent of allowable costs for the most recent cost reporting year, the commissioner shall adjust rates and provide payment for any such increased reasonable costs or expenditures within a reasonable period of time retroactive to the date of enforcement. Nothing in this section shall be construed to require the Department of Social Services to adjust rates and provide payment for any increases in costs resulting from an inspection of a facility by the Department of Public Health. Such assistance as the commissioner requires from other state agencies or departments in determining rates shall be made available to him at his request. Payment of the rates established hereunder shall be conditioned on the establishment by such facilities of admissions procedures which conform with this section, section 19a-533 and all other applicable provisions of the law and the provision of equality of treatment to all persons in such facilities. The established rates shall be the maximum amount chargeable by such facilities for care of such beneficiaries, and the acceptance by or on behalf of any such facility of any additional compensation for care of any such beneficiary from any other person or source shall constitute the offense of aiding a beneficiary to obtain aid to which he is not entitled and shall be punishable in the same manner as is provided in subsection (b) of section 17b-97. For the fiscal year ending June 30, 1992, rates for licensed residential care homes and intermediate care facilities for the mentally retarded may receive an increase not to exceed the most recent annual increase in the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items. Rates for newly certified intermediate care facilities for the mentally retarded shall not exceed one hundred fifty per cent of the median rate of rates in effect on January 31, 1991, for intermediate care facilities for the mentally retarded certified prior to February 1, 1991. Notwithstanding any provision of this section, the Commissioner of

Social Services may, within available appropriations, provide an interim rate increase for a licensed chronic and convalescent nursing home or a rest home with nursing supervision for rate periods no earlier than April 1, 2004, only if the commissioner determines that the increase is necessary to avoid the filing of a petition for relief under Title 11 of the United States Code; imposition of receivership pursuant to sections 19a-541 to 19a-549, inclusive; or substantial deterioration of the facility's financial condition that may be expected to adversely affect resident care and the continued operation of the facility, and the commissioner determines that the continued operation of the facility is in the best interest of the state. The commissioner shall consider any requests for interim rate increases on file with the department from March 30, 2004, and those submitted subsequently for rate periods no earlier than April 1, 2004. When reviewing a rate increase request the commissioner shall, at a minimum, consider: (1) Existing chronic and convalescent nursing home or rest home with nursing supervision utilization in the area and projected bed need; (2) physical plant long-term viability and the ability of the owner or purchaser to implement any necessary property improvements; (3) licensure and certification compliance history; [and] (4) reasonableness of actual and projected expenses; [, but shall not consider the immediate profitability of the operation of the facility] and (5) the ability of the facility to meet wage and benefit costs. No rate shall be increased pursuant to this subsection in excess of one hundred fifteen per cent of the median rate for the facility's peer grouping, established pursuant to subdivision (2) of subsection (f) of this section, unless recommended by the commissioner and approved by the Secretary of the Office of Policy and Management after consultation with the commissioner. Such median rates shall be published by the Department of Social Services not later than April first of each year. In the event that a facility granted an interim rate increase pursuant to this section is sold or otherwise conveyed for value to an unrelated entity less than five years after the effective date of such rate increase, the rate increase shall be deemed rescinded and the department shall recover an amount equal to the difference between payments made for all affected rate periods

and payments that would have been made if the interim rate increase was not granted. The commissioner may seek recovery from payments made to any facility with common ownership. With the approval of the Secretary of the Office of Policy and Management, the commissioner may waive recovery and rescission of the interim rate for good cause shown that is not inconsistent with this section, including, but not limited to, transfers to family members that were made for no value. The commissioner shall provide written quarterly reports to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies and to the select committee of the General Assembly having cognizance of matters relating to aging, that identify each facility requesting an interim rate increase, the amount of the requested rate increase for each facility, the action taken by the commissioner and the secretary pursuant to this subsection, and estimates of the additional cost to the state for each approved interim rate increase. [Notwithstanding any provision of the general statutes, on and after July 1, 2005, the commissioner shall not provide an interim rate increase for a licensed chronic and convalescent nursing home or a rest home with nursing supervision.] Nothing in this subsection shall prohibit the commissioner from increasing the rate of a licensed chronic and convalescent nursing home or a rest home with nursing supervision for allowable costs associated with facility capital improvements or increasing the rate in case of a sale of a licensed chronic and convalescent nursing home or a rest home with nursing supervision, pursuant to subdivision (16) of subsection (f) of this section, if receivership has been imposed on such home.

Sec. 2. Subdivision (4) of subsection (f) of section 17b-340 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(4) For the fiscal year ending June 30, 1992, (A) no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1991; (B) no facility whose rate, if determined pursuant

to this subsection, would exceed one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is five and one-half per cent more than the rate it received for the rate year ending June 30, 1991; and (C) no facility whose rate, if determined pursuant to this subsection, would be less than one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is six and one-half per cent more than the rate it received for the rate year ending June 30, 1991. For the fiscal year ending June 30, 1993, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1992, or six per cent more than the rate it received for the rate year ending June 30, 1992. For the fiscal year ending June 30, 1994, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1993, or six per cent more than the rate it received for the rate year ending June 30, 1993. For the fiscal year ending June 30, 1995, no facility shall receive a rate that is more than five per cent less than the rate it received for the rate year ending June 30, 1994, or six per cent more than the rate it received for the rate year ending June 30, 1994. For the fiscal years ending June 30, 1996, and June 30, 1997, no facility shall receive a rate that is more than three per cent more than the rate it received for the prior rate year. For the fiscal year ending June 30, 1998, a facility shall receive a rate increase that is not more than two per cent more than the rate that the facility received in the prior year. For the fiscal year ending June 30, 1999, a facility shall receive a rate increase that is not more than three per cent more than the rate that the facility received in the prior year and that is not less than one per cent more than the rate that the facility received in the prior year, exclusive of rate increases associated with a wage, benefit and staffing enhancement rate adjustment added for the period from April 1, 1999, to June 30, 1999, inclusive. For the fiscal year ending June 30, 2000, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 1999, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2000, shall receive a rate increase equal to one per cent applied to the rate the

facility received for the fiscal year ending June 30, 1999, exclusive of the facility's wage, benefit and staffing enhancement rate adjustment. For the fiscal year ending June 30, 2000, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2000, shall receive a rate increase that is more than one per cent more than the rate the facility received in the fiscal year ending June 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 2000, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2001, shall receive a rate increase equal to two per cent applied to the rate the facility received for the fiscal year ending June 30, 2000, subject to verification of wage enhancement adjustments pursuant to subdivision (15) of this subsection. For the fiscal year ending June 30, 2001, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2001, shall receive a rate increase that is more than two per cent more than the rate the facility received for the fiscal year ending June 30, 2000. For the fiscal year ending June 30, 2002, each facility shall receive a rate that is two and one-half per cent more than the rate the facility received in the prior fiscal year. For the fiscal year ending June 30, 2003, each facility shall receive a rate that is two per cent more than the rate the facility received in the prior fiscal year, except that such increase shall be effective January 1, 2003, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until December 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate increased two per cent effective June 1, 2003. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30,

2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until December 31, 2004, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective January 1, 2005, each facility shall receive a rate that is one per cent greater than the rate in effect December 31, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in this subdivision, but in no event earlier than July 1, 2005, and provided the user fee imposed under section 17b-320 of the 2006 supplement to the general statutes is required to be collected, for the fiscal year ending June 30, 2006, the department shall compute the rate for each facility based upon its 2003 cost report filing or, a subsequent cost year filing for facilities having an interim rate for the period ending June 30, 2005, as provided under section 17-311-55 of the regulations of Connecticut state agencies. For each facility not having an interim rate for the period ending June 30, 2005, the rate for the period ending June 30, 2006, shall be determined beginning with the higher of the computed rate based upon its 2003 cost report filing or the rate in effect for the period ending June 30, 2005. Such rate shall then be increased by [$11.80] eleven dollars and eighty cents per day except that in no event shall the rate for the period ending June 30, 2006, be [$32.00] thirty-two dollars more than the rate in effect for the period ending June 30, 2005, and for any facility with a rate below [$195.00] one hundred ninety-five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not be greater than [$217.43] two hundred seventeen dollars and forty-three cents per day and for any facility with a rate equal to or greater than [$195.00] one hundred ninety-five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one-half per cent. For each facility with

an interim rate for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by [$11.80] eleven dollars and eighty cents per day plus the per day cost of the user fee payments made pursuant to section 17b-320 of the 2006 supplement to the general statutes divided by annual resident service days, except for any facility with an interim rate below [$195.00] one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not be greater than [$217.43] two hundred seventeen dollars and forty-three cents per day and for any facility with an interim rate equal to or greater than [$195.00] one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one-half per cent. Such July 1, 2005, rate adjustments shall remain in effect unless (i) the federal financial participation matching funds associated with the rate increase are no longer available; or (ii) the user fee created pursuant to section 17b-320 of the 2006 supplement to the general statutes is not in effect. For fiscal year ending June 30, 2007, [all facility rates] each facility shall receive a rate that is three per cent greater than the rate in effect for the period ending June 30, 2006, [shall remain in effect,] except for any facility that would have been issued a lower rate effective July 1, 2006, than for the rate period ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. The Commissioner of Social Services shall add fair rent increases to any other rate increases established pursuant to this subdivision for a facility which has undergone a material change in circumstances related to fair rent. Interim rates may take into account reasonable costs incurred by a facility, including wages and benefits.

Sec. 3. Subdivision (16) of subsection (f) of section 17b-340 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(16) The interim rate established to become effective upon sale of any licensed chronic and convalescent home or rest home with nursing supervision for which a receivership has been imposed pursuant to sections 19a-541 to 19a-549, inclusive, shall not exceed the rate in effect for the facility at the time of the imposition of the receivership, subject to any annual increases permitted by this section; provided if such rate is less than the median rate for the facility's peer grouping, as defined in subdivision (2) of this subsection, the Commissioner of Social Services may, in the commissioner's discretion, establish an increased rate for the facility not to exceed such median rate unless the Secretary of the Office of Policy and Management, after review of area nursing facility bed availability and other pertinent factors, authorizes the Commissioner of Social Services to establish a rate higher than the median rate. In the event the rate in effect for the facility at the time of imposition of the receivership is greater than the median rate for the facility's peer grouping, as defined in subdivision (2) of this subsection, the Secretary of the Office of Policy and Management, after review of area nursing facility bed availability and other pertinent factors, may authorize the Commissioner of Social Services to establish an increased interim rate.

