Senate Bill No. 2013
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June Session, PUBLIC ACT NO. 91-8

AN ACT CONCERNING PROGRAMS, DUTIES AND EXPENDITURES OF THE DEPARTMENTS OF INCOME MAINTENANCE, CHILDREN AND YOUTH SERVICES AND HUMAN RESOURCES AND THE DEPARTMENT ON AGING.

Section 1. Subsection (b) of section 17-2 of the general statutes is repealed and the following is substituted in lieu thereof:

(b) [On July 1, 1985, the commissioner shall increase the standard of need under the program of aid to families with dependent children, the state program established pursuant to section 17-83o and for family cases under the general assistance program by four and three-tenths per cent over the standard for the fiscal year ending June 30, 1985, provided the commissioner shall apply the appropriate disregards.] On July 1, 1988, and annually thereafter, the commissioner shall increase the standard of need over that of the previous fiscal year under the program of aid to families with dependent children [, the state program established pursuant to section 17-83o] and for family cases under the general assistance program by the percentage increase, if any, in the most recent calendar year average in the consumer price index for urban consumers over the average for the previous calendar year, provided the annual increase, if any, shall not exceed five per cent EXCEPT THAT THE STANDARD OF NEED FOR THE FISCAL YEAR ENDING JUNE 30, 1992, SHALL NOT BE INCREASED.

Sec. 2. Section 17-12f of the general statutes is repealed and the following is substituted in lieu thereof:

On July 1, 1985, the commissioner shall increase the adult payment standards for the general assistance program and the state supplement to the Federal Supplemental Security Income Program by four and three-tenths per cent over the standards for the fiscal year ending June 30, 1985, provided the commissioner shall apply the appropriate disregards. NOTWITHSTANDING THE PROVISIONS OF ANY REGULATION TO THE CONTRARY, EFFECTIVE OCTOBER 1, 1991, THE COMMISSIONER SHALL REDUCE THE APPROPRIATE UNEARNED INCOME DISREGARD FOR RECIPIENTS OF THE STATE SUPPLEMENT TO THE FEDERAL SUPPLEMENTAL SECURITY INCOME PROGRAM BY NINE AND ONE-HALF PER CENT. On July 1, 1989, and annually thereafter, the commissioner

of income maintenance shall increase the adult payment standards over those of the previous fiscal year for the general assistance program and the state supplement to the Federal Supplemental Security Income Program by the percentage increase, if any, in the most recent calendar year average in the consumer price index for urban consumers over the average for the previous calendar year, provided the annual increase, if any, shall not exceed five per cent EXCEPT THAT THE ADULT PAYMENT STANDARDS FOR THE FISCAL YEAR ENDING JUNE 30, 1992, SHALL NOT BE INCREASED. EFFECTIVE OCTOBER 1, 1991, THE MAXIMUM MONTHLY PAYMENT LEVELS FOR SHELTER UNDER THE GENERAL ASSISTANCE PROGRAM SHALL NOT EXCEED THE MAXIMUM SHELTER PAYMENT LEVELS ESTABLISHED UNDER THE STATE SUPPLEMENT TO THE FEDERAL SUPPLEMENTAL SECURITY INCOME PROGRAM, EXCEPT THAT PAYMENTS ALREADY BEING MADE TO RECIPIENTS ON OCTOBER 1, 1991, SHALL NOT BE REDUCED FOR A PERIOD OF SIX MONTHS PROVIDED THE RECIPIENT REMAINS IN THE SAME HOUSING ARRANGEMENT. EFFECTIVE OCTOBER 1, 1991, (1) THE COVERAGE OF EXCESS UTILITY COSTS FOR RECIPIENTS OF THE STATE SUPPLEMENT TO THE FEDERAL SUPPLEMENTAL SECURITY INCOME PROGRAM IS ELIMINATED; AND (2) SINGLE ROOM OCCUPANCIES SHALL BE CONSIDERED UNSHARED LIVING ARRANGEMENTS UNDER THE GENERAL ASSISTANCE PROGRAM IN CASES WHERE A SINGLE ROOM IS OCCUPIED BY NOT MORE THAN ONE PERSON.

Sec. 3. Section 17-12p of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The commissioner of income maintenance shall implement Titles II, III, IV, V, VI and VII of the Family Support Act of 1988, Public Law No. 100-485. The commissioner shall maximize available federal funding by providing services to the following target populations: (1) AFDC recipients who have received aid for any thirty-six of the preceding sixty months; (2) custodial parents under the age of twenty-four who have not completed high school or have limited or no work experience in the previous year; and (3) individuals who are members of an AFDC family in which the youngest child is within two years of being ineligible for AFDC due to age. Within the target populations, first consideration shall be given to those who volunteer to participate. The commissioner shall submit the plan for implementing the Job Opportunities and Basic Skills Training Program (JOBS), required by title II of said act, to the federal government no later than July 1, 1989 and shall implement such plan upon approval of the federal government. Upon submittal of the program implementation plan to the Employment and Training Commission, the commissioner shall also submit such plan to the joint standing committee of the general assembly

having cognizance of matters relating to human services. The commissioner shall submit any subsequent significant changes to such plan to such committee.

(b) THE COMMISSIONER SHALL ADMINISTER SECTION 5081 OF THE OMNIBUS RECONCILIATION ACT OF 1990, PUBLIC LAW 101-508, SUBJECT TO AVAILABLE FUNDING.

Sec. 4. Subsection (a) of section 17-86e of the general statutes, as amended by public act 91-237, is repealed and the following is substituted in lieu thereof:

(a) The commissioner of income maintenance shall provide a special needs benefit for emergency housing to any recipient of payments under the program of aid to families with dependent children and the optional state supplementation program under chapter 302 who cannot remain in permanent housing because (1) a judgment has been entered against the recipient in a summary process action instituted pursuant to chapter 832, provided the action was not based on criminal activity, or a judgment has been entered against the recipient in a foreclosure action pursuant to chapter 846 and the time limited for redemption has passed; (2) the recipient has left to escape domestic violence; (3) a catastrophic event, such as a fire or flood, has made the permanent housing uninhabitable or the recipient has been ordered to vacate the housing by a local code enforcement official; (4) the recipient shares an apartment with a primary tenant who is being evicted or is engaged in criminal activity; (5) the recipient was illegally locked out by a landlord and has filed a police complaint concerning such lockout or (6) the recipient has been living with a tenant who received a preliminary notice under section 47a-15 or a notice to quit because of termination of a rental agreement for lapse of time. A person shall be eligible for the benefit under this section provided application is made to the commissioner within forty-five days of the loss of permanent housing by the recipient. [The] ON AND AFTER THE EFFECTIVE DATE OF THIS ACT, THE benefit shall be limited to not more than one [hundred days in any previous three-hundred-sixty-five-consecutive-day period] OCCURRENCE PER CALENDAR YEAR AND NOT MORE THAN EIGHTY DAYS PER OCCURRENCE. Any person receiving a benefit under this section shall agree to reside in any housing which was constructed, renovated or rehabilitated with state or federal financial assistance. [Subject to federal approval, persons receiving the benefit under this section shall have their benefits under the program of aid to families with dependent children reduced by not more than twenty-five per cent for each full month the recipient resides in emergency housing and have shelter costs met by a special

need benefit.] Under the program of aid to families with dependent children, any person not eligible for the benefit under this section shall be referred to the department of human resources for emergency shelter services.

Sec. 5. Section 17-12gg of the general statutes is amended by adding subsection (c) as follows:

(NEW) (c) Except as otherwise specified in this section, the insurance assistance for people with AIDS pilot program shall be operated in a manner consistent with the Medicaid program.

Sec. 6. Section 17-134f of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The department of income maintenance shall be subrogated to any right of recovery or indemnification which an applicant or recipient of medical assistance or any legally liable relative has against an insurer for the cost of hospitalization, pharmaceutical services, physician services, nursing services and other medical services, not to exceed the amount expended by the department for such care and treatment of the applicant or recipient. An applicant or recipient or legally liable relative, by the act of the applicant or recipient receiving medical assistance, shall be deemed to have made a subrogation assignment and an assignment of claim for benefits to the department. The department shall inform an applicant of such assignments at the time of application. In addition, any entitlements from a contractual agreement with an applicant or recipient or legally liable relative, a state or federal program or a claim or action against any responsible third party for such medical services, not to exceed the amount expended by the department, shall be so assigned. Such entitlements shall be directly reimbursable to the department by third party payors. The department of income maintenance may assign its right to subrogation or its entitlement to benefits to a designee or a health care provider participating in the Medicaid program and providing services to an applicant or recipient, in order to assist the provider in obtaining payment for such services. A provider that has received an assignment from the department shall notify the insurer of the assignment upon rendition of services to the applicant or recipient. Failure to so notify the insurer shall render the provider ineligible for payment from the department. The provider shall notify the department of any request by the applicant or recipient or his legally liable relative or representative for billing information. This subsection shall not be construed to give the department of income maintenance a right of action

against a third party tortfeasor, nor shall it affect the right of an applicant or recipient to maintain an independent cause of action against such third party tortfeasor.

(b) When a recipient of medical assistance has personal health insurance in force covering care or other benefits provided under such program, payment or part-payment of the premium for such insurance may be made when deemed appropriate by the commissioner of income maintenance. EFFECTIVE JANUARY 1, 1992, THE COMMISSIONER SHALL LIMIT REIMBURSEMENT TO MEDICAL ASSISTANCE PROVIDERS, EXCEPT THOSE PROVIDERS WHOSE RATES ARE ESTABLISHED BY THE COMMISSIONER OF HEALTH SERVICES PURSUANT TO CHAPTER 368d, FOR COINSURANCE AND DEDUCTIBLE PAYMENTS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT TO ASSURE THAT THE COMBINED MEDICARE AND MEDICAID PAYMENT TO THE PROVIDER SHALL NOT EXCEED THE MAXIMUM ALLOWABLE UNDER THE MEDICAID PROGRAM FEE SCHEDULES.

(c) Notwithstanding the provisions of subsection (c) of section 38a-553, no individual or group accident, health or accident and health policy or medical expense policy or medical service plan contract, delivered, issued for delivery or renewed in this state on or after July 1, 1984, shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who received medical assistance under this chapter.

(d) The commissioner of income maintenance shall not pay for any services provided under this chapter if the individual eligible for medical assistance has coverage for the services under an accident or health insurance policy.

Sec. 7. Section 17-134m of the general statutes is repealed and the following is substituted in lieu thereof:

[The] EFFECTIVE OCTOBER 1, 1991, THE commissioner of income maintenance shall permit patients residing in nursing homes, chronic disease hospitals and state humane institutions who are medical assistance recipients under this part to have a monthly personal fund allowance [of forty dollars. On July 1, 1988, and annually thereafter, the commissioner may increase such monthly personal fund allowance over that of the previous fiscal year to reflect the annual inflation adjustment in social security income, if any. Each such adjustment shall be determined to the nearest dollar] AT A LEVEL EQUAL TO THE MINIMUM PERMITTED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT.

