Agency Legislative Proposal – 2023 Session
Document Name:

Document Name	**2023 Agency Legislative Proposal Form_PSE Mandated Reporter Update 2023.docx**

Naming Format: AGENCY ACRONYM PROPOSAL NUMBER - TOPIC

Please insert a copy of the fully drafted bill at the end of this document (required for review)

Legislative Liaison	**David Seifel**
Division Requesting This Proposal	**Social Work Services**
Drafter	**Dorian Long**

Title of Proposal	**An Act Concerning Mandated Reporters**
Statutory Reference, if any	**17b-451**
Brief Summary and Statement of Purpose	**Add additional professionals to the mandated reporter list.**

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

Section is revised 17b-451to:

change clergyman to member of clergy to be gender neutral.

add a licensed professional counselor, dental hygienist, adult probation officer, adult parole officer, physician assistant, AND residential service coordinators and employees at housing authorities, municipal developments, and elderly housing projects.

BACKGROUND

Origin of Proposal **[X] New Proposal** **[ ] Resubmission**

If this is a resubmission, please share the prior bill number, the reason the bill did not move forward, and any changes made or conversations had since it was last proposed:

Please consider the following, if applicable:

Have there been changes in federal/state laws or regulations that make this legislation necessary?	**No**
Has this proposal or a similar proposal been implemented in other states? If yes, to what result?	**Included in the CT DCF mandated reporting laws are:** any person who is a licensed professional counselor, adult probation officer adult parole officer, dental hygienist, and physician assistant.
Have certain constituencies called for this proposal?	**Members of the housing services community have asked for clarity regarding their role. This proposal helps to ensure that older persons living in housing authorities, municipal developments, and elderly housing projects are protected.**

INTERAGENCY IMPACT
List each affected agency. Copy the table as needed.

[X] Check here if this proposal does NOT impact other agencies

1. Agency Name	
Agency Contact (name, title)	
Date Contacted	
Status	**[ ] Approved [ ] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT
Include the section number(s) responsible for the fiscal impact and the anticipated impact

[X] Check here if this proposal does NOT have a fiscal impact

State	
Municipal (Include any municipal mandate that can be found within legislation)	**Municipal funded housing programs are impacted as they may employ mandated reporters who work at some of these settings.**
Federal	**None**
Additional notes	**None**

MONITORING & EVALUATION PLAN
If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[ ] Check here if this proposal does NOT lead to any measurable outcomes

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Section 1. Subsection (a) of section 17b-451 the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2023):

For purposes of this subsection, "mandatory reporter" means any (1) physician or surgeon licensed under the provisions of chapter 370, (2) resident physician or intern in any hospital in this state, whether or not so licensed, (3) registered nurse, (4) nursing home administrator, nurse's aide or orderly in a nursing home facility or residential care home, (5) person paid for caring for a resident in a nursing home facility or residential care home, (6) staff person employed by a nursing home facility or residential care home, (7) residents' advocate, other than a representative of the Office of the Long-Term Care Ombudsman, as established under section 17a-405, including the State Ombudsman, (8) licensed practical nurse, medical examiner, dentist, optometrist, chiropractor, podiatrist, social worker, [clergyman] <u>member of the clergy</u>, police officer, pharmacist, psychologist or physical therapist, (9) person paid for caring for an elderly person by any institution, organization, agency or facility, including but not limited to, any employee of a community-based services provider, senior center, home care agency, homemaker and companion agency, adult day care center, village-model community and congregate housing facility, (10) person licensed or certified as an emergency medical services provider

pursuant to chapter 368d or 384d, including any such emergency medical services provider who is a member of a municipal fire department, [and] (11) driver of a paratransit vehicle, as defined in section 13b-38k, (12) any person who is a licensed professional counselor, (13) adult probation officer, (14) adult parole officer, (15) physician assistant, (16) dental hygienist and (17) residential service coordinators and employees at housing authorities, municipal developments, and elderly housing projects.