Sec. 4. Subsection (g) of section 17b-340 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

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

the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred forty per cent of the median of operating cost components in effect January 1, 1992. Any facility with real property other than land placed in service prior to October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding October 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request, allow actual debt service, comprised of principal and interest, in excess of property costs allowed pursuant to section 17-311-52 of the regulations of Connecticut state agencies, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. For the fiscal year ending June 30, 1995, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, no rate shall exceed three hundred seventy-five dollars per day unless the commissioner, in consultation with the Commissioner of Mental Retardation, determines after a review of program and management costs, that a rate in excess of this amount is necessary for care and treatment of facility residents. For the fiscal year ending June 30, 2002, rate period, the Commissioner of Social Services shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2000 costs to include a three and one-half per cent inflation factor. For the fiscal year ending June 30, 2003, rate period, the commissioner shall increase the inflation adjustment for rates made in

accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2001 costs to include a one and one-half per cent inflation factor, except that such increase shall be effective November 1, 2002, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until October 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate updated effective November 1, 2002, in accordance with applicable statutes and regulations. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until September 30, 2004. Effective October 1, 2004, each facility shall receive a rate that is five per cent greater than the rate in effect September 30, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 of the 2006 supplement to the general statutes is required to be collected, each facility shall receive a rate that is four per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (A) The federal financial participation matching funds associated with the rate increase are no longer available; or (B) the user fee created pursuant to section 17b-320 of the 2006 supplement to the general statutes is not in effect. For the fiscal year ending June 30, 2007,

rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than three per cent greater than the rate in effect for the facility on September 30, 2006, except for any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006.

Sec. 5. Subdivision (1) of subsection (h) of section 17b-340 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(h) (1) For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate in excess of one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate that is less than one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to sixty-five per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred thirty per cent of the median of operating cost components in effect January 1, 1992. Beginning with the fiscal year ending June 30, 1993, for the purpose of determining allowable fair rent, a residential care home with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Beginning with the fiscal year ending June 30, 1997, a residential care home with allowable fair rent less than three dollars and ten cents

per day shall be reimbursed as having allowable fair rent equal to three dollars and ten cents per day. Property additions placed in service during the cost year ending September 30, 1996, or any succeeding cost year shall receive a fair rent allowance for such additions as an addition to three dollars and ten cents per day if the fair rent for the facility for property placed in service prior to September 30, 1995, is less than or equal to three dollars and ten cents per day. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. Beginning with the fiscal year ending June 30, 1997, minimum allowable patient days for rate computation purposes for a residential care home with twenty-five beds or less shall be eighty-five per cent of licensed capacity. Beginning with the fiscal year ending June 30, 2002, for the purposes of determining the allowable salary of an administrator of a residential care home with sixty beds or less the department shall revise the allowable base salary to thirty-seven thousand dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies. The rates for the fiscal year ending June 30, 2002, shall be based upon the increased allowable salary of an administrator, regardless of whether such amount was expended in the 2000 cost report period upon which the rates are based. Beginning with the fiscal year ending June 30, 2000, the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall be increased by two per cent, and beginning with the fiscal year ending June 30, 2002, the inflation adjustment for rates made in accordance with subsection (c) of said section shall be increased by one per cent. Beginning with the fiscal year ending June 30, 1999, for the purpose of determining the allowable salary of a related party, the department shall revise the

maximum salary to twenty-seven thousand eight hundred fifty-six dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies and beginning with the fiscal year ending June 30, 2001, such allowable salary shall be computed on an hourly basis and the maximum number of hours allowed for a related party other than the proprietor shall be increased from forty hours to forty-eight hours per work week. For the fiscal year ending June 30, 2005, each facility shall receive a rate that is two and one-quarter per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 of the 2006 supplement to the general statutes is required to be collected, each facility shall receive a rate that is determined in accordance with applicable law and subject to appropriations, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (A) The federal financial participation matching funds associated with the rate increase are no longer available; or (B) the user fee created pursuant to section 17b-320 of the 2006 supplement to the general statutes is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than four per cent greater than the rate in

effect for the facility on September 30, 2006, except for any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006.

Sec. 6. Subsection (a) of section 17b-321 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) On or before July 1, 2005, and on or before July first [of each succeeding calendar year] biennially thereafter, the Commissioner of Social Services shall determine the amount of the user fee and promptly notify the commissioner and nursing homes of such amount. The user fee shall be the (1) the sum of each nursing home's anticipated nursing home net revenue, including but not limited to its estimated net revenue from any increases in Medicaid payments, during the twelve-month period ending on June thirtieth of the succeeding calendar year, (2) which sum shall be multiplied by six per cent, and (3) which product shall be divided by the sum of each nursing home's anticipated resident days during the twelve-month period ending on June thirtieth of the succeeding calendar year. The Commissioner of Social Services, in anticipating nursing home net revenue and resident days, shall use the most recently available nursing home net revenue and resident day information. On or before July 1, 2007, the Commissioner of Social Services shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services on the detrimental effects, if any, that a biennial determination of the user fee may have on private payors.

Sec. 7. Subsection (b) of section 17b-321 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(b) Upon approval of the waiver of federal requirements for

uniform and broad-based user fees in accordance with 42 CFR 433.68 pursuant to section 17b-323, the Commissioner of Social Services shall redetermine the amount of the user fee and promptly notify the commissioner and nursing homes of such amount. The user fee shall be the (1) the sum of each nursing home's anticipated nursing home net revenue, including but not limited to its estimated net revenue from any increases in Medicaid payments, during the twelve-month period ending on June thirtieth of the succeeding calendar year but not including any such anticipated net revenue of any nursing home exempted from such user fee due to waiver of federal requirements pursuant to section 17b-323, (2) which sum shall be multiplied by six per cent, and (3) which product shall be divided by the sum of each nursing home's anticipated resident days, but not including the anticipated resident days of any nursing home exempted from such user fee due to waiver of federal requirements pursuant to section 17b-323. Notwithstanding the provisions of this subsection, the amount of the user fee for each nursing home licensed for more than two hundred thirty beds or owned by a municipality shall be equal to the amount necessary to comply with federal provider tax uniformity waiver requirements as determined by the Commissioner of Social Services. The Commissioner of Social Services may increase retroactively the user fee for nursing homes not licensed for more than two hundred thirty beds and not owned by a municipality to the effective date of waiver of said federal requirements to offset user fee reductions necessary to meet the federal waiver requirements. [Thereafter, on] On or before July [first of each succeeding calendar year] 1, 2005, and biennially thereafter, the Commissioner of Social Services shall determine the amount of the user fee in accordance with this subsection. The Commissioner of Social Services, in anticipating nursing home net revenue and resident days, shall use the most recently available nursing home net revenue and resident day information. On or before July 1, 2007, the Commissioner of Social Services shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies

and human services on the detrimental effects, if any, that a biennial determination of the user fee may have on private payors.

Sec. 8. Section 17b-605a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) The Commissioner of Social Services shall seek a waiver from federal law to establish a personal care assistance program for persons [ages eighteen through sixty-four] eighteen years of age or older with disabilities funded under the Medicaid program. Such a program shall be limited to a specified number of slots available for eligible program recipients and shall be operated by the Department of Social Services within available appropriations. Such a waiver shall be submitted to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services in accordance with section 17b-8 no later than January 1, 1996.

(b) The Commissioner of Social Services shall amend the waiver specified in subsection (a) of this section to enable persons eligible for or receiving medical assistance under section 17b-597 to receive personal care assistance. Such amendment shall not be subject to the provisions of section 17b-8 provided such amendment shall consist only of modifications necessary to extend personal care assistance to such persons.

Sec. 9. Subsection (a) of section 17b-342a of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) The Commissioner of Social Services shall, within available appropriations, establish and operate a state-funded pilot program to allow no more than [one] two hundred fifty persons who are sixty-five years of age or older and meet the eligibility requirements of the Connecticut home-care program for the elderly established under section 17b-342, as amended, to receive personal care assistance provided such services are cost effective as determined by the

Commissioner of Social Services. Persons who receive personal care assistance services pursuant to the pilot program established by section 47 of public act 00-2 of the June special session* shall be included as participants of the pilot program established pursuant to this section. Personal care assistance under the program may be provided by nonspousal family members of the recipient of services under the program.

Sec. 10. (NEW) (*Effective July 1, 2006*) On and after July 1, 2006, and for each succeeding fiscal year thereafter, in determining costs eligible for reimbursement pursuant to subdivisions (2) and (3) of subsection (e) of section 10-76d of the 2006 supplement to the general statutes, subdivision (2) of subsection (a) of section 10-76g of the 2006 supplement to the general statutes and subsection (b) of said section 10-76g, Medicaid reimbursement received by any local or regional board of education from the Department of Social Services for students of such boards of education shall not be deducted from grants paid in accordance with said sections of the general statutes.

Sec. 11. Subsection (b) of section 17b-490 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(b) "Prescription drugs" means (1) legend drugs, as defined in section 20-571, (2) any other drugs which by state law or regulation require the prescription of a licensed practitioner for dispensing, except: (A) Products prescribed for cosmetic purposes as specified in regulations adopted pursuant to section 17b-494; (B) on and after September 15, 1991, diet pills, smoking cessation gum, contraceptives, multivitamin combinations, cough preparations and antihistamines; [and] (C) drugs for the treatment of erectile dysfunction, unless such drug is prescribed to treat a condition other than sexual or erectile dysfunction, for which the drug has been approved by the Food and Drug Administration; and (D) drugs for the treatment of erectile dysfunction for persons who have been convicted of a sexual offense who are required to register with the Commissioner of Public Safety

pursuant to chapter 969, and (3) insulin and insulin syringes.

Sec. 12. Section 17b-363b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) The Commissioner of Social Services may, within available appropriations, provide reimbursement to pharmacies or pharmacists for services provided to residents in long-term care facilities, including (1) residential care homes, nursing homes or rest homes, as defined in section 19a-490, as amended, (2) residential facilities for mentally retarded persons, as defined in section 17a-231, or (3) facilities served by assisted living services agencies, as defined in section 19a-490, as amended, in addition to those reimbursements provided in chapter 319v, provided such services improve the quality of care to residents of such facilities and produce cost savings to the state, as determined by the commissioner. Such services may include, but not be limited to, emergency and delivery services provided such services are offered on all medications, including intravenous therapy, twenty-four hours per day and seven days per week.

(b) The Commissioner of Social Services may reimburse for prescription drug costs in unit dose packaging, including blister packs and other special packaging, for clients residing in nursing facilities, chronic disease hospitals and intermediate care facilities for the mentally retarded.