Sec. 8. Section 17-134s of the general statutes is repealed and the following is substituted in lieu thereof:

The commissioner of income maintenance shall identify geographic areas of the state where

competitive bidding for medical transportation services provided to medical assistance recipients would result in cost savings to the state. For the identified areas the commissioner shall purchase medical transportation services through a competitive bidding process from providers who meet state licensure requirements and the medical transportation requirements established by the department, and who provide the most cost effective medical transportation service. The commissioner shall adopt regulations in accordance with the provisions of chapter 54 for purposes of the program and shall amend the state Medicaid plan as needed under Title XIX of the Social Security Act to maximize federal financial participation. The commissioner may operate one or more pilot programs prior to state-wide operation of a competitive bidding program for medical transportation services. BY ENROLLING IN THE MEDICAID PROGRAM, PROVIDERS OF MEDICAL TRANSPORTATION SERVICES AGREE TO OFFER TO RECIPIENTS OF MEDICAL ASSISTANCE ALL TYPES OR LEVELS OF TRANSPORTATION SERVICES FOR WHICH THEY ARE LICENSED OR CERTIFIED. EFFECTIVE OCTOBER 1, 1991, PAYMENT FOR SUCH SERVICES SHALL BE MADE ONLY FOR SERVICES PROVIDED TO AN ELIGIBLE RECIPIENT WHO IS ACTUALLY TRANSPORTED.

Sec. 9. Section 17-134bb of the general statutes is repealed and the following is substituted in lieu thereof:

Notwithstanding any provision of the regulations of Connecticut state agencies concerning payment for drugs provided to [medical aid] MEDICAID recipients [,] (1) effective July 1, 1989, the state shall reimburse for all legend drugs provided to such recipients at the rate established by the Health Care Finance Administration as the federal acquisition cost, or, if no such rate is established, the commissioner shall establish and periodically revise the estimated acquisition cost in accordance with federal regulations. The commissioner shall also establish a professional fee to be paid to licensed pharmacies for dispensing drugs to Medicaid recipients in accordance with federal regulations; AND (2) ON AND AFTER THE EFFECTIVE DATE OF THIS ACT, PAYMENT FOR LEGEND AND NONLEGEND DRUGS PROVIDED TO MEDICAID RECIPIENTS SHALL BE BASED UPON THE ACTUAL PACKAGE SIZE DISPENSED. EFFECTIVE OCTOBER 1, 1991, REIMBURSEMENT FOR OVER-THE-COUNTER DRUGS FOR SUCH RECIPIENTS SHALL BE LIMITED TO THOSE OVER-THE-COUNTER DRUGS AND PRODUCTS PUBLISHED IN THE CONNECTICUT FORMULARY, OR THE CROSS REFERENCE LIST, ISSUED BY THE COMMISSIONER. THE COST OF ALL OVER-THE-COUNTER DRUGS AND PRODUCTS PROVIDED TO RESIDENTS OF NURSING FACILITIES, CHRONIC DISEASE HOSPITALS, AND INTERMEDIATE CARE

FACILITIES FOR THE MENTALLY RETARDED SHALL BE INCLUDED IN THE FACILITIES' PER DIEM RATE.

Sec. 10. (NEW) (a) The commissioner of income maintenance shall extend the provisions of section 17-134d-11 of the regulations of Connecticut state agencies to monitor and control Medicaid recipient utilization of outpatient mental health services. The commissioner shall contract, through a competitive bidding process, for recipient surveillance and review services. Such contract shall authorize the imposition of utilization controls, including but not limited to, prior authorization requirements based on medical appropriateness and cost effectiveness.

(b) The rate paid for hospital outpatient mental health therapy services, except for partial hospitalization and other comprehensive services as defined by the commissioner, shall be that established in subsection (d) of section 17-312 of the general statutes for an outpatient clinic visit. Payment for partial hospitalization services shall be considered payment in full for all outpatient mental health services.

Sec. 11. (NEW) The commissioner of income maintenance shall, where feasible and cost effective, enter into contracts with suppliers of stock and standard durable medical equipment, medical surgical supplies, oxygen and laboratory services for such services provided to recipients of medical assistance excluding those services provided by hospitals or routinely provided by nursing homes as part of their rate. In the case of laboratory services billed through a hospital outpatient clinic, payment shall be made at the lower of the provider's charges to the general public or the contracted rate. Except for hospital based laboratory work and those laboratory tests specifically exempted by the commissioner, no payment shall be made for laboratory services except under contract, where feasible. Except for those facilities specifically exempted by the commissioner, all oxygen services for residents of nursing facilities and chronic disease hospitals shall be supplied through such a contract.

Sec. 12. Section 17-303 of the general statutes is repealed and the following is substituted in lieu thereof:

Any person who has in his possession or control any property of any person applying for or presently or formerly receiving aid or care from the state or who is indebted to such applicant or recipient or has knowledge of any insurance, including health insurance or property currently or formerly belonging to him, or information pertaining to eligibility for such aid or care, and any officer who has control of the books and accounts of any corporation which has possession

or control of any property belonging to any person applying for or receiving such aid or care or who is indebted to him, or has knowledge of any insurance, including health insurance or any person having in his employ any such person, shall, upon presentation by the commissioner of income maintenance, or the commissioner of administrative services, or the commissioner of public safety, or a support enforcement officer of the superior court, or any person deputized by any of them, of a certificate, signed by him, stating that such applicant, recipient or employee has applied for or is receiving or has received aid or care from the state, make full disclosure to said commissioner, such officer or such deputy of any such property, insurance, wages, indebtedness or information. AT THE REQUEST OF THE COMMISSIONER OF INCOME MAINTENANCE, INSURANCE COMPANIES LICENSED TO DO BUSINESS IN CONNECTICUT SHALL BE REQUIRED, WHEN COMPATIBLE DATA ELEMENTS ARE AVAILABLE, TO CONDUCT AUTOMATED DATA MATCHES TO IDENTIFY INSURANCE COVERAGE FOR RECIPIENTS AND THE PARENTS OF RECIPIENTS WHO ARE MINORS. UPON COMPLETION OF SUCH MATCHES THE COMMISSIONER SHALL REIMBURSE SUCH COMPANIES FOR THE REASONABLE DOCUMENTED COSTS OF CONDUCTING THE MATCHES. Such disclosure may be obtained in like manner of the property, wages or indebtedness of any person liable for the support of any such applicant or recipient, including the parents of any child receiving aid under the provisions of sections 17a-90 to 17a-124, inclusive, 17a-145 to 17a-155, inclusive, 17a-175 to 17a-185, inclusive and 46b-151 to 46b-151g, inclusive, or one adjudged or acknowledged to be the father of an illegitimate child. Such disclosure may be obtained in like manner by the commissioner of human resources, of the property, insurance, wages or indebtedness of any person liable for the support of any person applying for or presently or formerly receiving assistance under the provisions of part II of chapter 302. Any company or any officer who has control of the books and accounts of any corporation shall make full disclosure to the support enforcement officer of the superior court of any such property, wages or indebtedness in all support cases. The commissioner of income maintenance, the commissioner of administrative services, the commissioner of public safety or the commissioner of human resources, or a support enforcement officer of said court, or any person deputized by any of them, may compel, by subpoena, the attendance and testimony under oath of any person who refuses to disclose in accordance with the provisions of this section, or of any person liable for the support of any such applicant or recipient who refuses to disclose his own financial circumstances, and may

so compel the production of books and papers pertaining to such information. The commissioner of income maintenance may subpoena the financial records of any financial institution concerning property of any person applying for or presently or formerly receiving aid or care from the state or who is indebted to such applicant or recipient. The commissioner of human resources may subpoena such records of any parent or parents of any child applying for or presently or formerly receiving assistance under the provisions of part II of chapter 302. The commissioner, or a support enforcement officer of said court, or the person deputized by him shall set a time and place for such examination, and any person summoned who, without reasonable excuse, fails to appear and testify or to produce such books and papers shall be fined fifty dollars for each such offense.

Sec. 13. Subsection (d) of section 17-312 of the general statutes is repealed and the following is substituted in lieu thereof:

(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, but the established rate for an outpatient clinic visit shall not exceed one hundred sixteen per cent of the combined average fee of the general practitioner and specialist for an office visit according to the fee schedule for practitioners of the healing arts approved under section 4-67c, EXCEPT THAT THE OUTPATIENT CLINIC RATE IN EFFECT JUNE 30, 1992, SHALL INCREASE JULY 1, 1992, AND EACH JULY FIRST THEREAFTER BY NO MORE THAN THE MOST RECENT ANNUAL INCREASE IN THE CONSUMER PRICE INDEX FOR MEDICAL CARE. THE EMERGENCY ROOM VISIT RATES IN EFFECT JUNE 30, 1991, SHALL REMAIN IN EFFECT THROUGH JUNE 30, 1992, EXCEPT THOSE WHICH WOULD HAVE BEEN DECREASED EFFECTIVE JULY 1, 1991, SHALL BE DECREASED. To the extent that the commissioner receives approval for a disproportionate share exemption pursuant to federal regulations, the commissioner may establish a rate cap for qualifying hospital outpatient clinics up to one hundred seventy-five per cent of the combined average fee of the general practitioner and specialist for an office visit according to the fee schedule for practitioners of the healing arts approved under section 4-67c. 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.

Sec. 14. Subsection (a) of section 17-313a of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The rate to be paid by the state to rehabilitation centers, including but not limited to centers affiliated with the Easter Seal Society of Connecticut, Inc., for services to patients referred by any state agency, except employment opportunities and day services, as defined in section 17a-246, shall be determined annually by the commissioner of income maintenance who shall prescribe uniform forms on which such rehabilitation centers shall report their costs, except that rates effective April 30, 1989, shall remain in effect through May 31, 1990, AND RATES IN EFFECT FEBRUARY 1, 1991, SHALL REMAIN IN EFFECT THROUGH DECEMBER 31, 1992, EXCEPT THOSE WHICH WOULD BE DECREASED EFFECTIVE JANUARY 1, 1992, SHALL BE DECREASED. Such rates shall be determined on the basis of a reasonable payment for necessary services rendered. Nothing contained herein shall authorize a payment by the state to any such rehabilitation center in excess of the charges made by such center for comparable services to the general public.

Sec. 15. Section 17-313b of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The room and board component of the rates to be paid by the state to private facilities and facilities operated by regional education service centers which are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid program as intermediate care facilities for persons with mental retardation, shall be determined annually by the commissioner of income maintenance, except that rates effective April 30, 1989, shall remain in effect through October 31, 1989. FOR THE FISCAL YEAR ENDING JUNE 30, 1992, THE INFLATION FACTOR USED TO DETERMINE RATES SHALL BE ONE-HALF OF THE GROSS NATIONAL PRODUCT PERCENTAGE INCREASE FOR THE PERIOD BETWEEN THE MIDPOINT OF THE COST YEAR THROUGH THE MIDPOINT OF THE RATE YEAR. The commissioner of income maintenance shall prescribe uniform forms on which such facilities shall report their costs. Such rates shall be determined on the basis of a reasonable payment for necessary services. Nothing contained in this section shall authorize a payment by the state to any such facility in excess of the charges made by the facility for comparable services to the general public. The service component of the rates to be paid by the state to private facilities and facilities operated by regional education service centers

which are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid programs as intermediate care facilities for persons with mental retardation, shall be determined annually by the commissioner of mental retardation.

(b) The commissioner of income maintenance and the commissioner of mental retardation shall adopt regulations in accordance with the provisions of chapter 54 to implement the provisions of this section.

Sec. 16. (NEW) (a) Any rates established by the commissioner of income maintenance in effect February 1, 1991, for mental health and substance abuse residential facilities shall remain in effect through June 30, 1992, except those which would have been decreased effective July 1, 1991, shall be decreased.