Document Name	**DSS – HUSKY A and B for Certain Non-Citizen Children**

Naming Format: AGENCY ACRONYM PROPOSAL NUMBER - TOPIC
Please insert a copy of the fully drafted bill at the end of this document (required for review)

Legislative Liaison	David Seifel 860-249-3286 David.Seifel@ct.gov
Division Requesting This Proposal	Program Oversight & Grant Administration (POGA), Medical Eligibility Unit
Drafter	Graham Shaffer, Pete Hadler, Kristin Dowty

Title of Proposal	An Act Concerning HUSKY A and B Coverage for Certain Non-Citizen Children
Statutory Reference, if any	Conn. Gen. Stat. §§ 17b-261(*l)* and 17b-292(a)
Brief Summary and Statement of Purpose	This legislative proposal clarifies that the third-party liability rules set forth in section 17b-265 of the Connecticut General Statutes apply when medical assistance is provided pursuant to the new HUSKY A and B coverage groups for non-citizen children established under Connecticut General Statutes sections 17b-261(*l*) and 17b-292(a). While the provisions of those statutes preclude someone who qualifies for affordable, employer-sponsored insurance, as defined by the Affordable Care Act, from qualifying for new state-funded coverage, in practice, the Department has no way to verify that an applicant does not qualify for such insurance beyond self-attestation. Therefore, while it is unlikely that a non-citizen who otherwise qualifies for this new coverage will have such employer-sponsored insurance, extending the third-party liability rules set forth in section 17b-265 will enable the Department to recover the cost of any medical assistance paid under this coverage group where it is later discovered that employer-sponsored insurance

	was in place. Doing so will also clarify that the Department may recover from other liable third parties, such as tortfeasors.

SECTION-BY-SECTION SUMMARY
Summarize sections in groups where appropriate

BACKGROUND

Origin of Proposal **[x] New Proposal** **[ ] Resubmission**

If this is a resubmission, please share the prior bill number, the reason the bill did not move forward, and any changes made or conversations had since it was last proposed:

Please consider the following, if applicable:

Have there been changes in federal/state laws or regulations that make this legislation necessary?	**No**
Has this proposal or a similar proposal been implemented in other states? If	**No**

yes, to what result?	
Have certain constituencies called for this proposal?	**No**

INTERAGENCY IMPACT
List each affected agency. Copy the table as needed.

[ ] Check here if this proposal does NOT impact other agencies

1. Agency Name	
Agency Contact (name, title)	
Date Contacted	
Status	**[ ] Approved [ ] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT
Include the section number(s) responsible for the fiscal impact and the anticipated impact

[ ] Check here if this proposal does NOT have a fiscal impact

State	
Municipal (Include any municipal mandate that can be found within legislation)	

Federal	
Additional notes	There will likely be a savings associated with this proposal.

MONITORING & EVALUATION PLAN
If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[ ] Check here if this proposal does NOT lead to any measurable outcomes

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Section 1. Section 17b-261(*l*) of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

(*l*) On and after January 1, 2023, the Commissioner of Social Services shall, within available appropriations, provide state-funded medical assistance to any child twelve years of age and younger, regardless of immigration status, (1) whose household income does not exceed two hundred one per cent of the federal poverty level without an asset limit, and (2) who does not otherwise qualify for Medicaid, the Children's Health Insurance Program, or an offer of affordable, employer-sponsored insurance, as defined in the Affordable Care Act, as an employee or a dependent of an employee. A child eligible for such assistance under this

subsection shall continue to receive such assistance until such child is nineteen years of age, provided the child continues to meet the eligibility requirements prescribed in subdivisions (1) and (2) of this subsection. The provisions of section 17b-265 shall apply with respect to any medical assistance provided pursuant to this subsection.

Sec. 2. Section 17b-292(a) of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

(a) A child who resides in a household with household income that exceeds one hundred ninety-six per cent of the federal poverty level but does not exceed three hundred eighteen per cent of the federal poverty level may be eligible for benefits under HUSKY B. Not later than January 1, 2023, the Commissioner of Social Services shall, within available appropriations, provide state-funded medical assistance to any child twelve years of age and younger, regardless of immigration status, (1) with a household income that exceeds two hundred one per cent of the federal poverty level but does not exceed three hundred twenty-three per cent of the federal poverty level, and (2) who does not otherwise qualify for Medicaid, the Children's Health Insurance Program, or an offer of affordable, employer-sponsored insurance, as defined in the Affordable Care Act, as an employee or a dependent of an employee. A child eligible for such assistance under this subsection shall continue to receive such assistance until such child is nineteen years of age, provided the child continues to meet the eligibility requirements prescribed in subdivisions (1) and (2) of this subsection. The provisions of section 17b-265 shall apply with respect to any medical assistance provided pursuant to this subsection.