Sec. 13. Section 17b-265e of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) There is established a fund to be known as the "Medicare Part D Supplemental Needs Fund" which shall be an account within the General Fund under the Department of Social Services. The Commissioner of Social Services shall, within available appropriations, designate moneys to said fund. Moneys available in said fund shall be utilized by the Department of Social Services to provide financial assistance to Medicare Part D beneficiaries who are enrolled in the

ConnPACE program or who are full benefit dually eligible Medicare Part D beneficiaries, as defined in section 17b-265d, and who lack the financial means to obtain medically necessary nonformulary prescription drugs. A beneficiary requesting such financial assistance from the department shall be required to make a satisfactory showing of the medical necessity of obtaining such nonformulary prescription drug to the department. The department may require as a condition of receiving such financial assistance that a beneficiary establish, to the satisfaction of the department, that the beneficiary has made good faith efforts to: (1) Enroll in a Medicare Part D plan recommended by the commissioner or the commissioner's agent; and (2) utilize the exception process established by the prescription drug plan in which the beneficiary is enrolled. The department shall expeditiously review all requests for financial assistance pursuant to this section and shall notify the beneficiary as to whether the request for financial assistance has been granted not later than two hours after receiving the request from the beneficiary. The commissioner shall implement policies and procedures to administer the provisions of this section and to ensure that all requests for, and determinations made concerning financial assistance available pursuant to this section are expeditiously processed.

(b) The Department of Social Services shall, in accordance with the provisions of this section, pay claims for prescription drugs for Medicare Part D beneficiaries, who are also either Medicaid or ConnPACE recipients and who are denied coverage by the Medicare Part D Plan in which such beneficiary is enrolled because a prescribed drug is not on the formulary utilized by such Medicare Part D Plan. Payment shall initially be made by the department for a thirty-day supply, subject to any applicable copayment. The beneficiary shall appoint the commissioner as such beneficiary's representative for the purpose of appealing any denial of Medicare Part D benefits and for any other purpose allowed under said act and deemed necessary by the commissioner.

(c) Notwithstanding any provision of the general statutes, not later

than July 1, 2006, the Commissioner of Social Services shall contract with an entity specializing in Medicare appeals and reconsideration for the purpose of having such entity exhaust remedies for pursuing payment under Medicare Part D by Part D Plans for prescriptions denied as nonformulary drugs, including remedies available through reconsideration by an Independent Review Entity, review by an Administrative Law Judge, the Medicare Appeals Council or Federal District Court. Reimbursement secured by such entity from the Part D Plan shall be returned to the Department of Social Services.

(d) The entity contracting with the Department of Social Services pursuant to subsection (c) of this section shall submit appeals beyond the Independent Review Entity only upon authorization from the department. Upon determination by the department that it is not cost-effective to pursue further appeals, the department shall pay for the denied nonformulary drug for the remainder of the calendar year, provided the beneficiary remains enrolled in the Part D Plan that denied coverage. Pending the outcome of the appeals process, the department shall continue to pay claims for the nonformulary drug denied by the Part D Plan until the earlier of approval of such drug by the Part D Plan or for the remainder of the calendar year.

Sec. 14. Section 17b-256 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Social Services may administer, within available appropriations, a program providing payment for the cost of drugs prescribed by a physician for the [prevention or] treatment of acquired immunodeficiency syndrome [(AIDS)] or human immunodeficiency virus. [(HIV infection).] The commissioner, in consultation with the Commissioner of Public Health, shall determine specific drugs to be covered and may implement a pharmacy lock-in procedure for the program. The [commissioner] Commissioner of Social Services shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the purposes of this section. The commissioner may implement the program while in the process of

adopting regulations, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal within twenty days of implementation. The regulations may include eligibility for all persons with [AIDS or HIV infection] acquired immunodeficiency syndrome or human immunodeficiency virus whose income is below four hundred per cent of the federal poverty level. [The] Subject to federal approval, the commissioner [shall] may, within available federal resources, [purchase and] maintain existing insurance policies for eligible clients, including, but not limited to, coverage of costs associated with such policies, that provide a full range of [HIV] human immunodeficiency virus treatments and access to comprehensive primary care services as determined by the commissioner and as provided by federal law, and may provide payment, determined by the commissioner, for (1) drugs and nutritional supplements prescribed by a physician that prevent or treat opportunistic diseases and conditions associated with [AIDS or HIV infection] acquired immunodeficiency syndrome or human immunodeficiency virus; (2) ancillary supplies related to the administration of such drugs; and (3) laboratory tests ordered by a physician. On and after the effective date of this section, persons who previously received insurance assistance under the program established pursuant to section 17b-255 of the general statutes, revision of 1958, revised to 2005, shall continue to receive such assistance until the expiration of the insurance coverage, provided such person continues to meet program eligibility requirements established in accordance with this subsection. On or before March 1, 2007, and annually thereafter, the Commissioner of Social Services shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations and the budgets of state agencies on the projected availability of funds for the program established pursuant to this section.

(b) Applicants for and recipients of benefits under the program established pursuant to subsection (a) of this section shall, if eligible, enroll in Medicare Part D. The Commissioner of Social Services may be

the authorized representative of such an applicant or recipient for purposes of enrolling in a Medicare Part D plan or submitting an application to the Social Security Administration to obtain the low income subsidy benefit provided under Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The applicant or recipient shall have the opportunity to select a Medicare Part D plan and shall be notified of such opportunity by the commissioner. The applicant or recipient, prior to selecting a Medicare Part D plan, shall have the opportunity to consult with the commissioner, or the commissioner's designated agent, concerning the selection of a Medicare Part D plan that best meets the prescription drug needs of such applicant or recipient. In the event that such applicant or recipient does not select a Medicare Part D plan within a reasonable period of time, as determined by the commissioner, the commissioner shall enroll the applicant or recipient in a Medicare Part D plan designated by the commissioner in accordance with said act. The applicant or recipient shall appoint the commissioner as such applicant's or recipient's representative for the purpose of appealing any denial of Medicare Part D benefits and for any other purpose allowed under said act and deemed necessary by the commissioner. The commissioner may pay the premium and coinsurance costs of Medicare Part D coverage for eligible applicants or recipients.

Sec. 15. Section 17b-242a of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

The Commissioner of Social Services shall establish prior authorization procedures under the Medicaid program for home health services, such that prior authorization shall be required for skilled nursing visits that exceed two per week [. Unless there are revisions to the prior authorization received during the month, providers shall not] and for home health aide visits that exceed fourteen hours per week, except that no provider shall be required to submit a prior authorization [requests] request for a home health service for the same client more than once a month. The Commissioner

of Social Services may contract with an entity for administration of any such aspect of prior authorization or may expand the scope of an existing contract with an entity that performs utilization review services on behalf of the department. The commissioner, pursuant to section 17b-10, may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 16. Subsection (j) of section 17b-292 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(j) Not more than twelve months after the determination of eligibility for benefits under the HUSKY Plan, Part A and Part B and annually thereafter, the commissioner or the servicer, as the case may be, shall determine if the child continues to be eligible for the plan. The commissioner or the servicer shall mail an application form to each participant in the plan for the purposes of obtaining information to make a determination on eligibility. To the extent permitted by federal law, in determining eligibility for benefits under the HUSKY Plan, Part A or Part B with respect to family income, the commissioner or the servicer shall rely upon information provided in such form by the participant unless the commissioner or the servicer has reason to believe that such information is inaccurate or incomplete. The Department of Social Services shall annually review a random sample of cases to confirm that, based on the statistical sample, relying on such information is not resulting in ineligible clients receiving benefits under HUSKY Plan Part A or Part B. The determination of eligibility shall be coordinated with health plan open enrollment periods.

Sec. 17. Section 17b-84 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

Upon the death of any beneficiary [,] under the state supplement or the temporary family assistance program, the [commissioner] Commissioner of Social Services shall order the payment of a sum not to exceed [one thousand dollars for the fiscal year ending June 30, 1987, one thousand one hundred dollars for the fiscal year ending June 30, 1988, and one thousand two hundred dollars for the fiscal year ending June 30, 1989, and subsequent fiscal years,] one thousand eight hundred dollars as an allowance toward the funeral and burial expenses of such deceased. The payment for funeral and burial expenses shall be reduced by the amount in any revocable or irrevocable funeral fund, prepaid funeral contract or the face value of any life insurance policy owned by the recipient. Contributions may be made by any person for the cost of the funeral and burial expenses of the deceased over and above the sum established under this section without thereby diminishing the state's obligation.

Sec. 18. Section 17b-131 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

When a person in any town, or sent from such town to any licensed institution or state humane institution, dies or is found dead therein and does not leave sufficient estate or has no legally liable relative able to pay the cost of a proper funeral and burial, or upon the death of any beneficiary under the state-administered general assistance program, the Commissioner of Social Services shall give to such person a proper funeral and burial, and shall pay a sum not exceeding [twelve hundred] one thousand eight hundred dollars as an allowance toward the funeral expenses of such deceased, said sum to be paid, upon submission of a proper bill, to the funeral director, cemetery or crematory, as the case may be. Such payment for funeral and burial expenses shall be reduced by (1) the amount in any revocable or irrevocable funeral fund, (2) any prepaid funeral contract, (3) the face value of any life insurance policy owned by the decedent, and (4) contributions in excess of two thousand eight hundred dollars toward such funeral and burial expenses from all other sources including friends, relatives and all other persons, organizations, veterans and

other benefit programs and other agencies.

Sec. 19. Section 17b-264 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

All of the provisions of sections 17b-22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-83, inclusive, 17b-85 to 17b-103, inclusive, and 17b-600 to 17b-604, inclusive, are extended to the medical assistance program except such provisions as are inconsistent with federal law and regulations governing Title XIX of the Social Security Amendments of 1965 and sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, as amended, and 17b-357 to 17b-361, inclusive.

Sec. 20. Section 19a-55a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) There is established a newborn screening account that shall be a separate nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited into the account. Any balance remaining in said account at the end of any fiscal year shall be carried forward in the account for the next fiscal year.

(b) [Three hundred forty-five] Five hundred thousand dollars of the amount collected pursuant to section 19a-55, as amended, in each fiscal year, shall be credited to the newborn screening account, and be available for expenditure by the Department of Public Health for the expenses of the testing required by sections 19a-55, as amended, and 19a-59.

Sec. 21. Section 17b-239 of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) The rate to be paid by the state to hospitals receiving appropriations granted by the General Assembly and to freestanding chronic disease hospitals, providing services to persons aided or cared for by the state for routine services furnished to state patients, shall be

based upon reasonable cost to such hospital, or the charge to the general public for ward services or the lowest charge for semiprivate services if the hospital has no ward facilities, imposed by such hospital, whichever is lowest, except to the extent, if any, that the commissioner determines that a greater amount is appropriate in the case of hospitals serving a disproportionate share of indigent patients. Such rate shall be promulgated annually by the Commissioner of Social Services. Nothing contained [herein] in this section shall authorize a payment by the state for such services to any such hospital in excess of the charges made by such hospital for comparable services to the general public. Notwithstanding the provisions of this section, for the rate period beginning July 1, 2000, rates paid to freestanding chronic disease hospitals and freestanding psychiatric hospitals shall be increased by three per cent. For the rate period beginning July 1, 2001, a freestanding chronic disease hospital or freestanding psychiatric hospital shall receive a rate that is two and one-half per cent more than the rate it received in the prior fiscal year and such rate shall remain effective until December 31, 2002. Effective January 1, 2003, a freestanding chronic disease hospital or freestanding psychiatric hospital shall receive a rate that is two per cent more than the rate it received in the prior fiscal year. Notwithstanding the provisions of this subsection, for the period commencing July 1, 2001, and ending June 30, 2003, the commissioner may pay an additional total of no more than three hundred thousand dollars annually for services provided to long-term ventilator patients. For purposes of this subsection, "long-term ventilator patient" means any patient at a freestanding chronic disease hospital on a ventilator for a total of sixty days or more in any consecutive twelve-month period. Effective July 1, 2004, each freestanding chronic disease hospital shall receive a rate that is two per cent more than the rate it received in the prior fiscal year.