(b) Any rates established by the commissioner of income maintenance in effect February 1, 1991, for free-standing detoxification centers shall remain in effect through June 30, 1992, except those which would have been decreased effective July 1, 1991, shall be decreased.

Sec. 17. Subsection (a) of section 17-314 of the general statutes is repealed and the following is substituted in lieu thereof:

(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, chronic disease hospitals associated with chronic and convalescent nursing homes, rest homes with nursing supervision and to licensed homes for the aged, as defined by section 19a-490, 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 income maintenance, 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 (1) 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 (2) 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. 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. 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, 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 income maintenance to adjust rates and provide payment for any increases in costs resulting from an inspection of a facility by the department of health services. 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 17-83i. FOR THE FISCAL YEAR ENDING JUNE 30, 1992, RATES FOR LICENSED HOMES FOR THE AGED 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.

Sec. 18. Subsection (a) of section 19a-490 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) "Institution" means a hospital, home for the aged, health care facility for the handicapped, nursing home, rest home, home health care agency, homemaker-home health aide agency, coordination, assessment and monitoring agency, mental health facility, substance abuse treatment facility, an infirmary operated by an educational institution for the care of students

enrolled, and faculty and employees of, such institution; [and] a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency, except facilities for the care or treatment of mentally ill persons or persons with [mental retardation or] substance abuse problems; AND A RESIDENTIAL FACILITY FOR THE MENTALLY RETARDED LICENSED PURSUANT TO SECTION 17a-227 AND CERTIFIED TO PARTICIPATE IN THE TITLE XIX MEDICAID PROGRAM AS AN INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED.

Sec. 19. Subsection (a) of section 19a-507 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Notwithstanding the provisions of chapter 368c, New Horizons, Inc., a nonprofit, nonsectarian organization is authorized to construct and operate an independent living facility for severely physically disabled adults, in the town of Farmington, provided such facility shall be constructed in accordance with applicable building codes. The Farmington housing authority, or any issuer acting on behalf of said authority, subject to the provisions of this section, may issue tax-exempt revenue bonds on a competitive or negotiated basis for the purpose of providing construction and permanent mortgage financing for the facility in accordance with Section 103 of the Internal Revenue Code. Prior to the issuance of such bonds, plans for the construction of the facility shall be submitted to and approved by the commission on hospitals and health care. The commission shall approve or disapprove such plans within thirty days of receipt thereof. If the plans are disapproved they may be resubmitted. Failure of the commission to act on the plans within such thirty-day period shall be deemed approval thereof. The payments to residents of the facility who are eligible for assistance under chapter 302 for room and board and necessary services, shall be determined annually to be effective July first of each year. Such payments shall be determined on a basis of a reasonable payment for necessary services, which basis shall take into account as a factor the costs of providing those services and such other factors as the commissioner deems reasonable, including anticipated fluctuations in the cost of providing services. Such payments shall be calculated in accordance with the manner in which rates are calculated pursuant to section 17-314 and the cost related reimbursement system pursuant to said section except that efficiency incentives shall not be granted. The fair rental value calculated shall not exceed the sum of the building depreciation and mortgage interest reported by the

facility. The cost basis for such payment shall be subject to audit, and a recomputation of the rate shall be made based upon such audit. THE RATE IN EFFECT JUNE 30, 1991, SHALL REMAIN IN EFFECT THROUGH JUNE 30, 1992, EXCEPT THAT IF THE RATE WOULD HAVE BEEN DECREASED EFFECTIVE JULY 1, 1991, IT SHALL BE DECREASED. The facility shall report on a fiscal year ending on the thirtieth day of September on forms provided by the commissioner. The required report shall be received by the commissioner no later than December thirty-first of each year. The department of income maintenance may use its existing utilization review procedures to monitor utilization of the facility. If the facility is aggrieved by any decision of the commissioner, the facility may, within ten days, after written notice thereof from the commissioner, obtain by written request to the commissioner, a hearing on all items of aggrievement. If the facility is aggrieved by the decision of the commissioner after such hearing, the facility may appeal to the superior court in accordance with the provisions of section 4-183.

Sec. 20. Section 17-313 of the general statutes, as amended by section 5 of public act 91-406, is repealed and the following is substituted in lieu thereof:

The rate to be paid by the [state] DEPARTMENTS OF INCOME MAINTENANCE, HUMAN RESOURCES AND AGING to home health care agencies and homemaker-home health aide agencies FOR THE PERIOD FROM FEBRUARY 1, 1991, TO JANUARY 31, 1992, INCLUSIVE, for [services] EACH SERVICE to THE state [social services cases] shall be BASED UPON THE RATE FOR SUCH SERVICE AS determined annually by the commission on hospitals and health care pursuant to the provisions of subsection (b) of section 19a-151, EXCEPT THAT FOR THOSE PROVIDERS WHOSE MEDICAID RATES FOR THE YEAR ENDING JANUARY 31, 1991, EXCEED THE MEDIAN RATE, NO INCREASE SHALL BE ALLOWED. FOR THOSE PROVIDERS WHOSE RATES FOR THE YEAR ENDING JANUARY 31, 1991, ARE BELOW THE MEDIAN RATE, INCREASES SHALL NOT EXCEED THE LOWER OF THE PRIOR RATE INCREASED BY THE MOST RECENT ANNUAL INCREASE IN THE CONSUMER PRICE INDEX FOR URBAN CONSUMERS OR THE MEDIAN RATE. IN NO CASE SHALL ANY SUCH RATE EXCEED THE EIGHTIETH PERCENTILE OF RATES IN EFFECT JANUARY 31, 1991, NOR SHALL ANY RATE EXCEED THE CHARGE TO THE GENERAL PUBLIC FOR SIMILAR SERVICES. RATES EFFECTIVE FEBRUARY 1, 1992, AND ANNUALLY THEREAFTER, SHALL BE BASED UPON RATES AS DETERMINED BY THE COMMISSION ON HOSPITALS AND HEALTH CARE PURSUANT TO THE PROVISIONS OF SUBSECTION (b) OF SECTION 19a-151, EXCEPT THAT INCREASES SHALL NOT EXCEED THE PRIOR YEAR'S RATE INCREASED BY THE MOST RECENT ANNUAL INCREASE IN

THE CONSUMER PRICE INDEX FOR URBAN CONSUMERS. A HOME HEALTH CARE AGENCY OR HOMEMAKER-HOME HEALTH AIDE AGENCY WHICH, DUE TO ANY MATERIAL CHANGE IN CIRCUMSTANCES, IS AGGRIEVED BY A RATE DETERMINED PURSUANT TO THIS SECTION MAY, WITHIN TEN DAYS OF RECEIPT OF WRITTEN NOTICE OF SUCH RATE FROM THE COMMISSIONER OF INCOME MAINTENANCE, REQUEST IN WRITING A HEARING ON ALL ITEMS OF AGGRIEVEMENT. THE COMMISSIONER SHALL, UPON THE RECEIPT OF ALL DOCUMENTATION NECESSARY TO EVALUATE THE REQUEST, DETERMINE WHETHER THERE HAS BEEN SUCH A CHANGE IN CIRCUMSTANCES AND SHALL CONDUCT A HEARING IF APPROPRIATE.

Sec. 21. Section 17-314c of the general statutes is repealed and the following is substituted in lieu thereof:

The commissioner of income maintenance, in consultation with the commissioner of human resources and the commissioner on aging, shall establish annually the maximum allowable rate to be paid by said agencies for homemaker services, chore person services, companion services, respite care, meals on wheels, adult day care services, case management and assessment services, transportation, mental health counseling and elderly foster care, EXCEPT THAT THE MAXIMUM ALLOWABLE RATES IN EFFECT JULY 1, 1990, SHALL REMAIN IN EFFECT DURING THE FISCAL YEAR ENDING JUNE 30, 1992, AND RATES ESTABLISHED IN SUBCONTRACTS BETWEEN COORDINATION, ASSESSMENT AND MONITORING AGENCIES AND DIRECT CARE PROVIDERS IN EFFECT FEBRUARY 1, 1991, SHALL REMAIN IN EFFECT DURING THE FISCAL YEAR ENDING JUNE 30, 1992. The commissioner of income maintenance shall prescribe uniform forms on which agencies providing such services shall report their costs for such services. Such rates shall be determined on the basis of a reasonable payment for necessary services rendered. The maximum allowable rates established by the commissioner of income maintenance for the preadmission screening and community-based services program established under section 17-314b shall constitute the rates required under this section until revised in accordance with this section. Nothing contained in this section shall authorize a payment by the state to any agency for such services in excess of the amount charged by such agency for such services to the general public.

Sec. 22. Section 17-314 of the general statutes is amended by adding subsection (f) as follows:

(NEW) (f) For the fiscal year ending June 30, 1992, the rates paid by or for persons aided or cared for by the state or any town in this state to facilities for room, board and services specified in licensing regulations issued by the licensing agency, except intermediate care

facilities for the mentally retarded and homes for the aged, shall be based on the cost year ending September 30, 1989. For the fiscal years ending June 30, 1993, and June 30, 1994, such rates shall be based on the cost year ending September 30, 1990. Notwithstanding the provisions of section 17-314d, such rates shall be determined by the commissioner of income maintenance in accordance with this section and the regulations of Connecticut state agencies promulgated by the commissioner and in effect on April 1, 1991, except that:

(1) Allowable costs shall be divided into the following five cost components: Direct costs, which shall include salaries for nursing personnel, related fringe benefits and nursing pool costs; indirect costs, which shall include professional fees, dietary expenses, housekeeping expenses, laundry expenses, supplies related to patient care, salaries for indirect care personnel and related fringe benefits; fair rent, which shall be defined in accordance with section 17-311-52f of the regulations of Connecticut state agencies; capital-related costs, which shall include property taxes, insurance expenses, equipment leases and equipment depreciation; and administrative and general costs, which shall include maintenance and operation of plant expenses, salaries for administrative and maintenance personnel and related fringe benefits. Allowable costs shall not include costs for ancillary services payable under Part B of the Medicare program.

(2) Two geographic peer groupings of facilities shall be established for each level of care, as defined by the department of income maintenance for the determination of rates, for the purpose of determining allowable direct costs. One peer grouping shall be comprised of those facilities located in Fairfield county. The other peer grouping shall be comprised of facilities located in all other counties.

(3) For the fiscal year ending June 30, 1992, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred thirty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the commission on hospitals and health care pursuant to section 19a-154; for capital-related costs, there shall be no maximum; and for administrative and general costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1993, per

diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the commission on hospitals and health care pursuant to section 19a-154; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred fifteen per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1994, and any succeeding fiscal year, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the commission on hospitals and health care pursuant to section 19a-154; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred ten per cent of the state-wide median allowable cost. Costs in excess of the maximum amounts established under this subsection shall not be recognized as allowable costs, except that the commissioner of income maintenance may adopt regulations, in accordance with the provisions of chapter 54, to establish criteria whereby allowable costs may exceed such maximum amounts for beds approved on or after July 1, 1991, which are restricted to use by patients with acquired immune deficiency syndrome or traumatic brain injury.

(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 years ending June 30, 1992, and June 30, 1993, the commissioner of income maintenance shall exclude fair rent from any rate increase maximums established pursuant to this subsection for a facility which has undergone a material change in circumstances related to fair rent. Thereafter, the commissioner of income maintenance may exclude fair rent from any rate increase maximums established pursuant to this subdivision for a facility which has undergone a material change in circumstances related to fair rent.