Document Name	DSS Various Revisions

Naming Format: AGENCY ACRONYM PROPOSAL NUMBER - TOPIC
Please insert a copy of the fully drafted bill at the end of this document (required for review)

Legislative Liaison	David Seifel 860-249-3286 David.Seifel@ct.gov
Division Requesting This Proposal	DHS; OLCRAH; Reimbursement and CON;
Drafter	David Seifel Nicole Godburn; Melanie Dillon; Graham Shaffer

Title of Proposal	An Act Concerning Various Revisions to the Department of Social Services Statutes
Statutory Reference, if any	Section 1: 17b-8 (b) (repeal report) Section 2: 17b-306a (repeal report) Sec. 3 and 4: 17b-265 and 17b-265g (federally required tech revision) Section 5: 17b-807 (repeal emergency housing statute) Section 6 and 7: 17b-550 to 17b-554 (ConnMap; repeal) 12-746 (e) (removes reference to ConnMAP statute) Section 8: 16a-41a (CEAP vendor payment timeline) Section 9: New section (alternative payment methodologies)
Brief Summary and Statement of Purpose	The bill is meant to repeal obsolete DSS statutes and make technical revisions where needed.

SECTION-BY-SECTION SUMMARY
Summarize sections in groups where appropriate

Section 1: General Statutes § 17b-8 (b): Subsection (b) requires DSS to submit annual reports of potential Medicaid waivers and amendments that may result in a cost savings for the state. The commissioner shall also notify the committees of the possibility of any Medicaid waiver application or proposed amendment to the Medicaid state plan that the commissioner is considering in developing a budget for the next fiscal year before the commissioner submits such budget for legislative approval. A process already exists for the submission of cost savings ideas through the formal budget option submission process which occurs in early October or so each year. Finally, with the legislative requirement that any and all waivers go through the legislature's extensive review process, this provision is again very duplicative of their ability to review and reject any cost savings proposal.

Section 2: General Statutes Section 17b-306a: The statute mandates the Department, in collaboration with the Department of Public Health and the Department of Children and Families, to establish a child health quality improvement program to improve the delivery of and access to children's health services and report to the legislature on its findings. The statute was written during a period of time when the Department used a managed care approach, with multiple managed care companies operating at the same time and far fewer public reports available. At this time, we have one ASO for each of our core healthcare services: physical, behavioral health and dental. In addition, those three ASOs provide a significant amount of data to the public on a regular basis. As such, this statute is no longer relevant and should be repealed.

Section 3 and 4: General Statutes Sections 17b-265 and 17b-265g: 42 U.S.C. § 1396a(a)(25)(I) requires a state participating in Medicaid to ensure that its laws include certain provisions about the obligations of a third party doing business in the state when a claim for reimbursement for services and items paid for by Medicaid is received by such third party. Section 202 of the Consolidated Appropriations Act of 2022, Public Law 117-103, adds two new requirements of this nature that are not currently codified in Connecticut law. Specifically, section 202 requires that states enact laws providing that:

(1) With respect to items or services for which such third party (other than Medicare, a Medicare Advantage plan, or a Medicare Part D plan) requires prior authorization, the third party shall accept the state Medicaid agency's authorization that the item or service is covered under the Medicaid state plan (or a waiver of such plan) "as if such authorization were the prior authorization made by the third party for such item or service."

(2) That the third party must respond to a state Medicaid agency's inquiry about a claim for reimbursement within sixty days (current Connecticut law requires a response within ninety days).

This proposal incorporates these requirements into Connecticut General Statutes §§ 17b-265 and 17b-265g, the statutes dealing with Medicaid third-party liability claims and the duties owed to the Commissioner of Social Services by a health insurer doing business in Connecticut.

Federal law requires states to enact these state-law changes by January 1, 2024.

Section 5: CGS 17b-807 provides "No state funds appropriated for a special needs benefit for emergency housing for recipients of payments under the temporary family assistance program or state-administered general assistance shall be used to pay the costs of emergency shelter in hotels or motels except in cases of natural or man-made disasters or other catastrophic events."