(b) Effective October 1, 1991, the rate to be paid by the state for the cost of special services rendered by such hospitals shall be established annually by the commissioner for each such hospital based on the

reasonable cost to each hospital of such services furnished to state patients. Nothing contained herein shall authorize a payment by the state for such services to any such hospital in excess of the charges made by such hospital for comparable services to the general public.

(c) The term "reasonable cost" as used in this section means the cost of care furnished such patients by an efficient and economically operated facility, computed in accordance with accepted principles of hospital cost reimbursement. The commissioner may adjust the rate of payment established under the provisions of this section for the year during which services are furnished to reflect fluctuations in hospital costs. Such adjustment may be made prospectively to cover anticipated fluctuations or may be made retroactive to any date subsequent to the date of the initial rate determination for such year or in such other manner as may be determined by the commissioner. In determining "reasonable cost" the commissioner may give due consideration to allowances for fully or partially unpaid bills, reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons employed as managers or chief administrators, requirements for working capital and cost of development of new services, including additions to and replacement of facilities and equipment. The commissioner shall not give consideration to amounts paid by the facilities to employees as salary, or to attorneys or consultants as fees, where the responsibility of the employees, attorneys or consultants is to persuade or seek to persuade the other employees of the facility to support or oppose unionization. Nothing in this subsection shall prohibit the commissioner from considering amounts paid for legal counsel related to the negotiation of collective bargaining agreements, the settlement of grievances or normal administration of labor relations.

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

room visit rates in effect June 30, 1991, shall remain in effect through June 30, 1993, except those which would have been decreased effective July 1, 1991, or July 1, 1992, shall be decreased. Nothing contained herein shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public. For those outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios in effect June 30, 1991, shall be reduced effective July 1, 1991, by the most recent annual increase in the consumer price index for medical care. For those outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios computed to be effective July 1, 1994, shall be reduced by the most recent annual increase in the consumer price index for medical care. The emergency room visit rates in effect June 30, 1994, shall remain in effect through December 31, 1994. The Commissioner of Social Services shall establish a fee schedule for outpatient hospital services to be effective on and after January 1, 1995. Except with respect to the rate periods beginning July 1, 1999, and July 1, 2000, such fee schedule shall be adjusted annually beginning July 1, 1996, to reflect necessary increases in the cost of services. Notwithstanding the provisions of this subsection, the fee schedule for the rate period beginning July 1, 2000, shall be increased by ten and one-half per cent, effective June 1, 2001. Notwithstanding the provisions of this subsection, outpatient rates in effect as of June 30, 2003, shall remain in effect through June 30, 2005. Effective July 1, 2006, subject to available appropriations, the commissioner shall increase outpatient service fees for services that may include clinic, emergency room, magnetic resonance imaging, and computerized axial tomography. Not later than October 1, 2006, the commissioner shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies, identifying such fee increases and the associated cost increase estimates.

(e) The commissioner shall adopt regulations, in accordance with

the provisions of chapter 54, establishing criteria for defining emergency and nonemergency visits to hospital emergency rooms. All nonemergency visits to hospital emergency rooms shall be paid at the hospital's outpatient clinic services rate. Nothing contained in this subsection or the regulations adopted hereunder shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public.

(f) On and after October 1, 1984, the state shall pay to an acute care general hospital for the inpatient care of a patient who no longer requires acute care a rate determined by the following schedule: For the first seven days following certification that the patient no longer requires acute care the state shall pay the hospital at a rate of fifty per cent of the hospital's actual cost; for the second seven-day period following certification that the patient no longer requires acute care the state shall pay seventy-five per cent of the hospital's actual cost; for the third seven-day period following certification that the patient no longer requires acute care and for any period of time thereafter, the state shall pay the hospital at a rate of one hundred per cent of the hospital's actual cost. On and after July 1, 1995, no payment shall be made by the state to an acute care general hospital for the inpatient care of a patient who no longer requires acute care and is eligible for Medicare unless the hospital does not obtain reimbursement from Medicare for that stay.

(g) Effective June 1, 2001, the commissioner shall establish inpatient hospital rates in accordance with the method specified in regulations adopted pursuant to this section and applied for the rate period beginning October 1, 2000, except that the commissioner shall update each hospital's target amount per discharge to the actual allowable cost per discharge based upon the 1999 cost report filing multiplied by sixty-two and one-half per cent if such amount is higher than the target amount per discharge for the rate period beginning October 1, 2000, as adjusted for the ten per cent incentive identified in Section 4005 of Public Law 101-508. If a hospital's rate is increased pursuant to this

subsection, the hospital shall not receive the ten per cent incentive identified in Section 4005 of Public Law 101-508. For rate periods beginning October 1, 2001, through [March 31, 2008] September 30, 2006, the commissioner shall not apply an annual adjustment factor to the target amount per discharge. Effective April 1, 2005, the revised target amount per discharge for each hospital with a target amount per discharge less than three thousand seven hundred fifty dollars shall be three thousand seven hundred fifty dollars. [Effective October 1, 2006, the revised target amount per discharge for each hospital with a target amount per discharge less than four thousand dollars shall be four thousand dollars. Effective October 1, 2007, the revised target amount per discharge for each hospital with a target amount per discharge less than four thousand two hundred fifty dollars shall be four thousand two hundred fifty dollars.] Effective October 1, 2006, subject to available appropriations, the commissioner shall establish an increased target amount per discharge of not less than four thousand dollars for each hospital with a target amount per discharge less than four thousand dollars for the rate period ending September 30, 2006, and the commissioner may apply an annual adjustment factor to the target amount per discharge for hospitals that are not increased as a result of the revised target amount per discharge. Not later than October 1, 2006, the commissioner shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies identifying the increased target amount per discharge and the associated cost increase estimates.

Sec. 22. (*Effective July 1, 2006*) (a) The Department of Social Services, in consultation with the Connecticut Pharmacists Association, shall review the impact of the implementation of average manufacturer price reimbursement methodology that shall take effect on January 1, 2007, as required under the federal Deficit Reduction Act of 2005. Such review shall include, but not be limited to, the financial impact of the required change in pharmacy reimbursement received under the

Medicaid fee-for-service program and recommendations for potential changes in the dispensing fee, both for brand name drugs and generic drug products.

(b) Based on the outcome of such study, on or after April 1, 2007, and for the fiscal year ending on June 30, 2007, the Department of Social Services may, subsequent to the approval by the Secretary of the Office of Policy and Management, implement increased adjustments to dispensing fees paid to licensed pharmacies pursuant to section 17b-280 of the 2006 supplement to the general statutes for prescription drugs dispensed to Medicaid, ConnPACE and Connecticut AIDS drug assistance recipients. The Department of Social Services may provide, upon approval by the Secretary of the Office of Policy and Management, increased adjustments to the dispensing fee paid to licensed pharmacies providing services to ConnPACE, Medicaid, state-administered general assistance and Connecticut AIDS drug assistance recipients in order to indemnify and hold harmless those pharmacies that experience financial hardship attributable to their participation in said state-funded programs due to the implementation of the average manufacturer price reimbursement methodology required under the federal Deficit Reduction Act of 2005.

Sec. 23. (*Effective July 1, 2006*) The Children's Trust Fund Council and the Department of Children and Families shall enter into an agreement whereby the department shall transfer to the council six hundred fourteen thousand one hundred ten dollars appropriated to the department in house bill 5845 of the current session.

Sec. 24. (*Effective July 1, 2006*) Subject to the provisions of section 3-125a of the general statutes, the Department of Social Services is authorized to use moneys in the Medicaid appropriation for the fiscal year ending June 30, 2007, to pay proceeds of any settlement agreement in the action of Mary Carr, et al v. Patricia Wilson-Coker, Commissioner of the Department of Social Services, United States District Court, District of Connecticut, Civil Action No. 3: 00CV1050 (AVC) to comply with such agreement. The department shall, not later

than six months from the date of such settlement, report to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, human services and public health on a plan to achieve compliance with such settlement.

Sec. 25. Section 5-239a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

The Commissioner of Administrative Services may establish procedures for the assignment of permanent state employees of the executive branch, including institutions of higher education encompassing technical and junior colleges as well as four-year colleges and universities, to a federal agency, to the office of the court monitor at the Department of Children and Families established in accordance with the terms of the consent decree entered in the case of Juan F. v. O'Neill, United States District Court, Docket No. H-89-859 (D. Conn. January 7, 1991), to any municipality of the state or to institutions of higher education, including private as well as public institutions and technical and junior colleges as well as four-year colleges and universities, provided that the assignment meets with the written approval of the appointing authorities of the agencies and institutions involved in the assignment of the employee. State employees may only be assigned to such agencies and institutions with their personal consent. Assignments may be made for a period of up to two years and renewed once for an additional two years, provided any assignment of an employee to the court monitor at the Department of Children and Families shall not be subject to such durational time limits and may remain effective until December 31, [2006] 2007. An employee on such assignment may be deemed to be on detail to a regular work assignment of his or her agency or institution and entitled to full salary and benefits and all rights and privileges for his class or position. Employees of a federal agency or any municipality of the state or institutions of higher education, including private as well as public institutions and technical and junior colleges as well as four-year colleges and universities, on assignment with an agency of the

executive branch of state government shall serve under appointment made without regard to provisions of the general statutes regarding appointment in the classified service. The cost of any salary and benefits may be shared by the jurisdiction or be paid entirely by one or the other and shall be subject to negotiation between the agencies or institutions cooperating on the assignment. Once the agencies or institutions have agreed upon the assignment and all terms and conditions for the assignment, it shall be put into effect by a written agreement and submitted to the Commissioner of Administrative Services and the Secretary of the Office of Policy and Management for approval.

Sec. 26. Subdivision (9) of subsection (a) of section 10-76d of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(9) [For] Notwithstanding any provision of the general statutes, for purposes of Medicaid reimbursement, when recommended by the planning and placement team and specified on the individualized education program, a service eligible for reimbursement under the Medicaid program shall be deemed to be authorized by a practitioner of the healing arts under 42 CFR 440.130, provided such service is recommended by an appropriately licensed or certified individual and is within the individual's scope of practice. Certain items of durable medical equipment, recommended pursuant to the provisions of this subdivision, may be subject to prior authorization requirements established by the Commissioner of Social Services. Diagnostic and evaluation services eligible for reimbursement under the Medicaid program [,] and recommended by the planning and placement team [and specified on the individualized education program] shall also be deemed to be authorized by a practitioner of the healing arts under 42 CFR 440.130 provided such services are recommended by an appropriately licensed or certified individual and are within the individual's scope of practice.