(5) For the purpose of determining allowable fair rent, a facility 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.

(6) A facility shall receive a cost efficiency adjustment for indirect costs if such costs are below one hundred ten per cent of the state-wide median costs and for administrative and general costs if such costs are below one hundred five per cent of the state-wide median costs. The cost efficiency adjustment shall equal twenty-five per cent of the difference between allowable reported costs and the applicable maximum allowable cost established pursuant to this subdivision.

(7) For the fiscal year ending June 30, 1992, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban) - All Items minus one and one-half per cent. For the fiscal year ending June 30, 1993, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban) - All Items minus one and three-quarters per cent. For the fiscal year ending June 30, 1994, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban) - All Items minus two per cent. For fiscal years ending June 30, 1992, and June 30, 1993, allowable fair rent shall be those reported in the annual report of long-term care

facilities for the cost year ending the immediately preceding September thirtieth. The inflation index to be used pursuant to this subsection shall be computed to reflect inflation between the midpoint of the cost year through the midpoint of the rate year. The department of income maintenance shall study methods of reimbursement for fair rent and shall report its findings and recommendations to the joint standing committee of the general assembly having cognizance of matters relating to human services on or before January 15, 1993.

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

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

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

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

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

(13) A chronic and convalescent nursing home having an ownership affiliation with and operated at the same location as a chronic disease hospital may request that the commissioner approve an exception to applicable rate setting provisions for chronic and convalescent nursing homes and establish a rate for the fiscal years ending June 30, 1992 and June 30, 1993, in accordance with regulations in effect June 30, 1991. Any such rate shall not exceed 165% of the median rate established for chronic and convalescent nursing homes established under this section for the applicable fiscal year.

Sec. 23. Subsection (a) of section 17-314a of the general statutes is repealed and the following is substituted in lieu thereof:

(a) [The rates to be charged to self-pay patients in licensed chronic and convalescent nursing homes, chronic disease hospitals associated with chronic and convalescent nursing homes, rest homes with nursing supervision and

licensed homes for the aged, as defined in section 19a-490, shall be determined annually, after a public hearing, by the commissioner of income maintenance. Such rates] THE COMMISSIONER OF INCOME MAINTENANCE SHALL DETERMINE ANNUALLY, AFTER A PUBLIC HEARING, THE RATES TO BE CHARGED TO SELF-PAY PATIENTS IN ANY OF THE FOLLOWING LICENSED FACILITIES IF THE FACILITY DOES NOT HAVE A PROVIDER AGREEMENT WITH THE STATE TO PROVIDE SERVICES TO RECIPIENTS OF BENEFITS OBTAINED THROUGH TITLE XIX OF THE SOCIAL SECURITY AMENDMENTS OF 1965, EXCEPT A FACILITY THAT DID NOT HAVE A PROVIDER AGREEMENT IN EFFECT AS OF JANUARY 1, 1991 OR HAD ENTERED INTO A LIMITED PROVIDER AGREEMENT BEFORE JANUARY 1, 1991: CHRONIC AND CONVALESCENT NURSING HOMES, CHRONIC DISEASE HOSPITALS ASSOCIATED WITH CHRONIC AND CONVALESCENT NURSING HOMES AND REST HOMES WITH NURSING SUPERVISION. EACH SUCH FACILITY THAT DOES HAVE SUCH A PROVIDER AGREEMENT, EACH SUCH FACILITY THAT DID NOT HAVE A PROVIDER AGREEMENT IN EFFECT AS OF JANUARY 1, 1991 OR HAD ENTERED INTO A LIMITED PROVIDER AGREEMENT BEFORE JANUARY 1, 1991, AND EACH HOME FOR THE AGED SHALL DETERMINE ITS OWN SELF-PAY RATES. RATES DETERMINED PURSUANT TO THIS SECTION shall be effective [October 1, 1979] JULY 1, 1991, and on July first of each year thereafter THROUGH JUNE 30, 1993, and shall be determined for each facility individually, on the basis of payment for the reasonable costs of providing all services. All self-pay patients shall be given notice of a rate increase [, as determined by the commissioner,] at least thirty days prior to the effective date of such rate increase. In determining [such] rates TO BE CHARGED TO SELF-PAY PATIENTS the commissioner shall: (1) Consider the quality of care provided by each facility, based on information which the department of health services shall provide to the commissioner, and any testimony or information received from other interested parties; and (2) take into account the relevant cost considerations set forth in section 17-314 and in the regulations adopted in accordance with subsection (a) of section 17-311. Such regulations shall include but not be limited to the establishment of a formula for allowing profit or an operating surplus, and a fair rate of return on invested capital or equity. Nothing in this section shall authorize the commissioner to set a rate lower than the rate set under section 17-314 for comparable services. As used in this section "self-pay patient" means a patient who is not receiving state or municipal assistance to pay for the cost of care. EACH FACILITY DETERMINING ITS OWN SELF-PAY RATES SHALL REPORT SUCH RATES TO THE COMMISSIONER UPON DETERMINATION AND UPON ANY MODIFICATION. THE COMMISSIONER SHALL DOCUMENT

EACH RATE SO REPORTED AND EACH RATE DETERMINED FOR A FACILITY BY THE COMMISSIONER PURSUANT TO THIS SECTION AND SHALL REPORT ALL SUCH RATES TO THE JOINT STANDING COMMITTEE OF THE GENERAL ASSEMBLY HAVING COGNIZANCE OF MATTERS RELATING TO HUMAN SERVICES ON OR BEFORE DECEMBER 31, 1992.

Sec. 24. Section 17-314f of the general statutes is repealed and the following is substituted in lieu thereof:

(a) [Any] EFFECTIVE OCTOBER 1, 1991, EVERY chronic and convalescent nursing [facility] HOME, CHRONIC DISEASE HOSPITAL ASSOCIATED WITH A CHRONIC AND CONVALESCENT NURSING HOME, AND REST HOME WITH NURSING SUPERVISION, that participates in the medical assistance program provided in Title XIX of the Social Security Act shall, as a condition of participation in said program, IF ELIGIBLE, maintain or execute a provider agreement with the Secretary of Health and Human Services to participate in the Medicare program under Title XVIII of the Social Security Act to the same extent that the facility participates in the Title XIX medical assistance program. However, such facility may seek the approval of the department of income maintenance to have a larger portion of its facility certified for the Title XIX medical assistance program than for the Title XVIII Medicare program if the facility is certified for a distinct part pursuant to the Title XVIII Medicare program and the facility demonstrates to the satisfaction of the department that the number of beds in the distinct part will be adequate to ensure access to Title XVIII Medicare certified beds to all eligible Title XVIII recipients who might reasonably be expected to seek admission to, or return to, such facility.

(b) The commissioner may issue a rate for any facility which fails to comply with the provisions of this section provided such rate may not be lower than the lowest rate paid to a facility for the same level of care.

[(c) Any facility which, on May 1, 1989, participated in the medical assistance program but not in the Title XVIII Medicare program shall be exempt from the provisions of this section.]

Sec. 25. (NEW) Effective January 1, 1992, the commissioner of income maintenance shall administer a state-wide long-term care facility preadmission screening program to prevent admission to chronic and convalescent nursing homes, chronic disease hospitals associated with chronic and convalescent nursing homes, or rest homes with nursing supervision of persons (1) who do not meet the income eligibility requirements to receive services provided pursuant to section 17-314b of the general statutes and (2) whose medical and functional needs do not require a level of care necessitating admission to such a

facility. The commissioner shall use department staff to provide screening functions for the program. The commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, as are necessary to implement and administer the program and to establish uniform state-wide standards for the program and a uniform assessment tool for use in the screening process.

Sec. 26. (NEW) Effective January 1, 1992, no chronic and convalescent nursing home, chronic disease hospital associated with a chronic and convalescent nursing home, or rest home with nursing supervision licensed pursuant to chapter 368v of the general statutes shall admit a patient (1) who has not been screened by the department of income maintenance pursuant to section 17-314b of the general statutes, or pursuant to section 25 of this act, or (2) who has been so screened by such department and thereby found not to need a level of care requiring admission to the facility. No payment from any source shall be due to a nursing facility that admits a patient in violation of the requirements of subdivision (1) of this section.

Sec. 27. Section 19a-154 of the general statutes, as amended by section 1 of public act 91-48, is amended by adding subsections (d), (e) and (f) as follows:

(NEW) (d) Except for applications deemed complete as of August 9, 1991, the commission shall not approve any requests for additional nursing home beds or modify the capital cost or expiration date of any approval for the period of the effective date of this act through June 30, 1993, except (1) beds restricted to use by patients with acquired immune deficiency syndrome or traumatic brain injury and (2) beds associated with a continuing care facility which guarantees life care for its residents. Notwithstanding the provisions of this subsection, the commission may modify the expiration date of an approval, provided an expiration date shall not be modified to later than June 30, 1992.

(NEW) (e) Each approval for additional nursing home beds granted pursuant to this section on or before July 1, 1991, shall expire one year from the date of such approval, unless (1) construction has begun, (2) zoning and financing approvals have been obtained or (3) the expiration date of the approval has been modified pursuant to subsection (d) of this section.

(NEW) (f) The commission shall not approve any requests for beds in residential facilities for the mentally retarded which are licensed pursuant to section 17a-227 and are certified to participate in the Title XIX Medicaid Program as intermediate care facilities for the mentally

retarded, except those beds necessary to implement the residential placement goals of the department of mental retardation which are within available appropriations.

Sec. 28. Subsection (b) of section 19a-493 of the general statutes is repealed and the following is substituted in lieu thereof:

(b) A nursing home license may be renewed biennially after (1) an unscheduled inspection conducted by the department, (2) submission of the information required by subsections (a) and (c) of section 19a-491a and any other information required by the commissioner pursuant to subsection (b) of said section, and (3) submission of evidence satisfactory to the department that the nursing home is in compliance with the provisions of this chapter, the public health code and licensing regulations. Any change in the ownership of an institution, as defined in said subsection (c) of section 19a-490, owned by an individual, partnership or association or the change in ownership or beneficial ownership of ten per cent or more of the stock of a corporation which owns, conducts, operates or maintains such facility or institution, shall be subject to prior approval of the department of health services after a scheduled inspection of such facility is conducted by the department, provided such approval shall be conditioned upon a showing by such facility or institution to the commissioner that it has complied with all requirements of this chapter, the regulations relating to licensure and all applicable requirements of the public health code. ANY SUCH CHANGE IN OWNERSHIP OR BENEFICIAL OWNERSHIP RESULTING IN A TRANSFER TO A PERSON RELATED BY BLOOD OR MARRIAGE TO SUCH AN OWNER OR BENEFICIAL OWNER SHALL NOT BE SUBJECT TO PRIOR APPROVAL OF THE DEPARTMENT UNLESS (1) OWNERSHIP OR BENEFICIAL OWNERSHIP OF TEN PER CENT OR MORE OF THE STOCK OF A CORPORATION, PARTNERSHIP OR ASSOCIATION WHICH OWNS, CONDUCTS, OPERATES OR MAINTAINS MORE THAN ONE FACILITY OR INSTITUTION IS TRANSFERRED; (2) OWNERSHIP OR BENEFICIAL OWNERSHIP IS TRANSFERRED IN MORE THAN ONE FACILITY OR INSTITUTION; OR (3) THE FACILITY OR INSTITUTION IS THE SUBJECT OF A PENDING COMPLAINT, INVESTIGATION OR LICENSURE ACTION. If the facility is not in compliance, the commissioner may require the new owner to sign a consent order providing reasonable assurances that the violations shall be corrected within a specified period of time. Notice of any such proposed change of ownership shall be given to the department of health services at least ninety days prior to the effective date of such proposed change. FOR THE PURPOSES OF THIS SUBSECTION "A PERSON RELATED BY BLOOD OR MARRIAGE" MEANS A PARENT, SPOUSE OR CHILD.