DSS does not believe we are limiting (or are able to limit) the use of hotels and motels as a source of emergency housing to situations where the individual or family needs the housing due to a natural or man-made disaster. The statute precludes DSS from placing individuals or families in need of emergency housing in a hotel or motel unless the need for the emergency housing was caused by a natural or man-made disaster, but in reality we

cannot so limit our placements. Families in need of emergency housing due to events like evictions or lead abatement are sometimes located in areas where the only option is to utilize a hotel or motel, and this is what we do in practice if necessary.

Section 6 and 7: CGS 17b-550 to 17b-554. These statutes establish ConnMAP, a program intended to limit amounts providers can charge for certain items, but which we believe to be effectively defunct due to other protections that have been enacted since the time ConnMAP was first envisioned. Repeal and remove cross references to statute (CGS 12-746(e)).

Section 8: CGS 16a-41a. The revision will ensure that a fuel vendor for CEAP who completes deliveries will be paid by the CAA not later than 10 business days after the CAA receives an authorized invoice. It had previously been a 30 day time period.

Section 9: New section. This allows DSS to implement alternative payment programs using policy and procedure pending regulation finalization.

BACKGROUND

Origin of Proposal **[X] New Proposal** **[ ] Resubmission**

If this is a resubmission, please share the prior bill number, the reason the bill did not move forward, and any changes made or conversations had since it was last proposed:

Please consider the following, if applicable:

Have there been changes in federal/state laws or regulations that make this legislation necessary?	*Yes, with regard to Sections 3 and 4*
Has this proposal or a similar proposal been implemented in other states? If	No

yes, to what result?	
Have certain constituencies called for this proposal?	*With regard to Section 8, CEMA requested several changes to CEAP. DSS obliged to incorporate this change to increase efficiencies for the fuel vendors.*

INTERAGENCY IMPACT
List each affected agency. Copy the table as needed.

[ ] Check here if this proposal does NOT impact other agencies

Agency Name	DCF, DPH (re Sec. 2: 17b-306a)
Agency Contact (name, title)	Vin Russo, Miriam Miller, Adam Skowera
Date Contacted	8/31/2022
Status	**[X] Approved [ ] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT
Include the section number(s) responsible for the fiscal impact and the anticipated impact

[ ] Check here if this proposal does NOT have a fiscal impact

State	With regard to Sections 3 and 4, there will likely be fewer disputes with health insurers to whom claims for reimbursement are submitted, which will result in some degree of savings for the State of Connecticut.
Municipal (Include any municipal mandate that can be found within legislation)	None

Federal	With regard to Sections 3 and 4, there will likely be fewer disputes with health insurers to whom claims for reimbursement are submitted, which will result in some degree of savings for the State of Connecticut.
Additional notes	

MONITORING & EVALUATION PLAN
If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[X] Check here if this proposal does NOT lead to any measurable outcomes

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

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

Section 1. Subsection (b) of section 17b-8 of the general statutes is repealed (*Effective Upon Passage*):

Sec. 2. Section 17b-306a of the general statutes is repealed in its entirety. (*Effective Upon Passage*):

Sec. 3. Section 17b-265 of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) In accordance with 42 USC 1396k, the Department of Social Services shall be subrogated to any right of recovery or indemnification that an applicant or recipient of medical assistance or any legally liable relative of such applicant or recipient has against an insurer or other legally liable third party including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, for the cost of all health care items or services furnished to the applicant or recipient, including, but not limited to, hospitalization, pharmaceutical services, physician services, nursing services, behavioral health services, long-term care services and other medical services, not to exceed the amount expended by the department for such care and treatment of the applicant or recipient. In the case of such a recipient who is an enrollee in a care management organization under a Medicaid care management contract with the state or a legally liable relative of such an enrollee, the department shall be subrogated to any right of recovery or indemnification which the enrollee or legally liable relative has against such a private insurer or other third party for the medical costs incurred by the care management organization on behalf of an enrollee. Whenever funds owed to a person are collected pursuant to this section and the person who otherwise would have been entitled to such funds is subject to a court-ordered current or arrearage child support payment obligation in an IV-D support case, such funds shall first be paid to the state for reimbursement of Medicaid funds paid on behalf of such person for medical expenses incurred for injuries related to a legal claim by such person that was the subject of the state's right of subrogation, and remaining funds, if any, shall then be paid to the Office of Child Support Services for distribution pursuant to the federally mandated child support distribution system implemented pursuant to subsection (j) of section 17b-179. Any additional claim of the state to the remainder of such funds, if any, shall be paid in accordance with state law.