Sec. 27. Subsection (a) of section 17b-597 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) The Department of Social Services shall establish and implement a working persons with disabilities program to provide medical assistance as authorized under [Section 201(a)(1) of Public Law 106-170] 42 USC 1396a(a)(10)(A)(ii), as amended from time to time, to persons who are disabled and regularly employed.

Sec. 28. Subsection (b) of section 17a-22j of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(b) The council shall consist of the following members:

(1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, appropriations and the budgets of state agencies, or their designees;

(2) A member of the Community Mental Health Strategy Board, established pursuant to section 17a-485b, as selected by said board;

(3) The Commissioner of Mental Health and Addiction Services, or said commissioner's designee;

(4) Sixteen members appointed by the chairpersons of the advisory council on Medicaid managed care, established pursuant to section 17b-28;

(A) Two of whom are representatives of general or specialty psychiatric hospitals;

(B) One of whom is an adult with a psychiatric disability;

(C) One of whom is an advocate for adults with psychiatric disabilities;

(D) Two of whom are parents of children who have a behavioral

health disorder or have received child protection or juvenile justice services from the Department of Children and Families;

(E) One of whom has expertise in health policy and evaluation;

(F) One of whom is an advocate for children with behavioral health disorders;

(G) One of whom is a primary care provider serving HUSKY children;

(H) One of whom is a child psychiatrist serving HUSKY children;

(I) One of whom is either an adult with a substance use disorder or an advocate for adults with substance use disorders;

(J) One of whom is a representative of school-based health clinics;

(K) One of whom is a provider of community-based behavioral health services for adults;

(L) One of whom is a provider of residential treatment for children;

(M) One of whom is a provider of community-based services for children with behavioral health problems; and

(N) One of whom is a member of the advisory council on Medicaid managed care;

(5) [Four] Seven nonvoting ex-officio members, one each appointed by the Commissioners of Social Services, Children and Families [and] Mental Health and Addiction Services and Education to represent his or her department and one appointed by the State Comptroller, the Secretary of the Office of Policy and Management and the Office of Health Care Access to represent said [department] offices; [and]

(6) One or more consumers appointed by the chairpersons of the council, to be nonvoting ex-officio members; and

[(6)] (7) One representative from the administrative services organization and from each Medicaid managed care organization, to be nonvoting ex-officio members.

Sec. 29. Subsection (c) of section 17a-22j of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(c) All appointments to the council shall be made no later than July 1, 2005, except that the chairpersons of the council may appoint additional consumers to the council as nonvoting ex-officio members. Any vacancy shall be filled by the appointing authority.

Sec. 30. Section 17a-22*l* of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

The Departments of Children and Families and Social Services shall develop consumer [grievance] and provider appeal procedures and shall submit such procedures to the Behavioral Health Partnership Oversight Council for review and comment. Such procedures shall include, but not be limited to, procedures for a consumer or any provider acting on behalf of a consumer to appeal a denial or determination. The Departments of Children and Families and Social Services shall establish time frames for appealing decisions made by the administrative services organization, including an expedited review in emergency situations. Any procedure for appeals shall require that an appeal be heard not later than thirty days after such appeal is filed and shall be decided not later than forty-five days after such appeal is filed.

Sec. 31. (NEW) *(Effective July 1, 2006)* (a) On or before October 1, 2007, the Commissioner of Mental Health and Addiction Services, within available appropriations set forth in section 52 of this act and in consultation with the Community Mental Health Strategy Board established under section 17a-485b of the general statutes, shall establish and implement (1) a pilot program for general pediatric,

family medicine and geriatric health care professionals to improve their ability to identify, diagnose, refer and treat patients with mental illness, and (2) a pilot program of peer-counseling in the Division of the State Police.

(b) On or before January 1, 2009, the Commissioner of Mental Health and Addiction Services shall evaluate the pilot programs established under subsection (a) of this section and shall submit a report of the commissioner's findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes.

Sec. 32. (NEW) (*Effective from passage*) (a) The Department of Social Services, in consultation with the Department of Mental Health and Addiction Services and the Community Mental Health Strategy Board established under section 17a-485b of the general statutes, may seek approval of an amendment to the state Medicaid plan or a waiver from federal law, whichever is sufficient and most expeditious, to establish and implement a Medicaid-financed home and community-based program to provide community-based services and, if necessary, housing assistance, to adults with severe and persistent psychiatric disabilities being discharged or diverted from nursing home residential care.

(b) On or before January 1, 2007, and annually thereafter, the Commissioner of Social Services, in consultation with the Commissioner of Mental Health and Addiction Services, shall submit a report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes, on the status of any amendment to the state Medicaid plan or waiver from federal law pursuant to subsection (a) of this section and on the establishment and implementation of the program authorized under said subsection (a).

Sec. 33. Subdivision (12) of subsection (a) of section 38a-226c of the

2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(12) Each utilization review company shall annually file with the commissioner:

(A) [the] The names of all managed care organizations, as defined in section 38a-478, as amended, that the utilization review company services in Connecticut; [,]

(B) [any] Any utilization review services for which the utilization review company has contracted out for services and the name of such company providing the services; [, and]

(C) [the] The number of utilization review determinations not to certify an admission, service, procedure or extension of stay and the outcome of such determination upon appeal within the utilization review company. Determinations related to mental or nervous conditions, as defined in section 38a-514, shall be reported separately from all other determinations reported under this subdivision; and

(D) The following information relative to requests for utilization review of mental health services for enrollees of fully insured health benefit plans or self-insured or self-funded employee health benefit plans, separately and by category: (i) The reason for the request, including, but not limited to, an inpatient admission, service, procedure or extension of inpatient stay or an outpatient treatment, (ii) the number of requests denied by type of request, and (iii) whether the request was denied or partially denied.

Sec. 34. Section 38a-478*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(a) Not later than March 15, 1999, and annually thereafter, the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall develop and distribute a consumer report card on all managed care organizations. The commissioner shall develop the

consumer report card in a manner permitting consumer comparison across organizations.

(b) The consumer report card shall include (1) all health care centers licensed pursuant to chapter 698a, [and] (2) the fifteen largest licensed health insurers that use provider networks and that are not included in subdivision (1) of this subsection, and (3) information concerning mental health services, as specified in subsection (c) of this section. The insurers selected pursuant to subdivision (2) of this subsection shall be selected on the basis of Connecticut direct written health premiums from such network plans.

(c) With respect to mental health services, the consumer report card shall include information or measures with respect to the percentage of enrollees receiving mental health services, utilization of mental health and chemical dependence services, inpatient and outpatient admissions, discharge rates and average lengths of stay. Such data shall be collected in a manner consistent with the Natural Committee for Quality Assurance Health Plan Employer Data and Information Set (HEDIS) measures.

[(c)] (d) The commissioner shall test market a draft of the consumer report card prior to its publication and distribution. As a result of such test marketing, the commissioner may make any necessary modification to its form or substance.

Sec. 35. (NEW) (*Effective October 1, 2006*) The Insurance Commissioner shall provide written notification to each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or any other entity that delivers or issues for delivery, in this state, any individual or group health insurance plan (1) of any benefits required to be provided in such plan pursuant to chapter 700c of the general statutes, or of any modification to such benefits on or after October 1, 2006, at least thirty days prior to the date such benefits or modification becomes effective, and (2) instructing such company, society, corporation, center or other

entity to submit to the Insurance Commissioner, prior to the date such benefits or modification becomes effective or upon the renewal date of the plan, any necessary policy forms, in accordance with the provisions of section 38a-481 or 38a-513 of the general statutes, as applicable, that reflect such benefits or modification.

Sec. 36. (*Effective July 1, 2006*) Funds appropriated to the Department of Mental Health and Addiction Services, from the General Fund, for the fiscal year ending June 30, 2007, for purposes of the Community Mental Health Strategy Board, may, upon the recommendation of the Community Mental Health Strategy Board established under section 17a-485b of the general statutes and with the approval of the Secretary of the Office of Policy and Management, be expended for the purpose of providing services and programs that result in maximization of federal Medicaid reimbursement for community-based mental health care and a reduction in inappropriate emergency hospitalization, inpatient psychiatric care, nursing home admission, incarceration or referral to juvenile justice and other institutionalization of adults and children with serious mental illness. Such services and programs may include, but shall not be limited to, (1) housing support to participants in the program authorized by section 32 of this act, and (2) consultations with mental health professionals for early care and education providers.

Sec. 37. (NEW) (*Effective July 1, 2006*) (a) The Commissioner of Mental Retardation, in consultation with the Commissioners of Social Services and Mental Health and Addiction Services and any other commissioner the Commissioner of Mental Retardation deems appropriate, shall establish a pilot autism spectrum disorders program, to provide a coordinated system of supports and services, including case management, for persons with autism spectrum disorders who do not have mental retardation, as defined in section 1-1g of the general statutes, and their families. The pilot program shall serve up to fifty adults with autism spectrum disorders who are not eligible for services from the Department of Mental Retardation under chapter 319b of the general statutes.

(b) The Commissioner of Mental Retardation shall establish eligibility requirements for participation in the program.

(c) The Commissioner of Mental Retardation, or the commissioner's designee, shall identify appropriate individualized services and supports for each person in the program and the family of each person in the program and shall coordinate the provision of such services and supports to such person and family.

(d) The pilot program shall commence on or before October 1, 2006, and shall terminate not later than October 1, 2008.

(e) The Commissioner of Mental Retardation shall report, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health not later than January 1, 2009, concerning the results of such pilot program. The report shall include, recommendations concerning a system for addressing the needs of persons with autism spectrum disorder, including, but not limited to, recommendations (1) establishing an independent council to advise the Department of Mental Retardation with respect to system design, implementation and quality enhancement, (2) establishing procedural safeguards, (3) designing and implementing a quality enhancement and improvement process, and (4) designing and implementing an interagency data and information management system.