Sec. 29. Section 19a-533 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section, "nursing home" means any chronic and convalescent facility or any rest home with nursing supervision, as defined in section 19a-521, which has a provider agreement with the state to provide services to recipients of funds obtained through Title XIX of the Social Security Amendments of 1965; and "indigent person" means any person who is eligible for or who is receiving medical assistance benefits from the state or general assistance benefits from a town.

(b) A nursing home which receives payment from the state for rendering care to indigent persons shall:

(1) Be prohibited from discriminating against indigent persons who apply for admission to such facility on the basis of source of payment. Except as otherwise provided by law, all applicants for admission to such facility shall be admitted in the order in which such applicants apply for admission. Each nursing home shall (A) provide a receipt to each applicant for admission to its facility who requests placement on a waiting list stating the date and time of such request and (B) maintain a dated list of such applications which shall be available at all times to any applicant, his bona fide representative, authorized personnel from the departments of health services, income maintenance, aging and such other state agencies or other bodies established by state statute whose statutory duties necessitate access to such lists. Indigent persons shall be placed on any waiting list for admission to a facility and shall be admitted to the facility as vacancies become available, in the same manner as self-pay applicants, EXCEPT AS PROVIDED IN SUBSECTIONS (f) AND (g) OF THIS SECTION;

(2) Post in a conspicuous place a notice informing applicants for admission that the facility is prohibited by statute from discriminating against indigent applicants for admission on the basis of source of payment. Such notice shall advise applicants for admission of the remedies available under this section and shall list the name, address and telephone number of the ombudsman who serves the region in which the facility is located;

(3) Be prohibited from requiring that an indigent person pay any sum of money or furnish any other consideration, including but not limited to the furnishing of an agreement by the relative, conservator or other responsible party of an indigent person which obligates such party to pay for care rendered to an indigent person as a condition for admission of such indigent person;

(4) Maintain a daily log of the number of requests for admission, the number of indigent persons requesting admission, the number of vacancies, the number of persons admitted to the facility and the number of indigent persons admitted to the facility.

(c) Upon the receipt of a complaint concerning a violation of this section, the regional ombudsman shall conduct an investigation into such complaint and shall report his findings to the department of income maintenance.

(d) The department of income maintenance is authorized to decrease the daily reimbursement rate to a nursing home for one year for a violation of this section which occurred during the twelve-month period covered by the cost report upon which the per diem rate is calculated. The per diem rate shall be reduced by one quarter of one per cent for an initial violation of this section and one per cent for each additional violation.

(e) Prior to imposing any sanction, the department of income maintenance shall notify the nursing home of the alleged violation and the accompanying sanction, and shall permit such facility to request an administrative hearing, in accordance with sections 4-176e to 4-181a, inclusive. A facility shall request such hearing within fifteen days of receipt of the notice of violation from the department of income maintenance. The department shall stay the imposition of any sanction pending the outcome of the administrative hearing.

(f) A NURSING HOME WITH A NUMBER OF SELF-PAY RESIDENTS EQUAL TO OR LESS THAN TWENTY PER CENT OF ITS TOTAL NUMBER OF RESIDENTS SHALL NOT BE REQUIRED TO ADMIT AN INDIGENT PERSON ON A WAITING LIST FOR ADMISSION WHEN A VACANCY BECOMES AVAILABLE DURING THE SUBSEQUENT SIX MONTHS, PROVIDED NO BED MAY BE HELD OPEN FOR MORE THAN THIRTY DAYS.

(g) A NURSING HOME SHALL NOT BE REQUIRED TO ADMIT AN INDIGENT PERSON ON A WAITING LIST FOR ADMISSION WHEN A VACANCY BECOMES AVAILABLE IF THE VACANCY IS IN A PRIVATE ROOM.

(h) THE DEPARTMENT OF INCOME MAINTENANCE SHALL REVIEW THE DOCUMENTATION REQUIREMENTS IMPOSED ON NURSING HOMES PURSUANT TO THIS SECTION AND SECTIONS 17-311-206 TO 17-311-207, INCLUSIVE, OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND SHALL PROPOSE OPTIONS FOR REDUCING ADMINISTRATIVE REQUIREMENTS TO THE JOINT STANDING COMMITTEE OF THE GENERAL ASSEMBLY HAVING COGNIZANCE OF MATTERS RELATING TO HUMAN SERVICES ON OR BEFORE FEBRUARY 1, 1992.

Sec. 30. The commission on hospitals and health care, the department of health services and the department of income maintenance shall (1)

evaluate methods to (A) improve accuracy in better determining the need for nursing home beds in this state; (B) monitor the certificate of need process to track the number of nursing home beds approved that are then completed; and (C) limit approvals of certificates of need for additional nursing home beds by expanding geographic areas used as a basis for approval, implementing an expiration date for such approvals and implementing guidelines for the construction of facilities with less than one hundred twenty beds; and (2) develop a plan to improve interagency coordination of information concerning (A) certificate of need approvals for nursing home beds and subsequent licensure of such beds; (B) facility deficiencies; and (C) federal regulations for the licensing and payment of homes for the aged. Said commission and departments shall report their findings and recommendations to the joint standing committees of the general assembly having cognizance of matters relating to human services and public health on or before February 1, 1992.

Sec. 31. The department of health services shall evaluate state and federal regulations for the licensure of nursing homes to determine the impact of such regulations on nursing home costs and areas where federal certification requirements overlap state requirements. The department shall develop a plan for coordinating the process of certification and licensure of nursing homes, including, but not limited to, the performance of renewal of licensure and certification inspections simultaneously whenever possible, the waiver of licensure renewal inspections when certification requirements have been met and licensure requirements are substantially the same as certification requirements, and the application of a single sanction on a nursing home when state and federal sanctions overlap. The department shall report its findings and recommendations to the joint standing committees of the general assembly having cognizance of matters relating to human services and public health on or before February 1, 1992.

Sec. 32. The department of income maintenance, with the assistance of the department of health services, shall, on or before February 1, 1992, implement an automated system of collecting nursing home patient acuity data and shall evaluate implementation of a case-mix system for determining nursing home rates based on such data. If the evaluation of the patient acuity data determines that a chronic and convalescent nursing home having an ownership affiliation with and operated at the same location as a chronic disease hospital has an acuity level which is substantially greater than all other facilities in the state, the facility may request

that the commissioner approve an exception to applicable rate setting provisions for chronic and convalescent nursing homes and establish a rate for the fiscal year ending June 30, 1992 and June 30, 1993, in accordance with regulations in effect June 30, 1991. The department shall report its findings and recommendations to the joint standing committees of the general assembly having cognizance of matters relating to human services and public health on or before January 1, 1993.

Sec. 33. The department of income maintenance, with the assistance of the department of health services, shall: (1) Review requirements for homes for the aged concerning licensure, payment of wages to related parties and financial reporting; (2) track any changes in federal law concerning coverage of homes for the aged under Medicaid; and (3) report their findings and recommendations for reduction of requirements imposed on such homes to the joint standing committees of the general assembly having cognizance of matters relating to human services and public health on or before March 1, 1992.

Sec. 34. (NEW) On and after July 1, 1992, the department of health services shall, whenever possible, conduct dual inspections of chronic and convalescent nursing homes or rest homes with nursing supervision when an inspection of such a facility is necessary for the purpose of the facility's maintaining state licensure and certification for participation in the Title XIX Medicaid program or the Title XVIII Medicare program, provided such dual inspections shall be conducted in not less than fifty per cent of such facilities. On and after January 1, 1993, the department shall conduct such dual inspections in not less than seventy per cent of such facilities.

Sec. 35. (NEW) In each licensed chronic and convalescent nursing home, chronic disease hospital associated with a chronic and convalescent nursing home, rest home with nursing supervision and home for the aged, at least a three-foot clearance shall be provided at the sides and the foot of each bed.

Sec. 36. Section 17-273 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each person who has not estate sufficient for his support, and has no relatives of sufficient ability who are obliged by law to support him, shall be provided for and supported at the expense of the town in which he resides, except as otherwise provided in this section, or, if he has no residence, of the town in which he becomes in need of aid, subject to the provisions of section 17-273b, subsection (a) of section 17-281a, and in accordance with section 17-292g except that in making a determination of liability

for support under this section the income of a stepparent living in the same home as a dependent child or dependent children shall be considered in the same manner and to the same extent as under the aid to families with dependent children program pursuant to section 17-85. Any such person who enters an institution, or a series of institutions, shall be provided for and supported at the expense of the town in which he resided at the time he entered such institution or institutions for sixty days following his discharge from such institution or institutions. If a town is liable for any part of the cost of the institutionalization of such person, the town in which such person resided at the time he entered the institution or institutions shall be liable for such cost. Upon the admission of any such person to a state-operated facility, as defined in section 17a-458, those persons responsible for the person's discharge planning shall contact the town in which such person resided prior to entering such facility and make arrangements for the support of such person by that town for sixty days following his discharge from such facility. As used herein, the term "reside" means "occupy an established place of abode" and "institution" means a health or mental health residential facility such as a hospital or nursing home or any nonpermanent housing facility such as a halfway house, or shelter for battered women. When such person is in need of hospital or convalescent home care, it shall be similarly provided subject to the provisions of section 17-274. A PERSON WHO IS A RECIPIENT OF FINANCIAL AID UNDER CHAPTER 302 SHALL BE CONSIDERED TO BE PROVIDED FOR BY THE STATE, PURSUANT TO SECTION 17-292a. ON AND AFTER THE EFFECTIVE DATE OF THIS ACT, NO SUCH PERSON SHALL BE ELIGIBLE TO RECEIVE GENERAL ASSISTANCE FINANCIAL OR MEDICAL AID. NO TOWN SHALL BE LIABLE TO SUPPLEMENT A RECIPIENT OF FINANCIAL AID UNDER CHAPTER 302 WHOSE AWARD HAS BEEN REDUCED OR SUSPENDED, OR WHO HAS BEEN PENALIZED WITH A PERIOD OF INELIGIBILITY, DURING SUCH PERIOD OF INELIGIBILITY. A PERSON WHO IS A RECIPIENT OF MEDICAL AID UNDER CHAPTER 302 SHALL BE CONSIDERED TO HAVE HIS MEDICAL NEEDS PROVIDED FOR BY THE STATE AND NO SUCH PERSON SHALL BE ELIGIBLE TO RECEIVE GENERAL ASSISTANCE MEDICAL AID.

(b) On and after April 1, 1984, no town shall refuse to accept an application for general assistance or general assistance medical benefits because a person is deemed not to be a resident. In such a case, the town shall accept the application and contact the department of income maintenance. The department shall arrange to have the application transferred to the appropriate town of residence. If a dispute arises between two

towns as to liability for support, the dispute shall be referred to the commissioner of income maintenance in accordance with the provisions of section 17-292.

(c) Except as provided in sections 17-280 and 17-281, a person whose assets exceed two hundred fifty dollars shall not be eligible for assistance pursuant to this section or section 17-274. The commissioner of income maintenance may adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection.