(b) An applicant or recipient or legally liable relative, by the act of the applicant's or recipient's 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. Any entitlements from a contractual agreement with an applicant or recipient, legally liable relative or a state or federal program 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 Social Services 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. In accordance with subsection (b) of section 38a-472, a provider that has received an assignment from the department shall notify the recipient's health insurer or other

legally liable third party including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, of the assignment upon rendition of services to the applicant or recipient. Failure to so notify the health insurer or other legally liable third party 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 legally liable relative or representative of such applicant or recipient for billing information. This subsection shall not be construed to affect the right of an applicant or recipient to maintain an independent cause of action against such third party tortfeasor.

(c) Claims for recovery or indemnification submitted by the department, or the department's designee, shall not be denied solely on the basis of the date of the submission of the claim, the type or format of the claim, the lack of prior authorization or the failure to present proper documentation at the point-of-service that is the basis of the claim, if (1) the claim is submitted by the state within the three-year period beginning on the date on which the item or service was furnished; and (2) any action by the state to enforce its rights with respect to such claim is commenced within six years of the state's submission of the claim.

(d) (1) A party to whom a claim for recovery or indemnification is submitted for an item or item or service furnished under the Medicaid state plan, or a waiver of such plan, who requires prior authorization for such item or service shall accept authorization provided by the Department of Social Services that the item or service is covered under such plan or waiver as if such authorization were the prior authorization made by such party for the item or service.

(2) The provisions of subdivision (1) of this subsection shall not apply with respect to a claim for recovery or indemnification submitted to Medicare, a Medicare Advantage plan, or a Medicare Part D plan.

[(d)**]** (e) 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 Social Services. The commissioner shall limit reimbursement to medical assistance providers 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.

[(e)**]** (f) No self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care plan, or any plan offered or administered by a health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, shall contain any

provision that has the effect of denying or limiting enrollment benefits or excluding coverage because services are rendered to an insured or beneficiary who is eligible for or who received medical assistance under this chapter. No insurer, as defined in section 38a-497a, shall impose requirements on the state Medicaid agency, which has been assigned the rights of an individual eligible for Medicaid and covered for health benefits from an insurer, that differ from requirements applicable to an agent or assignee of another individual so covered.

[(f)**]** (g) The Commissioner of Social Services 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.

[(g)**]** (h) An insurer or other legally liable third party, upon receipt of a claim submitted by the department or the department's designee, in accordance with the requirements of subsection (c) of this section, for payment of a health care item or service covered under a state medical assistance program administered by the department, shall, not later than **[**ninety**]** sixty days after receipt of the claim or not later than **[**ninety**]** sixty days after the effective date of this section, whichever is later, (1) make payment on the claim, (2) request information necessary to determine its legal obligation to pay the claim, or (3) issue a written reason for denial of the claim. Failure to pay, request information necessary to determine legal obligation to pay or issue a written reason for denial of a claim not later than one hundred twenty days after receipt of the claim, or not later than one hundred twenty days after the effective date of this section, whichever is later, creates an uncontestable obligation to pay the claim. The provisions of this subsection shall apply to all claims, including claims submitted by the department or the department's designee prior to July 1, 2021.

[(h)**]** (i) On and after July 1, 2021, an insurer or other legally liable third party who has reimbursed the department for a health care item or service paid for and covered under a state medical assistance program administered by the department shall, upon determining it is not liable and at risk for cost of the health care item or service, request any refund from the department not later than twelve months from the date of its reimbursement to the department.