Sec. 38. Section 1 of special act 02-7 is amended to read as follows (*Effective July 1, 2006*):

[The Office of Policy and Management shall conduct] The General Assembly, after consultation with the Commission on Aging, the Long-Term Care Advisory Council and the Long-Term Care Planning Committee, shall contract for a comprehensive needs assessment of the unmet long-term care needs in the state and project future demand for [such] services. Such assessment shall include, [a review of the Department of Mental Retardation's waiting list] but not be limited to, a review and evaluation of: (1) The number of persons presently at risk

for having unmet long-term care needs, (2) the number of persons potentially at risk for having long-term care needs over the course of the next thirty years, (3) both costs and public and private resources available to meet long-term care needs, including the adequacy of current resources, projected costs and the projected resources needed to address long-term care needs over the next thirty years, (4) the existing array of services available to persons with long-term care needs, (5) existing and potential future models of public and private service delivery systems for persons with long-term care needs, (6) state government's programmatic structure in meeting the needs of persons requiring long-term care, (7) strategies that may assist families in making provisions for their own long-term care needs at reasonable costs, and (8) the service needs of the state's elderly population with long-term care needs with emphasis on healthcare, housing, transportation, nutrition, employment, prevention and recreation services. Such assessment shall also include recommendations on qualitative and quantitative changes that should be made to existing programs or service delivery systems, including recommendations on new programs or service delivery systems to better serve persons with long-term care needs.

Sec. 39. Section 12-818 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

For the fiscal year ending June 30, 2000, the Connecticut Lottery Corporation shall transfer the sum of eight hundred seventy-five thousand dollars of the revenue received from the sale of lottery tickets to the chronic gamblers treatment and rehabilitation account created pursuant to section 17a-713. For [the fiscal year ending June 30, 2001, and each fiscal year thereafter] each of the fiscal years ending June 30, 2001, to June 30, 2006, inclusive, the Connecticut Lottery Corporation shall transfer the sum of one million two hundred thousand dollars of the revenue received from the sale of lottery tickets to the chronic gamblers treatment and rehabilitation account created pursuant to section 17a-713. For the fiscal year ending June 30, 2007, and each fiscal year thereafter, the Connecticut Lottery Corporation shall

transfer one million five hundred thousand dollars of the revenue received from the sale of lottery tickets to the chronic gamblers treatment rehabilitation account created pursuant to section 17a-713.

Sec. 40. Section 55 of public act 05-280 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[During] For the fiscal [year] years ending June 30, 2006, and June 30, 2007, the Commissioner of Social Services shall, within existing budgetary resources, [in an amount not to exceed one hundred thousand dollars,] provide grants not to exceed [twenty-five] fifty thousand dollars over the two-year period for each grant, to four municipalities with populations of twenty-five thousand or more, or to a nonprofit organization located within any such municipality. Such grants shall be used by such municipality or nonprofit organization to develop and plan financially self-sustaining community-based regional transportation systems that, through a combination of private donations and user fees, provide transportation services on behalf of elderly persons. Prior to the disbursement of any grant made pursuant to this section, a municipality selected to receive such grant shall demonstrate to the satisfaction of the commissioner, that such municipality has secured additional private funds, in an amount of not less than twenty-five thousand dollars that shall be used to develop and plan financially self-sustaining community-based regional transportation systems. Any municipality selected to receive a grant pursuant to this section shall, to the extent practicable, model such community-based regional transportation system on the ITNAmerica model and shall work cooperatively with the regional planning agency of which the municipality is a member in planning and developing such community-based regional transportation system.

Sec. 41. (*Effective from passage*) The unexpended balance of funds appropriated to the Department of Social Services for the provision of grants to be used in the development and implementation of self-sustaining community-based regional transportation systems, pursuant to section 55 of public act 05-280, shall not lapse on June 30,

2006, and such funds shall continue to be available for expenditure during the fiscal year ending on June 30, 2007.

Sec. 42. (*Effective from passage*) (a) There is established a Families With Service Needs Advisory Board. The board shall consist of the following members: (1) Two representatives of the Department of Children and Families, appointed by the Commissioner of Children and Families, one of whom shall be a representative from the division of said department that provides juvenile justice services and one of whom shall be a representative of said department who is responsible for providing services to girls; (2) the Chief Court Administrator, or the Chief Court Administrator's designee; (3) a judge of the Superior Court assigned to hear juvenile matters, appointed by the Chief Justice; (4) a public defender, assistant public defender or deputy assistant public defender specializing in cases involving families with service needs, appointed by the Chief Public Defender; (5) the Child Advocate, or the Child Advocate's designee; (6) the Chief Child Protection Attorney, or the Chief Child Protection Attorney's designee; (7) the Chief State's Attorney, or the Chief State's Attorney's designee; (8) the Secretary of the Office of Policy and Management, or the secretary's designee; (9) the chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to the judiciary and human services, or their designees; (10) one member appointed by the Governor; and (11) two members to serve as chairpersons of the board, one of whom shall be appointed by the speaker of the House of Representatives and one of whom shall be appointed by the president pro tempore of the Senate. All appointments to the board shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority. The chairpersons of the board shall schedule the first meeting of the board, which shall be held not later than sixty days after the effective date of this section.

(b) The Families With Service Needs Advisory Board shall (1) monitor the progress being made by the Department of Children and Families in developing services and programming for girls from

families with service needs and other girls, (2) monitor the progress being made by the Judicial Department in the implementation of the requirements of public act 05-250, (3) provide advice with respect to such implementation upon the request of the Judicial Department or the General Assembly, and (4) not later than December 31, 2007, make written recommendations to the Judicial Department and the General Assembly, in accordance with the provisions of section 11-4a of the general statutes, with respect to the accomplishment of such implementation by the effective date of public act 05-250. The board shall terminate on December 31, 2007.

Sec. 43. (*Effective from passage*) (a) Notwithstanding the provisions of subsection (l) of section 46b-129 of the general statutes, no person who as a child or youth, was the beneficiary of payments made for his or her care and maintenance, shall be liable to the state for repayment of the cost of such care and maintenance, if such person subsequently becomes entitled to the proceeds of a cause of action or insurance payments based upon the death of a minor child, occurring on or after June 25, 2005, but not later than the effective date of this section.

(b) Notwithstanding the provisions of subsection (a) of section 46b-130 of the general statutes, no person who as a child or youth was the beneficiary of payments made for his or her care and maintenance, shall be liable to the state for repayment of the cost of such care and maintenance, if such person subsequently becomes entitled to the proceeds of a cause of action or insurance payments based upon the death of a minor child, occurring on or after June 25, 2005, but not later than the effective date of this section.

Sec. 44. (NEW) (*Effective July 1, 2006*) The Commissioner of Social Services, pursuant to Section 6071 of the Deficit Reduction Act of 2005, may submit an application to the Secretary of Health and Human Services to establish a Money Follows the Person demonstration project. In the event the state is selected to participate in the demonstration project and the Department of Social Services elects to participate in such project, such project shall serve not more than one

hundred persons and shall be designed to achieve the objectives set forth in Section 6071(a) of the Deficit Reduction Act of 2005. Services available under the demonstration project shall include, but not be limited to, personal care assistance services. The commissioner may apply for a Medicaid research and demonstration waiver under Section 1115 of the Social Security Act, if such waiver is necessary to implement the demonstration project. The commissioner may, if necessary, modify any existing Medicaid home or community-based waiver if such modification is required to implement the demonstration project.

Sec. 45. (*Effective from passage*) Commencing on July 1, 2006, and quarterly thereafter, the Commissioner of Social Services, in consultation with the Labor Commissioner and the Secretary of the Office of Policy and Management, shall provide to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies and to the council established pursuant to section 17b-29 of the general statutes, status reports on the implementation of programs operated by said departments and included as part of the budget for the fiscal year ending on June 30, 2007, that are intended to bring the state into compliance with new federal requirements set forth in the federal Deficit Reduction Act of 2005 concerning the operation of the temporary assistance for needy families program. Such status reports shall contain a description of mechanisms that are currently being utilized, or contemplated to be utilized, by said departments to measure the outcomes and effects of programmatic revisions on program beneficiaries, enacted to effectuate the requirements of the federal Deficit Reduction Act of 2005. Programmatic revisions implemented by said departments to comply with the requirements of the federal Deficit Reduction Act of 2005 shall, to the extent permitted by federal law, emphasize vocational and educational training programs, work experience programs and the expansion of employment services and child care services. Such revisions shall be designed to promote the employment of participants in a manner

consistent with the work participation rates required by federal law.

Sec. 46. Subsections (a) and (b) of section 17b-28 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2006*):

(a) There is established a council which shall advise the Commissioner of Social Services on the planning and implementation of a system of Medicaid managed care and shall monitor such planning and implementation and shall advise the Waiver Application Development Council, established pursuant to section 17b-28a, on matters including, but not limited to, eligibility standards, benefits, access and quality assurance. The council shall be composed of the chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, [and] public health and appropriations and the budgets of state agencies, or their designees; two members of the General Assembly, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; the director of the Commission on Aging, or a designee; the director of the Commission on Children, or a designee; two community providers of health care, to be appointed by the president pro tempore of the Senate; two representatives of the insurance industry, to be appointed by the speaker of the House of Representatives; two advocates for persons receiving Medicaid, one to be appointed by the majority leader of the Senate and one to be appointed by the minority leader of the Senate; one advocate for persons with substance abuse disabilities, to be appointed by the majority leader of the House of Representatives; one advocate for persons with psychiatric disabilities, to be appointed by the minority leader of the House of Representatives; two advocates for the Department of Children and Families foster families, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; two members of the public who are currently recipients of Medicaid, one to be appointed by the majority leader of the House of Representatives

and one to be appointed by the minority leader of the House of Representatives; two representatives of the Department of Social Services, to be appointed by the Commissioner of Social Services; two representatives of the Department of Public Health, to be appointed by the Commissioner of Public Health; two representatives of the Department of Mental Health and Addiction Services, to be appointed by the Commissioner of Mental Health and Addiction Services; two representatives of the Department of Children and Families, to be appointed by the Commissioner of Children and Families; two representatives of the Office of Policy and Management, to be appointed by the Secretary of the Office of Policy and Management; one representative of the office of the State Comptroller, to be appointed by the State Comptroller and the members of the Health Care Access Board who shall be ex-officio members and who may not designate persons to serve in their place. The council shall choose a chair from among its members. The joint committee on Legislative Management shall provide administrative support to such chair. The council shall convene its first meeting no later than June 1, 1994.

(b) The council shall make recommendations concerning (1) guaranteed access to enrollees and effective outreach and client education; (2) available services comparable to those already in the Medicaid state plan, including those guaranteed under the federal Early and Periodic Screening, Diagnostic and Treatment Services Program under 42 USC 1396d; (3) the sufficiency of provider networks; (4) the sufficiency of capitated rates provider payments, financing and staff resources to guarantee timely access to services; (5) participation in managed care by existing community Medicaid providers; (6) the linguistic and cultural competency of providers and other program facilitators; (7) quality assurance; (8) timely, accessible and effective client grievance procedures; (9) coordination of the Medicaid managed care plan with state and federal health care reforms; (10) eligibility levels for inclusion in the program; (11) cost-sharing provisions; (12) a benefit package; (13) coordination with coverage under the HUSKY Plan, Part B; (14) the need for program quality studies within the areas

identified in this section and the department's application for available grant funds for such studies; [and] (15) managed care portion of the state-administered general assistance program; and (16) other issues pertaining to the development of a Medicaid Research and Demonstration Waiver under Section 1115 of the Social Security Act.