(d) ON AND AFTER THE EFFECTIVE DATE OF THIS ACT, IF AN INDIVIDUAL SPONSORS A PERSON ADMITTED AS A RESIDENT OF THE UNITED STATES UNDER COLOR OF LAW, SUCH INDIVIDUAL'S INCOME SHALL BE DEEMED TO BE AVAILABLE FOR THE SUPPORT OF THE PERSON FOR THREE YEARS FROM THE DATE THE PERSON ENTERS THE UNITED STATES.

Sec. 37. Section 17-274 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each town shall provide medically necessary services by one or more competent physicians for all persons receiving general assistance benefits from such town, or eligible to be supported by such town, or unable to pay for the same over a two-year period, when such persons are in need thereof, and each town shall furnish necessary hospitalization, in accordance with section 17-292g, for all such persons if such person has not made, within twenty-four months prior to the date of application for such aid, an assignment or transfer or other disposition of property for less than fair market value, for the purpose of establishing eligibility for benefits or assistance under this chapter. Any such disposition shall be presumed to have been made for the purpose of establishing eligibility for benefits or assistance unless such person furnishes convincing evidence to establish that the transaction was exclusively for some other purpose. Ineligibility because of such disposition shall continue only for either (1) twenty-four months after the date of disposition or (2) that period of time from the date of disposition over which the fair market value of such property, less any consideration received in exchange for its disposition, together with all other income and resources, would furnish support on a reasonable standard of health and decency, whichever period is shorter, except that in any case where the uncompensated value of disposed of resources exceeds twelve thousand dollars, the commissioner of income maintenance shall provide for a period of ineligibility based on the uncompensated value which exceeds twenty-four months. The ability of a person to pay for medically necessary services over a two-year period shall be determined by a

town in accordance with regulations adopted by the department of income maintenance in accordance with the provisions of chapter 54, provided income in excess of the maximum income levels established pursuant to such regulations and any assets in excess of two hundred fifty dollars shall be applied toward medical bills incurred during the two-year period and assistance shall be granted only for the remaining balance of the cost of medically necessary services. Any person receiving medical treatment or hospitalization under this section shall make to the selectmen full disclosure of his financial condition as provided in section 17-278. A completed application for medical assistance under this section may be filed by the person seeking assistance, a member of such person's immediate family or a medical provider, including a physician or a hospital, within sixty days of commencement of treatment or hospitalization. In the event that the filer is unable to obtain the necessary eligibility information the town shall accept an incomplete application if the filer has made reasonable efforts to obtain such information in accordance with criteria established by regulations adopted by the department in accordance with chapter 54, except that a town shall be liable for medical bills only for those persons whose eligibility can be determined in accordance with standards established pursuant to section 17-3a. [If any person is entitled to any third party payment a town shall not be liable for the payment of any medical bill until an application has been completed on behalf of such person for such] NO APPLICANT WHO MAY BE ELIGIBLE FOR A third party payment to which he is entitled, including private insurance, hospital or medical service corporation benefits, veterans' benefits, Medicare and medical assistance pursuant to part IV of chapter 302 SHALL BE ELIGIBLE FOR GENERAL ASSISTANCE MEDICAL AID UNTIL HE HAS COMPLETED THE APPLICATION PROCESS FOR SUCH BENEFITS. ON AND AFTER OCTOBER 1, 1991, A TOWN SHALL NOT BE LIABLE FOR PAYMENT OF THE APPLICANT'S MEDICAL BILLS IF THE APPLICANT FAILS TO PROVIDE SUFFICIENT DOCUMENTATION TO DETERMINE HIS ELIGIBILITY FOR SUCH BENEFITS. FAILURE OF A PERSON OR A LEGALLY LIABLE RELATIVE OF THE PERSON TO COOPERATE IN THE APPLICATION PROCESS SHALL NOT PREVENT PAYMENT TO A MEDICAL PROVIDER FOR SERVICES RENDERED TO THE PERSON IF ADEQUATE INFORMATION IS OTHERWISE AVAILABLE TO DETERMINE THE PERSON'S ELIGIBILITY UNDER THIS SECTION.

(b) The medical services for which a town shall be liable under this section and for which a town shall be reimbursed by the state shall be limited to the following medically necessary services: (1) Physician services, (2) hospital

services, on an inpatient basis subject to the provisions of section 17-292g and outpatient care, (3) community clinic services, (4) prescription drugs, excluding over-the-counter drugs, (5) glasses, (6) hearing aids, (7) laboratory and x-ray services, (8) emergency dental services, (9) emergency medical transportation, (10) convalescent home services for persons who were receiving such services paid for by a town prior to January 1, 1983, (11) examinations (A) needed to determine employability for participation in a work program pursuant to section 17-281a, (B) required by a prospective employer but not paid for by such employer, or (C) requested by an attorney to establish the eligibility of a person receiving general assistance benefits for federal supplementary security income benefits pursuant to section 17-273c. ON AND AFTER OCTOBER 1, 1991, NO TOWN SHALL BE LIABLE FOR SERVICES PROVIDED BY A NATUREOPATH, PODIATRIST OR CHIROPRACTOR. In lieu of providing medical services, in accordance with this section, a town or group of towns may submit a plan to the department of income maintenance for approval to provide medical services in some other manner. The department shall approve the plan only if the persons served under it receive at least the services listed in this subsection and the plan offers the possibility of improved medical care or cost savings.

(c) If a town is required by administrative or judicial action to grant medical assistance to a person, such town shall be reimbursed for such assistance in accordance with the provisions of section 17-292, provided such town has followed general assistance program requirements, established pursuant to regulations adopted in accordance with chapter 54, in determining the eligibility of the person for assistance.

Sec. 38. (NEW) The commissioner of income maintenance shall amend the state's medicaid plan to eliminate coverage under the program, on and after October 1, 1991, for services provided by natureopaths, podiatrists and chiropractors.

Sec. 39. Section 17-281 of the general statutes is repealed and the following is substituted in lieu thereof:

If any person receiving such aid neglects or refuses to sign such agreement, the selectmen are authorized to file a lien against such property OR AGAINST THE REAL PROPERTY OF ANY LEGALLY LIABLE RELATIVE OF ANY PERSON RECEIVING AID OR SUPPORT UNDER THIS CHAPTER, to secure the disbursements of such town made prior to filing such lien and any disbursements thereafter made, and such lien from the time of filing shall have the same force and effect and may be foreclosed in the same manner as any agreement provided for in section 17-280.

Sec. 40. Section 17-286 of the general statutes is repealed and the following is substituted in lieu thereof:

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, the selectmen, or the public official charged with the administration of general assistance in such town, shall give to such person a proper funeral and burial, and such selectmen or public official may pay a sum not exceeding the sum established under section 17-82i 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. ON AND AFTER OCTOBER 1, 1991, SUCH PAYMENT FOR FUNERAL AND BURIAL EXPENSES SHALL BE REDUCED BY THE AMOUNT IN ANY REVOCABLE OR IRREVOCABLE FUNERAL FUND, ANY PREPAID FUNERAL CONTRACT, THE FACE VALUE OF ANY LIFE INSURANCE POLICY OWNED BY THE DECEDENT, AND CONTRIBUTIONS 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. For the purpose of reimbursement from the state, such funeral and burial expense shall be considered a general assistance expenditure within the meaning of section 17-292. Any person burying or causing to be buried any such person in violation of the provisions of this section shall be fined not less than twenty-five dollars. This section shall not affect the provisions of section 19a-270.

Sec. 41. Subsection (b) of section 17-292 of the general statutes, as amended by public act 91-235, is repealed and the following is substituted in lieu thereof:

(b) At the end of each quarter, one of the selectmen or the public official charged with the administration of general assistance in each town shall send to the commissioner of income maintenance, in the form prescribed by said commissioner, a statement of the cost to such town of general assistance during such quarter, which report shall be signed and sworn to by such selectman or public official. Such report form shall be uniform throughout the state and shall include, but not be limited to, the following information: (1) The approved budget of each town for general assistance, (2) the number of applications received, (3) compilation of data required under section 17-278, (4) the extent to which recipients participated in work relief programs, if any, (5) reports required by section 17-281d, (6) the amount of the support and medical

aid furnished, (7) the amount of the town's share of the cost for inpatient hospital services paid by the department of income maintenance pursuant to section 17-292g and (8) such other information the commissioner deems necessary for the proper administration and oversight of the general assistance program. "Cost", as used herein, means the actual relief expenditure made by such town for persons therein or sent from such town to such licensed institutions, including expenses, except attorneys' fees, incurred in an appeal of a denial of Supplemental Security Income Assistance as provided in section 17-273c, but not including administrative costs, except the administrative costs for which a town is compensated under the provisions of subsection (e) of section 17-281a, provided the expenditures for medical care shall not exceed the amounts set forth in the various fee schedules promulgated by the commissioner of income maintenance for medical, dental and allied services and supplies or the charges made for comparable services and supplies to the general public, whichever is less. Any hospital receiving state aid shall charge a uniform rate for paupers receiving medical treatment or being supported or cared for in such hospital under the provisions of this section, not in excess of the rate established under the provisions of section 17-311 for room, board, ordinary nursing care and routine medications and not in excess of the daily average cost rate for special professional services as established under the provisions of subsection (b) of section 17-312. The commissioner, if satisfied that the statements are substantially true and if the town has complied with the reporting requirements of this section, shall certify them to the comptroller, who shall pay within sixty days of receipt of such certification, subject to subsequent audits, to the town for general assistance expenditures, subject to section 17-292g, ninety per cent, except that [one hundred] EFFECTIVE JULY 1, 1991, NINETY-FIVE per cent shall be paid to each town which maintains a work program or training or education program, pursuant to section 17-281a, for that portion of such town's employable recipients who participated in such program and one hundred per cent shall be paid in accordance with section 17-292a for the cost of medical assistance provided pursuant to said section. The commissioner may reduce by twenty-five per cent the amount otherwise payable to the town in accordance with this section for any statement which is submitted more than six months after the close of the quarter for which the statement was prepared. Reimbursement for general assistance payments to employable recipients not

participating in such program shall be subject to the requirements of section 17-281a. Such payment shall be in lieu of all other payments to the town by way of reimbursement for relief expenditures. If not satisfied, the commissioner may reject such claim and shall notify the selectmen or other public official submitting the report of his decision. Notwithstanding any other provision of this section, the state shall charge the town for ten per cent of the inpatient hospital expenses of a person who is hospitalized and is eligible for or is receiving general assistance benefits in the form of an adjustment to the quarterly statement submitted by the town pursuant to this section. Any town aggrieved by the action of the commissioner may, within thirty days after receipt of such notice, request a hearing before the commissioner. The commissioner shall fix a time and place for the hearing, which shall be not more than thirty days after the receipt of such request and notify the town of the time and place not later than fifteen days before the date of the hearing. The hearing shall be conducted in accordance with the procedures established under sections 4-176e, 4-177, 4-177c and 4-180 for contested cases. The commissioner or the person authorized by him to conduct the hearing shall render a decision within thirty days after the hearing and notify the town by mailing a copy of the decision to the selectmen or the public official charged with the administration of general assistance. If the town is aggrieved by the decision, it may appeal to the superior court in accordance with the provisions of section 4-183.

Sec. 42. (NEW) On and after the effective date of this act, the commissioner of income maintenance shall reimburse municipalities for general assistance granted to applicants for financial assistance under chapter 302 of the general statutes, at not more than ninety per cent of the cost of such assistance.