Sec. 4: Section 17b-265g of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*)

Any health insurer, including a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, and which may or may not be financially at risk for the cost of a health care item or service, shall, as a condition of doing business in the state, be required to: **[**(1)**]** (a) Provide, with respect to an individual who is eligible for, or is provided, medical assistance under the Medicaid state plan, to all third-party administrators, pharmacy benefit

managers, dental benefit managers or other entities with which the health insurer has a contract or arrangement to adjudicate claims for a health care item or service, and to the Commissioner of Social Services, or the commissioner's designee, any and all information in a manner and format prescribed by the commissioner, or commissioner's designee, necessary to determine when the individual, his or her spouse or the individual's dependents may be or have been covered by a health insurer and the nature of the coverage that is or was provided by such health insurer including the name, address and identifying number of the plan; **[**(2)**]** (b) accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the health insurer for an item or service for which payment has been made under the Medicaid state plan; **[**(3)**]** (c) respond within sixty days to any inquiry by the commissioner, or the commissioner's designee, regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the item or service; and **[**(4)**]** (d) agree (1) to accept authorization provided by the Department of Social Services that an item or service is covered under the Medicaid state plan, or a waiver of such plan, as if such authorization were the prior authorization made by said health insurer for such item or service, and (2) not to deny a claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if (A) the claim is submitted by the state or its agent within the three-year period beginning on the date on which the item or service was furnished; and (B) any legal action by the state to enforce its rights with respect to such claim is commenced within six years of the state's submission of such claim.

Sec. 5. Section 17b-807 of the Connecticut General Statutes is repealed. (*Effective Upon Passage*)

Sec. 6: Sections 17b-550 through Section 17b-554 of the general statutes are repealed (*Effective Upon Passage*):

Sec. 7: Subsection (e) of Section 12-746 of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective Upon Passage*)

Amounts rebated pursuant to this section shall not be considered income for purposes of sections 8-119l, 8-345, 12-170d, 12-170aa, [17b-550,] 47-88d and 47-287.

Sec. 8: Section 16a-41a of the Connecticut General Statutes is repealed and the following is substitute in lieu thereof (*Effective July 1, 2023*)

(a) The Commissioner of Social Services shall submit to the joint standing committees of the General Assembly having cognizance of energy planning and activities, appropriations, and human services the following on the implementation of the block grant program authorized under the Low-Income Home Energy Assistance Act of 1981, as amended:

(1) Not later than August first, annually, a Connecticut energy assistance program annual plan which establishes guidelines for the use of funds authorized under the Low-Income Home Energy Assistance Act of 1981, as amended, and includes the following:

(A) Criteria for determining which households are to receive emergency and weatherization assistance;

(B) A description of systems used to ensure referrals to other energy assistance programs and the taking of simultaneous applications, as required under section 16a-41;

(C) A description of outreach efforts;

(D) Estimates of the total number of households eligible for assistance under the program and the number of households in which one or more elderly or physically disabled individuals eligible for assistance reside;

(E) Design of a basic grant for eligible households that does not discriminate against such households based on the type of energy used for heating; and

(F) A payment plan for fuel deliveries beginning November 1, 2018, that ensures a vendor of deliverable fuel who completes deliveries authorized by a community action agency that contracts with the commissioner to administer a fuel assistance program is paid by the community action agency not later than [thirty] ten business days after the date the community action agency receives an authorized fuel slip or invoice for payment from the vendor;

(b) The Commissioner of Social Services shall implement a program to purchase deliverable fuel for low-income households participating in the Connecticut energy assistance program and the state-appropriated fuel assistance program. The commissioner shall ensure that no fuel vendor discriminates against fuel assistance program recipients who are under the vendor's standard payment, delivery, service or other similar plans. The commissioner may take advantage of programs offered by fuel vendors that reduce the cost of the fuel purchased, including, but not limited to, fixed price, capped price, prepurchase or summer-fill programs that reduce program cost and that make the maximum use of program revenues. As funding allows, the commissioner shall ensure that all agencies administering the fuel assistance program shall make payments to program fuel vendors in advance of the delivery of energy where vendor provided price-management strategies require payments in advance.

(c) Each community action agency administering a fuel assistance program shall submit reports, as requested by the Commissioner of Social Services, concerning pricing information from vendors of deliverable fuel participating in the program. Such information shall include, but not be limited to, the state-wide or regional retail price per unit of deliverable fuel, the reduced price per unit paid by the state for the deliverable fuel in utilizing price management strategies offered by program vendors for all consumers, the number of units delivered to the state under the program and the total savings under the program due to the purchase of deliverable fuel utilizing price-management strategies offered by program vendors for all consumers.