Sec. 47. (NEW) (*Effective from passage*) On or after January 1, 2007, and within any available federal or private funds, the Commissioner of Public Health, in consultation with the Medicaid managed care organizations administering the HUSKY Plan, Part A, as defined in section 17b-290 of the 2006 supplement to the general statutes, may establish a medical home pilot program in one region of the state to be determined by said commissioner in order to enhance health outcomes for children, including children with special health care needs, by ensuring that each child has a primary care physician who will provide continuous comprehensive health care for such child. Said commissioner may solicit and accept private funds to implement such pilot program.

Sec. 48. (*Effective October 1, 2006*) Not later than one year following the establishment of the medical home pilot program under section 47 of this act, the Commissioner of Public Health, shall evaluate such pilot program to ascertain specific improved health outcomes and any cost efficiencies achieved. Not later than thirty days following such evaluation, the Commissioner of Public Health shall submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies on the evaluation of such pilot program.

Sec. 49. Section 17b-261 of the 2006 supplement to the general statutes is amended by adding subsection (j) as follows (*Effective July 1, 2006*):

(NEW) (j) The Commissioner of Social Services shall provide Early and Periodic, Screening, Diagnostic and Treatment program services,

as required by 42 USC 1396a(a)(43), 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal regulations to all persons who are under the age of twenty-one and otherwise eligible for medical assistance under this section.

Sec. 50. (NEW) (*Effective July 1, 2006*) The Commissioner of Social Services shall provide reimbursement under the Medicaid program to children for services provided by a home health care agency, as defined in section 19a-490 of the 2006 supplement to the general statutes, in the child's home or a substantially equivalent environment. For purposes of such reimbursement, a substantially equivalent environment may include, but not be limited to, facilities that provide child day care services, as defined in subsection (a) of section 19a-77 of the 2006 supplement to the general statutes, and after school programs, as defined in section 10-16x of the 2006 supplement to the general statutes.

Sec. 51. (*Effective July 1, 2006*) The sum of $50,000 appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2007, for community health services, shall be transferred to other expenses.

Sec. 52. (*Effective July 1, 2006*) The sum of two hundred seventy-five thousand dollars of the amount appropriated to the Department of Mental Health and Addiction Services in section 8 of house bill 5845 of the current session, for purposes of the Community Mental Health Strategy Board, shall be expended for the purposes of establishing and implementing the pilot programs authorized by section 31 of this act.

Sec. 53. (*Effective July 1, 2006*) Up to the sum of one million seven hundred twenty-five thousand dollars of the amount appropriated to the Department of Mental Health and Addiction Services in section 8 of house bill 5845 of the current session, for purposes of the Community Mental Health Strategy Board, shall be expended for the purposes of establishing and implementing the Medicaid-financed home and community-based program authorized by section 32 of this

act.

Sec. 54. Section 17a-317 of the 2006 supplement to the general statutes shall take effect July 1, 2007. (*Effective from passage*)

Sec. 55. Section 17b-255 of the general statutes is repealed. (*Effective from passage*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2006*	17b-340(a)
Sec. 2	*July 1, 2006*	17b-340(f)(4)
Sec. 3	*July 1, 2006*	17b-340(f)(16)
Sec. 4	*July 1, 2006*	17b-340(g)
Sec. 5	*July 1, 2006*	17b-340(h)(1)
Sec. 6	*July 1, 2006*	17b-321(a)
Sec. 7	*July 1, 2006*	17b-321(b)
Sec. 8	*July 1, 2006*	17b-605a
Sec. 9	*July 1, 2006*	17b-342a(a)
Sec. 10	*July 1, 2006*	New section
Sec. 11	*July 1, 2006*	17b-490(b)
Sec. 12	*July 1, 2006*	17b-363b
Sec. 13	*July 1, 2006*	17b-265e
Sec. 14	*from passage*	17b-256
Sec. 15	*July 1, 2006*	17b-242a
Sec. 16	*July 1, 2006*	17b-292(j)
Sec. 17	*July 1, 2006*	17b-84
Sec. 18	*July 1, 2006*	17b-131
Sec. 19	*July 1, 2006*	17b-264
Sec. 20	*July 1, 2006*	19a-55a
Sec. 21	*July 1, 2006*	17b-239
Sec. 22	*July 1, 2006*	New section
Sec. 23	*July 1, 2006*	New section
Sec. 24	*July 1, 2006*	New section
Sec. 25	*July 1, 2006*	5-239a
Sec. 26	*July 1, 2006*	10-76d(a)(9)
Sec. 27	*July 1, 2006*	17b-597(a)
Sec. 28	*October 1, 2006*	17a-22j(b)
Sec. 29	*October 1, 2006*	17a-22j(c)

Sec. 30	*October 1, 2006*	17a-22*l*
Sec. 31	*July 1, 2006*	New section
Sec. 32	*from passage*	New section
Sec. 33	*October 1, 2006*	38a-226c(a)(12)
Sec. 34	*October 1, 2006*	38a-478*l*
Sec. 35	*October 1, 2006*	New section
Sec. 36	*July 1, 2006*	New section
Sec. 37	*July 1, 2006*	New section
Sec. 38	*July 1, 2006*	SA 02-7, Sec. 1
Sec. 39	*July 1, 2006*	12-818
Sec. 40	*from passage*	PA 05-280, Sec. 55
Sec. 41	*from passage*	New section
Sec. 42	*from passage*	New section
Sec. 43	*from passage*	New section
Sec. 44	*July 1, 2006*	New section
Sec. 45	*from passage*	New section
Sec. 46	*July 1, 2006*	17b-28(a) and (b)
Sec. 47	*from passage*	New section
Sec. 48	*October 1, 2006*	New section
Sec. 49	*July 1, 2006*	17b-261
Sec. 50	*July 1, 2006*	New section
Sec. 51	*July 1, 2006*	New section
Sec. 52	*July 1, 2006*	New section
Sec. 53	*July 1, 2006*	New section
Sec. 54	*from passage*	17a-317
Sec. 55	*from passage*	Repealer section

512

SENATE AMENDMENT

Calendar: 512

LCO: 5589

Bill: 203

A

ADOPTED voice ☒ REJECTED voice ☐

ADOPTED roll ☐ REJECTED roll ☐

General Assembly

[SENATE] **Amendment** [B. 7]

February Session, 2006

LCO No. **5606**

Offered by:
SEN. HARP, 10th Dist.

To: Senate Bill No. **703** File No. Cal. No. 512

(As Amended by Senate Amendment Schedule "A")

"AN ACT REQUIRING A STUDY OF STATE SOCIAL SERVICES INSTITUTIONS AND DEPARTMENTS WITH RESPECT TO THE EXPENDITURES OF SUCH INSTITUTIONS AND DEPARTMENTS AND THE PROGRAMS ADMINISTERED OR SERVICES PROVIDED BY SUCH INSTITUTIONS AND DEPARTMENTS."

Strike section 50 in its entirety and substitute the following in lieu thereof:

"Sec. 50. (NEW) (*Effective July 1, 2006*) The Commissioner of Social Services shall provide reimbursement under the Husky Plan, Part A program to children for services provided by a home health care agency, as defined in section 19a-490 of the 2006 supplement to the general statutes, in the child's home or a substantially equivalent environment. For purposes of such reimbursement, a substantially equivalent environment may include, but not be limited to, facilities that provide child day care services, as defined in subsection (a) of section 19a-77 of the 2006 supplement to the general statutes, and after

school programs, as defined in section 10-16x of the 2006 supplement to the general statutes."

512

SENATE AMENDMENT

Calendar: 512

LCO: 5606

Bill: 703 B

ADOPTED voice ☒ REJECTED voice ☐

ADOPTED roll ☐ REJECTED roll ☐

OFFICE OF FISCAL ANALYSIS

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[1067]

EMERGENCY CERTIFICATION

SB-703

AN ACT REQUIRING A STUDY OF STATE SOCIAL SERVICES INSTITUTIONS AND DEPARTMENTS WITH RESPECT TO THE EXPENDITURES OF SUCH INSTITUTIONS AND DEPARTMENTS AND THE PROGRAMS ADMINISTERED OR SERVICES PROVIDED BY SUCH INSTITUTIONS AND DEPARTMENTS.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The reporting requirements mandated by the bill would not result in additional cost to the agency because it already reports on its budget and programs to the Appropriations Committee on an annual basis.

The Out Years

State Impact: None

Municipal Impact: None

The preceding Fiscal Impact statement is prepared for the benefit of the members of the General Assembly, solely for the purposes of information, summarization and explanation and does not represent the intent of the General Assembly or either House thereof for any purpose.

Primary Analyst: NA
Contributing Analyst(s):

5/2/06

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SB-703

AN ACT REQUIRING A STUDY OF STATE SOCIAL SERVICES INSTITUTIONS AND DEPARTMENTS WITH RESPECT TO THE EXPENDITURES OF SUCH INSTITUTIONS AND DEPARTMENTS AND THE PROGRAMS ADMINISTERED OR SERVICES PROVIDED BY SUCH INSTITUTIONS AND DEPARTMENTS.

As Amended by Senate "A" (LCO 5589), Senate "B" (LCO 5606)

House Calendar No.: 510

Senate Calendar No.: 512

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 07 $	FY 08 $
Various State Agencies	GF - See Below	See Below	See Below

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 07 $	FY 08 $
Various Municipalities	Revenue Gain	Potential	Potential

Explanation

Section 1 of the bill specifies that when setting rates for nursing home facilities, the Department of Social Services (DSS) shall consider the ability of the facility to meet wage and benefit costs, among other factors. While this change may affect the rates set for particular homes, it is not expected to have a direct impact on the overall rate setting process.

Sections 2 through 5 provide FY07 rate increases for nursing homes, intermediate care facilities for the mentally retarded (ICF-MR's) and residential care homes. The HB 5845 (the Budget Bill, as approved by the House and Senate) include $41.1 million for these rate increases. These sections also contain language clarifying DSS's ability to

Primary Analyst: NA
Contributing Analyst(s): CA, JS, AS, DC, CP, JW

5/3/06

establish interim rates.

Sections 6 and 7 delay the recalculation of the nursing home user fee until July 1, 2007. This maintains the currently established fees through the biennium, which would have otherwise risen for all nursing home residents due to the rate increases noted above. HB 5845 assumed no increase in these fees in FY07.

Section 8 eliminates the age limit in the personal care assistance waiver program under Medicaid. As this program is restricted to have a specific number of slots, raising the age will not increase the enrollment in the program. Therefore, there is no associated fiscal impact.

Section 9 increases the state funded pilot program for personal care assistance from 150 slots to 250 slots. This increase is expected to cost $2.1 million annually, which is included in HB 5845.