Sec. 43. Subsection (b) of section 17-312 of the general statutes is repealed and the following is substituted in lieu thereof:

(b) [The] 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.

Sec. 44. (NEW) The commissioner of income maintenance may administer a program providing

payment for the cost of azidothymidine (AZT) or a similarly effective drug prescribed by a physician for a person diagnosed by a physician as having acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) or human immunodeficiency virus (HIV infection). The commissioner may implement a pharmacy lock-in procedure for the program. The commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to carry out the purposes of this section.

Sec. 45. Section 17a-340 of the general statutes is repealed and the following is substituted in lieu thereof:

As used in sections 17a-340 and 17a-342 to 17a-349, inclusive:

(a) "Pharmacy" means a pharmacy licensed under section 20-168 or a pharmacy located in a health care institution, as defined in subsection (a) of section 19a-490, which elects to participate in the program;

(b) "Prescription drugs" means (1) legend drugs, as defined in section 20-184a, (2) any other drugs which by state law or regulation require the prescription of a licensed practitioner for dispensing, except products prescribed for cosmetic purposes as specified in regulations adopted pursuant to section 17a-345, AND ON AND AFTER SEPTEMBER 15, 1991, DIET PILLS, SMOKING CESSATION GUM, CONTRACEPTIVES, MULTIVITAMIN COMBINATIONS, COUGH PREPARATIONS AND ANTIHISTAMINES, and (3) insulin, insulin syringes and insulin needles;

(c) "Reasonable cost" means the cost of the prescription drug determined in accordance with the formula adopted by the commissioner of income maintenance in regulations for medical assistance purposes plus a dispensing fee equal to the fee determined by said commissioner for medical assistance purposes; [, and, if applicable, a generic incentive dispensing fee equal to the fee provided for under subsection (a) of section 17-134q;]

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

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

(f) "Commissioner" means the commissioner on aging;

(g) "Income" means adjusted gross income as determined for purposes of the federal income tax

plus any other income of such person not included in such adjusted gross income. The amount of any Medicaid payments made on behalf of such person or the spouse of such person shall not constitute income;

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

(i) "PHARMACEUTICAL MANUFACTURER" MEANS ANY ENTITY HOLDING LEGAL TITLE TO OR POSSESSION OF A NATIONAL DRUG CODE NUMBER ISSUED BY THE FEDERAL FOOD AND DRUG ADMINISTRATION;

(j) "WHOLESALE PRICE" MEANS THE AVERAGE PRICE PAID BY A WHOLESALER TO A PHARMACEUTICAL MANUFACTURER, AFTER THE DEDUCTION OF ANY CUSTOMARY PROMPT PAYMENT DISCOUNTS, FOR A PRODUCT DISTRIBUTED FOR RETAIL SALE.

Sec. 46. Section 17a-342 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) There shall be a "Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program" which shall be within the department on aging. The program shall consist of payments by the state to pharmacies for the reasonable cost of prescription drugs dispensed to eligible persons minus a copayment charge, EFFECTIVE SEPTEMBER 15, 1991, of [six] TEN dollars for each prescription. [The] EFFECTIVE SEPTEMBER 15,1991, THE pharmacy shall collect the [six-dollar] TEN-DOLLAR copayment charge from the eligible person at the time of each purchase of prescription drugs, and shall not waive, discount or rebate in whole or in part such amount. [On July 1, 1991, and annually thereafter, the commissioner shall increase the copayment charge over that of the previous fiscal year by the percentage increase, if any, in the most recent calendar year average in the consumer price index for pharmaceutical products over the average for the previous calendar year. The amount of such increase shall be determined to the nearest twenty-five cents.]

(b) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (a), EFFECTIVE SEPTEMBER 15, 1991, PAYMENT BY THE STATE TO A PHARMACY UNDER THE PROGRAM MAY BE BASED ON THE PRICE PAID DIRECTLY BY A PHARMACY TO A PHARMACEUTICAL MANUFACTURER FOR DRUGS DISPENSED UNDER THE PROGRAM MINUS THE COPAYMENT CHARGE, PLUS THE DISPENSING FEE, IF THE DIRECT PRICE PAID BY THE PHARMACY IS LOWER THAN THE REASONABLE COST OF SUCH DRUGS.

(c) EFFECTIVE SEPTEMBER 15, 1991, REIMBURSEMENT TO A PHARMACY FOR PRESCRIPTION DRUGS DISPENSED UNDER THE PROGRAM SHALL BE BASED UPON ACTUAL PACKAGE SIZE COSTS OF DRUGS PURCHASED BY THE PHARMACY IN UNITS LARGER THAN OR SMALLER THAN

ONE HUNDRED.

(d) ON AND AFTER JULY 1, 1991, THE COMMISSIONER SHALL ENTER INTO PRESCRIPTION DRUG REBATE AGREEMENTS WITH INDIVIDUAL PHARMACEUTICAL MANUFACTURERS UNDER WHICH THE DEPARTMENT SHALL RECEIVE A REBATE FROM THE PHARMACEUTICAL MANUFACTURER EQUAL TO ELEVEN PER CENT OF THE MANUFACTURER'S WHOLESALE PRICE FOR EVERY PRESCRIPTION DRUG DISPENSED UNDER THE PROGRAM. EACH SUCH AGREEMENT SHALL PROVIDE THAT THE PHARMACEUTICAL MANUFACTURER SHALL MAKE QUARTERLY REBATE PAYMENTS TO THE DEPARTMENT EQUAL TO ELEVEN PER CENT OF THE MANUFACTURER'S WHOLESALE PRICE FOR THE TOTAL NUMBER OF DOSAGE UNITS OF EACH FORM AND STRENGTH OF A PRESCRIPTION DRUG WHICH THE DEPARTMENT REPORTS AS REIMBURSED TO PROVIDERS OF PRESCRIPTION DRUGS, PROVIDED SUCH PAYMENTS SHALL NOT BE DUE UNTIL THIRTY DAYS FOLLOWING THE MANUFACTURER'S RECEIPT OF UTILIZATION DATA FROM THE DEPARTMENT INCLUDING THE NUMBER OF DOSAGE UNITS REIMBURSED TO PROVIDERS OF PRESCRIPTION DRUGS DURING THE QUARTER FOR WHICH PAYMENT IS DUE.

(e) UPON RECEIPT OF SUCH DATA FROM THE DEPARTMENT, THE PHARMACEUTICAL MANUFACTURER SHALL CALCULATE THE QUARTERLY PAYMENT. THE DEPARTMENT MAY, AT ITS EXPENSE, HIRE A MUTUALLY AGREED UPON INDEPENDENT AUDITOR TO VERIFY THE CALCULATION AND PAYMENT. IN THE EVENT THAT A DISCREPANCY IS DISCOVERED BETWEEN THE PHARMACEUTICAL MANUFACTURER'S CALCULATION AND THE INDEPENDENT AUDITOR'S CALCULATION, THE PHARMACEUTICAL MANUFACTURER SHALL JUSTIFY ITS CALCULATIONS OR MAKE PAYMENT TO THE DEPARTMENT FOR ANY ADDITIONAL AMOUNT DUE. THE PHARMACEUTICAL MANUFACTURER MAY, AT ITS EXPENSE, HIRE A MUTUALLY AGREED UPON INDEPENDENT AUDITOR TO VERIFY THE ACCURACY OF THE UTILIZATION DATA PROVIDED BY THE DEPARTMENT. IN THE EVENT THAT A DISCREPANCY IS DISCOVERED, THE DEPARTMENT SHALL JUSTIFY ITS DATA OR REFUND ANY EXCESS PAYMENT TO THE PHARMACEUTICAL MANUFACTURER.

(f) ALL PRESCRIPTION DRUGS OF A PHARMACEUTICAL MANUFACTURER THAT ENTERS INTO AN AGREEMENT PURSUANT TO SUBSECTION (d) OF THIS SECTION SHALL BE IMMEDIATELY AVAILABLE AND THE COST OF SUCH DRUGS SHALL BE REIMBURSED AND NOT SUBJECT TO ANY RESTRICTIONS OR PRIOR AUTHORIZATION REQUIREMENTS. ANY PRESCRIPTION DRUG OF A MANUFACTURER THAT DOES NOT ENTER INTO SUCH AN AGREEMENT SHALL NOT BE REIMBURSABLE, UNLESS THE DEPARTMENT DETERMINES THE PRESCRIPTION DRUG IS ESSENTIAL TO PROGRAM PARTICIPANTS.

Sec. 47. Section 17a-343 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Eligibility for participation in the program shall be limited to any resident (1) who is sixty-five years of age or older or who is disabled, [and] (2) whose annual income, if

unmarried, is less than thirteen thousand [three] EIGHT hundred dollars, or whose annual income, if married, when combined with that of his spouse is less than sixteen thousand SIX HUNDRED dollars, AND (3) ON AND AFTER SEPTEMBER 15, 1991, WHO PAYS A FIFTEEN-DOLLAR REGISTRATION FEE TO THE DEPARTMENT ON AGING. On July 1, 1988, and annually thereafter, the commissioner may, by the adoption of regulations in accordance with chapter 54, increase the income limits established under this subsection over those of the previous fiscal year to reflect the annual inflation adjustment in Social Security income, if any. Each such adjustment shall be determined to the nearest one hundred dollars.

(b) Payment for a prescription under the program shall be made only if no other plan of insurance or assistance is available to an eligible person for such prescription at the time of dispensing. The pharmacy shall make reasonable efforts to ascertain the existence of other insurance or assistance.

Sec. 48. Section 17a-344 of the general statutes is repealed and the following is substituted in lieu thereof:

A pharmacist [may, in accordance with the provisions of subsection (a) of section 20-185b and section 20-185c and] SHALL, except as limited by subsection (b) of section 20-185b, substitute a therapeutically and chemically equivalent generic drug product for a prescribed drug product when filling a prescription for an eligible person under the program.

Sec. 49. Section 17a-345 of the general statutes is repealed and the following is substituted in lieu thereof:

The commissioner on aging shall adopt regulations, in accordance with the provisions of chapter 54, to establish (1) a system for determining eligibility and disqualification under the program, including provisions for an identification number and a renewable, nontransferable identification card; (2) requirements for the use of the identification number and card by the pharmacy and the eligible person; (3) a system of payments; (4) limitations on the maximum quantity per prescription which shall not exceed a thirty-day supply or one hundred twenty oral dosage units whichever is greater; (5) requirements as to records to be kept by the pharmacy, including patient profiles; [and] (6) products prescribed for cosmetic AND OTHER purposes which shall not be covered under the program; AND (7) SUCH OTHER PROVISIONS AS ARE NECESSARY TO IMPLEMENT THE PROVISIONS OF SECTIONS 45 TO 50, INCLUSIVE, OF THIS ACT.

Sec. 50. Section 17a-346 of the general

statutes, as amended by section 2 of public act 91-190, is repealed and the following is substituted in lieu thereof:

(a) The commissioner may enter into an agreement with a fiscal intermediary which may be an agency of the state, or a person, firm or public or nonprofit corporation, for the administration of the whole or any part of the program. Any such contract shall be subject to the provisions of sections 4a-57 and 4a-59, except that preference shall be given to persons, firms or corporations doing business in the state.