(d) If funding allows, the Commissioner of Social Services, in consultation with the Secretary of the Office of Policy and Management, shall require that, each community action agency administering a fuel assistance program begin accepting applications for the program not later than September first of each year.

(e) Not later than November 1, 2018, the Commissioner of Social Services shall require each community action agency administering a fuel assistance program to make payment to a vendor of deliverable fuel not later than **[**thirty**]** ten business days after the community action agency receives an authorized fuel slip or invoice for payment from the vendor.

(f) The Commissioner of Social Services shall submit each plan or report described in subsection (a) of this section to the Low-Income Energy Advisory Board, established pursuant to section 16a-41b, not later than seven days prior to submitting such plan or report to the joint standing committee of the General Assembly having cognizance of matters relating to energy and technology, appropriations and human services.

Sec. 9: (NEW) (*Effective July 1, 2023*)

To the extent permissible under federal law and within available appropriations, as the single state Medicaid agency designated under sections 17b-2 and 17b-260 of the Connecticut General Statutes, the Commissioner of Social Services may implement a bundled payment for maternity services and any other alternative payment methodology or combination of methodologies that the commissioner determines are designed to improve health quality, equity, member experience, cost containment and coordination of care. The commissioner may implement policies and procedures to the extent that regulations may be required to carry out any of the provisions of this section while in the process of adopting such policies and procedures as regulations, provided the commissioner publishes notice of intent to adopt regulations on the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Agency Legislative Proposal – 2023 Session
Document Name:

Document Name	**Nursing Home Excess Beds and Non-Patient Care Proposal**

Naming Format: AGENCY ACRONYM PROPOSAL NUMBER - TOPIC

Please insert a copy of the fully drafted bill at the end of this document (required for review)

Legislative Liaison	**David Seifel**
Division Requesting This Proposal	**Division of Health Services**
Drafter	

Title of Proposal	**An Act Concerning Excess Nursing Home Beds and Payment for Nonpatient Care in Nursing Homes**
Statutory Reference, if any	**NA**
Brief Summary and Statement of Purpose	This proposal seeks to pay less for unoccupied beds in facilities that are below a minimum occupancy percentage of 90% for those beds that have been empty for longer than 12 months. The intent is to incentivize facilities to delicense out of service (unoccupied) beds if empty for longer than 12 months for facilities with lower occupancy. If the home does not delicense, then they will receive a lower rate for the empty bed. The 12-month period will correspond to the same period as the cost report annual filing (i.e., 10/1 to 9/30). The reduction in reimbursement will be in the form of a reduction in a facility's administrative and general (A&G) cost reimbursement. This proposal also limits the portion of the Medicaid payment that supports spend on owner salaries, management company fees, or other nonpatient care by changing the current payment model to a price-based one whereby the A&G reimbursement would be set at the median of the peer grouping.

SECTION-BY-SECTION SUMMARY
Summarize sections in groups where appropriate

Low-occupancy homes spend a higher percentage of their dollars on "non-patient care" in part because they have fewer residents to amortize fixed costs. Per Medicaid reimbursement principles, Medicaid programs cannot pay for idle capacity or space not used for resident care. (To satisfy this federal requirement, DSS applies a 90% minimum occupancy standard.) This proposal intends to incentivize homes to delicense unused space / empty beds by paying less for beds that are not occupied.

Today, we pay nursing homes based on their own costs thus giving them little incentive to innovate and lower costs, especially those related to non-patient care. This proposal would limit the portion of the Medicaid payment that supports spend on owner salaries, management company fees, or other nonpatient care by changing the current payment model to a price-based one whereby the administrative and general (A&G) reimbursement would be set at the median of the peer grouping. Current management fees, which represent a portion of the A&G cost reimbursement, range from $0 (zero) to $22.63 and averaged $6.21 in 2021.

Peer grouping to be determined based on bed size and location. A floor and a ceiling would be established based on peer groupings after a period of stakeholder engagement with the licensing agency (DPH) and the industry.