Section 10 provides an incentive for school districts to seek reimbursement for certain Medicaid eligible care provided outside their districts. This is expected to increase federal reimbursement received for these services. Any such revenue received will be equally divided between the district and the state. Under current Special Education - Excess Cost funding levels this may result in a minor shifting of aid to local and regional school districts that claim additional Medicaid eligible expenditures.

Section 11 prohibits the payment for erectile dysfunction (ED) drugs under the ConnPACE program, unless the drugs are prescribed for a condition other than sexual or erectile dysfunction. The ConnPACE program pays approximately $250,000 annually on these drugs. It is not known what portion of these expenditures is prescribed for conditions other than dysfunction.

Section 12 allows DSS to reimburse for prescription drugs dispensed in unit dose packaging for clients in nursing homes, chronic disease facilities and ICF-MR's. This may lead to a minimal savings

through reduced pharmaceutical waste.

Section 13 requires DSS to contract with an entity to develop a uniform appeals procedure for Medicaid and ConnPACE clients who have had prescriptions denied under the Medicare Part D program. HB 5845 includes $1.5 million for the development and administration of this contract. This section also requires DSS to pay for denied non-formulary drugs during the appeals process and at certain times after the appeals process has been exhausted. HB 5845 includes $5 million in the Medicare Part D Supplemental Needs Fund to pay for these prescriptions.

Section 14 and 55 make several changes to the Connecticut AIDS Drug Assistance Program (CADAP), including requiring eligible applicants and recipients to enroll in the Medicare Part D program. These changes may reduce CADAP costs as Medicare Part D may pay for some costs that are currently incurred by CADAP. However, as this program is primarily supported through federal funds, only minimal General Fund impact is anticipated.

Section 15 lowers the threshold for prior authorization for Medicaid home health services from 20 hours to 14 hours. This change is expected to save $880,000 annually, which is reflected in HB 5845.

Section 16 restores the self-declaration policy under the HUSKY program. HB 5845 includes $2 million in FY07 for this change.

Sections 17 through 19 raise the burial allowance for the Temporary Family Assistance, Supplemental Assistance, and State Administered General Assistance programs from $1,200 to $1,800. This increase is expected to cost $1 million annually, which is included in HB 5845.

Section 20 increases a statutory transfer of funding from newborn genetic screening fee receipts from $345,000 to $500,000. A comparable reduction in General Fund revenues of $155,000 annually will result.

Section 21 increases certain Medicaid hospital outpatient fees and target discharge rates, subject to available appropriation. The cost of

these increases would be dependent upon the rates and fees established, which are not known at this time. HB 5845 contains $7 million for rate increases for general hospitals.

Section 22 gives DSS flexibility, in FY07, to increase pharmacy dispensing fees based on changes in federal pharmaceutical pricing policies. The federal changes are expected to result in a reduction in the price paid for the pharmaceuticals. DSS is expected to increase the dispensing fee in order to hold the pharmacies harmless in light of the federal changes.

Section 23 requires DCF to enter into a memorandum of understanding with the Council to Administer the Children's Trust Fund so as to facilitate the transfer of $614,110 for the purpose of supporting an expansion of Nurturing Families Network programming within New Haven. The following sums have been included within HB 5845 under DCF's budget for this purpose: $72,000 in Personal Services; $10,000 in Other Expenses; and $532,110 in the Community Based Prevention Programs account.

Section 24 gives DSS the authority to pay any settlement in the Carr v. Wilson-Coker dental access case from the Medicaid account. As this section does not mandate any payment, but just specifies how such a settlement is to be paid, no direct fiscal impact is anticipated. DSS must also report to the General Assembly concerning the dental settlement.

Section 25 would extend by up to 12 months (from 1/1/07 to 1/1/08) the date by which an employee currently on leave from the Department of Children and Families (DCF) must return to state employment. A Director of Community Services is currently on assignment as the Court Monitor for the Juan F. Consent Decree.

The Court Monitor's office is reimbursed for salary and fringe benefits costs associated with this position by the Office of the State Comptroller via the non-appropriated Adjudicated Claims account. Salary and benefits paid while on assignment are equal to those that

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would otherwise have been paid had the individual remained in regular state employment. Therefore, extending the assignment will result in a cost avoidance to the DCF (under the Personal Services account) as well as miscellaneous accounts administered by the Comptroller, and an equivalent cost to the Adjudicated Claims Account.

Section 26 makes durable medical equipment (DME) supplied to students at school based health centers eligible for Medicaid reimbursement. This does not change the eligibility for DME, but allows the state to receive federal reimbursement for goods currently purchased. This change is expected to generate an additional $1 million to $2 million in federal revenue annually. Any such additional revenue will be evenly divided between the state and the municipalities.

Section 27 allows people enrolled in the Medicaid Employed Disabled coverage group to maintain Medicaid coverage beyond the age of 65. Currently individuals who reach the age of 65 must either cease working or enter spend down in order to maintain health benefits. These individuals usually thus end up remaining on Medicaid, but not working. Therefore, a net increase in Medicaid expenditures is not expected.

Sections 28 and 29 make several changes to the composition of the Community Mental Health Strategy Board (CMHSB). These changes are not expected to result in any fiscal impact.

Section 30 requires DSS and DCF to develop grievance procedures for providers and specifies that these procedures include certain appeals. This may lead to increased administrative costs to the departments.

Section 31 allows the Department of Mental Health and Addiction Services (DMHAS), in consultation with the CMHSB, to implement pilot programs on mental health and peer counseling. **Section 52** specifies that of the $2 million in FY06 surplus funds appropriated to

[OFA]

the CMHSB in HB 5845, $275,000 is designated to implement these pilots.

Section 32 allows DSS to seek a Medicaid Home and Community Based waiver or state plan amendment for adults with psychiatric disabilities being discharged or diverted from nursing home care. **Section 53** specifies that of the $2 million in FY06 surplus funds appropriated to the CMHSB in HB 5845, up to $1,725,000 can be allocated to fund the housing component of this plan. Under federal requirements, the additional medical cost of the home and community based services must be offset by institutional savings from nursing homes. This program is expected to have on-going costs of approximately $3.5 million when fully annualized. DSS must report on the status of this program annually.

Section 33 increases the information that must be reported by utilization review companies. This has no fiscal impact for the state.

Section 34 and 35 add additional reporting and notification requirements for the Department of Insurance. These requirements result in a minimal increase in administrative costs for the department.

Section 36 allows funds appropriated to the CMHSB to be expended for programs and services that result in maximization of federal reimbursement for community based mental health care. As the language is permissive and no funds are included in HB 5845 for this purpose, no new programs are expected to be established.

Sections 37 requires the Department of Mental Retardation (DMR) to establish a pilot program to provide a coordinated system of supports and services for up to 50 adults with autism spectrum disorders who are not eligible for DMR services. HB 5845 includes $1 million in funding in FY 07 to support the pilot program for autism services (including service coordination, supported employment, supported living and transportation). The annual cost per person may vary from $15,000 - $30,000. The $1 million funding in FY 07 supports a phase-in of services starting October 1, 2006.

The section also requires the department to submit a report to the Public Health Committee no later than January 1, 2009, with the results of the pilot program and recommendations. The department can meet this reporting requirement without additional resources.

Section 38 requires the General Assembly to contract for a comprehensive needs assessment of the unmet long term care needs in the state and specifies what is to be reviewed. HB 5845 contains $200,000 under the Commission on Aging to conduct this needs assessment.

Section 39 increases from $1.2 million to $1.5 million the amount of funds that the Connecticut Lottery Corporation (CLC) must transfer to the chronic gamblers treatment rehabilitation account under DMHAS. This constitutes an increase in operating expenses to the CLC and will reduce the amount of revenue that CLC transfers to the General Fund by $300,000.

Section 40 and 41 allows towns that are selected for a grant for the Independent Transportation Network (ITN) program to receive grants in FY07 as well as FY06, and allows unspent FY06 funds to be carried forward. This does not result in a fiscal impact, as it only specifies how FY07 funds will be spent. HB 5845 includes $100,000 in FY07 for ITN's.

Section 42 establishes a Families with Service Needs Advisory Board. A minimal cost would be incurred related to the Board's activities that could be accommodated by the participating agencies within their respective budgeted resources until the Board terminates in FY08.

Section 43 prohibits the Department of Administrative Services from seeking repayment of the cost of assistance from an individual who was the beneficiary of certain payments made for his care as a child or youth when such individual subsequently becomes entitled to the proceeds of a cause of action or insurance payment upon the death of a minor child occurring on or after June 25, 2005. This will result in an indeterminate General Fund revenue loss.

[OFA]

Section 44 allows DSS to apply for a federal Money Follow the Person grant to establish a 100 person demonstration project. As the establishment of the project is contingent upon the successful receipt of a federal grant to cover the costs of the program, no state cost is expected.

Section 45 requires DSS, along with the Department of Labor (DOL) and the Office of Policy and Management to report to the General Assembly concerning administration efforts to bring the state into compliance with new federal requirements for the Temporary Assistance for Needy Families (TANF) programs. HB 5845 contains $6.5 million in DOL and $1.5 million in DSS to comply with the new federal requirements.

Section 46 makes changes to the composition and purview of the Medicaid Managed Care Council. These changes are not expected to result in any fiscal impact.

Section 47 allows the Department of Public Health (DPH), within available federal or private funds, to establish a medical home pilot program in one region of the state. No state fiscal impact is anticipated, as it is expected that the development of the pilot program would be contingent upon the department's receipt of sufficient federal or private funds for this purpose.

Section 48 requires the DPH to evaluate the pilot program within one year of establishment, and report on the evaluation within the following thirty days. Should the pilot program be established, it is anticipated that the agency would be able to perform these duties without requiring additional state resources.

Section 49 specifies that DSS provide Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) services to medical assistance recipients under the age of 21. As this is the current practice of the department, it is not expected to change any aspect of the current services provided by DSS.

Section 50 requires Medicaid to reimburse for services provided by a home health agency when such services are performed on a child at a child day care or after school setting. Such home health services are currently reimbursable under the Medicaid program at other locations. This change would allow more flexible scheduling of currently approved services. Although this flexibility could increase utilization of these services, any related increased cost is expected to be minimal.

Section 51 adjusts HB 5845 to transfer $50,000 from the community health services account in the Department of Public Health to the other expenses account.

Section 54 delays the establishment of the Department on Aging until July 1, 2007. HB 5845 includes funds for a comprehensive needs assessment that is necessary prior to the establishment of this agency.

Senate "A" struck the underlying bill and its associated fiscal impact. The language in the amendment results in the above fiscal impact.

Senate "B" made a clarifying change that had a minimal fiscal impact.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

The preceding Fiscal Impact statement is prepared for the benefit of the members of the General Assembly, solely for the purposes of information, summarization and explanation and does not represent the intent of the General Assembly or either House thereof for any purpose.