(b) The contract shall require the fiscal intermediary to submit quarterly reports to the commissioner on the operation of the program, including financial and utilization statistics as to drug use by therapeutic category, actuarial projections, an outline of problems encountered in the administration of the program and suggested solutions to the same and any recommendations to enhance the program.

(c) The commissioner shall verify the propriety and reasonableness of payments to providers [, including the generic incentive dispensing fee,] through field audit examinations and other reasonable means, to the extent possible within available appropriations. The commissioner shall submit an annual report, on or before February first of each year, to the secretary of the office of policy and management and the chairpersons of the joint standing committee of the general assembly having cognizance of matters relating to appropriations and the budgets of state agencies outlining the program for carrying out such verifications and including the results of such verifications.

(d) The commissioner shall submit quarterly reports, within thirty days after the end of each fiscal quarter, to the governor, the chairpersons of the joint standing committees of the general assembly having cognizance of matters relating to appropriations and the budgets of state agencies and public health. The report shall include a copy of the most recent report of the fiscal intermediary, if any, and (1) the number of consumers eligible for the program, (2) the number of consumers utilizing the program, (3) an outline of and a report on the educational outreach program, (4) the number of appeals, (5) an outline of problems encountered in the administration of the program and suggested solutions and any recommendations to enhance the program.

Sec. 51. The commissioner on aging shall report on prescription drug rebate agreements entered into under the ConnPACE program pursuant to section 45 of this act to the chairmen and ranking members of the joint standing committees

of the general assembly having cognizance of matters relating to human services and appropriations on or before January 1, 1993.

Sec. 52. (NEW) (a) The department on aging shall, within available appropriations, maintain a program for promotion of independent living for the elderly whereby community services are provided to persons who, without such services, would be unable to maintain themselves in their own homes.

(b) On and after September 15, 1991, eligibility for participation in the program shall be limited to any person sixty years of age or older who (1) if unmarried, has a gross income equal to or less than three hundred per cent of the maximum Supplemental Security Income benefit for an individual living independently, or (2) if married, has a gross income which when combined with that of his spouse is equal to or less than three hundred per cent of the maximum Supplemental Security Income benefit for a married couple living independently. A married person who maintains a residence separate from his spouse and who receives no support from the income of his spouse shall be treated as an unmarried person for the purpose of determining eligibility for the program.

(c) The commissioner on aging shall adopt regulations in accordance with the provisions of chapter 54 of the general statutes to carry out the purposes of this section and to establish a sliding fee scale for program participants. The commissioner may make direct payments to persons eligible to receive services under the program who have transferred to the program from the essential services program and who previously received such payments from the department of human resources.

Sec. 53. Subsection (a) of section 17-621 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The commissioner of human resources shall establish and administer a homefinders program, which includes participation by housing authorities, to assist families including recipients of aid to families with dependent children who are homeless or in imminent danger of eviction or foreclosure. THE COMMISSIONER SHALL ADMINISTER THE PROGRAM WITHIN AVAILABLE APPROPRIATIONS.

Sec. 54. Subsection (l) of section 1-79 of the general statutes is repealed and the following is substituted in lieu thereof:

(l) "Quasi-public agency" means the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Health and Education Facilities Authority, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority,

Connecticut Housing Authority, Connecticut Resources Recovery Authority [,] AND THE Connecticut Hazardous Waste Management Service. [and the New Haven Family Alliance.]

Sec. 55. Section 17a-3 of the general statutes is repealed and the following is substituted in lieu thereof:

The department shall plan, create, develop, operate or arrange for, administer and evaluate a comprehensive and integrated state-wide program of services, including preventive services, for children and youth whose behavior does not conform to the law or to acceptable community standards, or who are mentally ill, emotionally disturbed, delinquent, abused, neglected or uncared for, including all children and youth who are or may be committed to it by any court, and all children and youth voluntarily admitted to the department for services of any kind. Services shall not be denied to any such child or youth solely because of other complicating or multiple disabilities. The department shall work in cooperation with other child-serving agencies and organizations to provide or arrange for preventive programs, including but not limited to youth suicide prevention, for children and youth and their families. In furtherance of this purpose, the department shall: (a) Maintain Long Lane School and other appropriate facilities exclusively for delinquents; (b) develop a comprehensive program for prevention of problems of children and youth and provide a flexible, innovative and effective program for the placement, care and treatment of children and youth committed by any court to the department, transferred to the department by other departments, or voluntarily admitted to the department; (c) provide appropriate services to families of children and youth as needed to achieve the purposes of sections 17a-1 to 17a-26, inclusive, 17a-28 to 17a-49, inclusive, and 17a-51; (d) establish incentive paid work programs for children and youth under the care of the department, the rates to be paid such children and youth for work done in such programs and may provide allowances to children and youth in his custody; (e) be responsible to collect, interpret and publish statistics relating to children and youth within the department; (f) conduct studies of any program, service or facility developed, operated, contracted for or supported by the department in order to evaluate its effectiveness; (g) establish staff development and other training and educational programs designed to improve the quality of departmental services and programs and may establish educational or training programs for children, youth, parents or other interested persons on any matter related to the promotion of the well being of children, or the prevention of

mental illness, emotional disturbance, delinquency and other disabilities in children and youth; (h) develop and implement aftercare and follow-up services appropriate to the needs of any child or youth under his care; (i) PROVIDE OUTREACH AND ASSISTANCE TO PERSONS CARING FOR CHILDREN WHOSE PARENTS ARE UNABLE TO DO SO BY INFORMING SUCH PERSONS OF PROGRAMS AND BENEFITS FOR WHICH THEY MAY BE ELIGIBLE; (j) COLLECT DATA SUFFICIENT TO IDENTIFY THE HOUSING NEEDS OF CHILDREN SERVED BY THE DEPARTMENT AND SHARE SUCH DATA WITH THE DEPARTMENT OF HOUSING; (k) prepare and submit biennially to the general assembly a five-year master plan. The master plan shall include, but not be limited to: (1) The long range goals and the current level of attainment of such goals of the department; (2) a detailed description of the types and amounts of services presently provided to the department's clients; (3) a detailed forecast of the service needs of current and projected target populations; (4) detailed cost projections for alternate means of meeting projected needs; (5) funding priorities for each of the five years included in the plan and specific plans indicating how the funds are to be used; (6) a written plan for the prevention of child abuse and neglect; (7) a comprehensive mental health plan for children and adolescents, and (8) an overall assessment of the adequacy of children's services in Connecticut. The plan shall be prepared within existing funds appropriated to the department.

Sec. 56. Section 17-12o of the general statutes is repealed and the following is substituted in lieu thereof:

The department of income maintenance shall establish a program to provide, on and after April 1, 1989, a special need payment of fifty dollars per month, for shelter costs, under the aid to families with dependent children program [, the state program established under section 17-83o] and the general assistance program. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 to prescribe the eligibility criteria for participation in the program, the application process and the method of providing the special need payment. The regulations shall limit eligibility for the special need payment to applicants or recipients under such programs whose shelter costs are equal to or greater than fifty per cent of their income, and who are not residing in public housing or receiving a federal, state or local housing subsidy.

Sec. 57. Section 17-82m of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Except for cases requiring an

administrative hearing under subsection (c) of this section, if a beneficiary of public assistance under this chapter receives any award or grant [five hundred] TWO THOUSAND dollars or more over the amount to which he is entitled under the laws governing eligibility, the department of income maintenance shall immediately INITIATE ADMINISTRATIVE RECOUPMENT ACTION AND refer such overpayment to the division of state police within the department of public safety, with full supporting information, for investigation and determination as to whether such overpayment should be submitted to a prosecuting authority for prosecution, or to the attorney general for civil recovery, or referred back to the department of income maintenance for such other action as conforms to federal regulations, and the division of state police shall take such of said actions as the facts of the case warrant.

(b) Except for cases requiring an administrative hearing under subsection (c) of this section, if a beneficiary of assistance under this chapter receives any award or grant less than [five hundred] TWO THOUSAND dollars over the amount to which he is entitled under the laws governing eligibility, the commissioner of income maintenance, in his discretion, shall take such action as the facts of the case warrant including, but not limited to, submitting the case to a prosecuting authority, referring the case to the attorney general for civil recovery or initiating administrative recoupment efforts consistent with applicable federal law.

(c) The commissioner of income maintenance shall establish in accordance with federal law and regulations an administrative hearing process for cases involving alleged fraud in the food stamp program of less than one thousand dollars and cases involving alleged fraud in both the aid to families with dependent children program and the food stamp program totaling less than one thousand dollars.

Sec. 58. (NEW) The commissioner of public safety may appoint not more than two persons nominated by the commissioner of the department of human resources as special policemen in the bureau of child support enforcement of the department of human resources for the service of any warrant or capias mittimus issued by the courts on child support matters. Such appointees, having been sworn, shall serve at the pleasure of the commissioner of public safety and, during such tenure, shall have all the powers conferred on the state policemen, sheriffs and their deputies.

Sec. 59. Funds in the amount of two million dollars appropriated to the department of income maintenance in section 1 of public act 91-3 of the June, 1991 session, for medicaid, may be used by

the commissioner to make grant-in-aid to hospitals which request financial hardship relief resulting from providing outpatient clinic services to a disproportionate share of patients receiving assistance under chapter 302 of the general statutes. The commissioner shall have sole discretion in determining financial hardship, the number of such hospital outpatient clinics which will receive such grants, the basis upon which the grant-in-aid will be allocated, and the payment schedules for such grants, except that such grants may not be made to a hospital whose medicaid funded outpatient clinic visits are less than 40% of the hospital's total annual outpatient clinic visits.

Sec. 60. Notwithstanding the provisions of section 157 of public act 91-3 of the June, 1991 session, the effective dates of any increase or decrease in the rates or payments which are determined by the commissioner of income maintenance shall be as provided in sections 1 to 44, inclusive, of this act.

Sec. 61. Subsection (e) of section 17-314 of the general statutes is repealed and the following is substituted in lieu thereof:

(e) Except as provided in this subsection, the provisions of subsections (c) and (d) of this section shall not apply to any facility subject to the requirements of this section, which on October 1, 1981, (1) was accepting payments from the commissioner in accordance with the provisions of subsection (a), (2) was accepting medical assistance payments from another state for at least twenty per cent of its patients and (3) had not notified the commissioner of any intent to terminate its provider agreement, in accordance with section 17-134l, provided [, on and after May 22, 1984, any such facility shall not permit the number of beds available to medical assistance patients from this state to be less than the number of beds occupied by such patients during the period commencing on October 1, 1980, and ending on September 30, 1981, and provided further] no patient residing in any such facility on May 22, 1984, shall be removed from such facility for purposes of meeting the requirements of this subsection. If the commissioner finds that the number of beds available to medical assistance patients from this state in any such facility is less than [the number required by this subsection,] FIFTEEN PER CENT the provisions of subsections (c) and (d) shall apply to that number of beds which is less than [the required number] SAID PERCENTAGE.

Sec. 62. (a) Section 17-83o of the general statutes is repealed.

(b) Sections 17a-195 to 17a-201, inclusive, of the general statutes, are repealed.

(c) Section 49 of public act 91-3 of the June session is repealed.

Sec. 63. This act shall take effect from its passage, except sections 45 to 51, inclusive, shall take effect September 1, 1991; sections 24 to 26, inclusive, and sections 55, 56 and subsection (a) of section 62 shall take effect October 1, 1991; and section 54 and subsection (b) of section 62 shall take effect January 1, 1992.

Approved September 4, 1991