BACKGROUND

Origin of Proposal **[X] New Proposal** **[ ] Resubmission**

If this is a resubmission, please share the prior bill number, the reason the bill did not move forward, and any changes made or conversations had since it was last proposed:

Please consider the following, if applicable:

Have there been changes in federal/state laws or regulations that make this	**No**

legislation necessary?	
Has this proposal or a similar proposal been implemented in other states? If yes, to what result?	**Yes, Massachusetts adjusts the capital portion of the rate for beds out of service. For beds out of service, the capital payment is set at the lower of the historic capital payment rate or the most recent capital payment rate.** **California limits indirect care non-labor costs to the 75th percentile of each facility's respective peer-group.**
Have certain constituencies called for this proposal?	

INTERAGENCY IMPACT
List each affected agency. Copy the table as needed.

[ ] Check here if this proposal does NOT impact other agencies

1. Agency Name	
Agency Contact (name, title)	
Date Contacted	
Status	**[ ] Approved [ ] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT
Include the section number(s) responsible for the fiscal impact and the anticipated impact

[ ] Check here if this proposal does NOT have a fiscal impact

State	Assumes minimal savings in the last quarter of FY 25 but full impact is unknown. Statewide census is increasing and rebalancing efforts have decreased the number of unoccupied beds. Potential savings from the A&G reduction for homes with low census would decrease as more beds become occupied or delicensed. Establishing A&G reimbursement based on median peer groupings could result in a fiscal impact, but full evaluation is needed before that fiscal impact can be known. Any potential savings would be realized in FY 25 and future years.
Municipal (Include any municipal mandate that can be found within legislation)	
Federal	
Additional notes	

MONITORING & EVALUATION PLAN
If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[ ] Check here if this proposal does NOT lead to any measurable outcomes

Monthly monitoring of statewide census data to track if policy is leading to a decrease/delicensure of empty beds. Geographic regions would be monitored as well to ensure access for residents and that decreases align with statewide rebalancing efforts. Monitor annual cost report filings and make future recommendations on A&G price rebase frequency to account for inflation and market adjustments.

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Section 1. Section 17b-340d is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

(a) The Commissioner of Social Services shall implement an acuity-based methodology for Medicaid reimbursement of nursing home services effective July 1, 2022. Notwithstanding section 17b-340, for the fiscal year ending June 30, 2023, and annually thereafter, the Commissioner of Social Services shall establish Medicaid rates paid to nursing home facilities based on cost years ending on September thirtieth in accordance with the following:
(1) Case-mix adjustments to the direct care component, which will be based on Minimum Data Set resident assessment data as well as cost data reported for the cost year ending September 30, 2019, shall be made effective beginning July 1, 2022, and updated every quarter thereafter. After modeling such case-mix adjustments, the Commissioner of Social Services shall evaluate impact on a facility by facility basis and, not later than October 1, 2021, (A) make recommendations to the Secretary of the Office of Policy and Management, and (B) submit a report on the recommendations, in accordance with the provisions of section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services on any adjustments needed to facilitate the transition to the new methodology on July 1, 2022. This evaluation may include a review of inflationary allowances, case mix and budget adjustment factors and stop loss and stop gain corridors and the ability to make such adjustments within available appropriations.
(2) Beginning July 1, 2022, facilities will be required to comply with collection and reporting of quality metrics as specified by the Department of Social Services, after consultation with the nursing home industry, consumers, employees and the Department of Public Health. Rate adjustments based on performance on quality metrics will be phased in, beginning July 1, 2022, with a period of reporting only.
(3) Geographic peer groupings of facilities shall be established by the Department of Social Services pursuant to regulations adopted in accordance with subsection (b) of this section.
(4) Allowable costs shall be divided into the following five cost components:
(A) Direct costs, which shall include salaries for nursing personnel, related fringe benefits and costs for nursing personnel supplied by a temporary nursing services agency;
(B) 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;
(C) fair rent, which shall be defined in regulations adopted in accordance with subsection (b) of this section;
(D) capital-related costs, which shall include property taxes, insurance expenses, equipment leases and equipment depreciation; and

(E) administrative and general costs, which shall include maintenance and operation of plant expenses, salaries for administrative and maintenance personnel and related fringe benefits. For (i) direct costs, the maximum cost shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; (ii) indirect costs, the maximum cost shall be equal to one hundred fifteen per cent of the state-wide median allowable cost; (iii) fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 17b-353; (iv) capital-related costs, there shall be no maximum; and (v) administrative and general costs, the maximum shall be equal to the state-wide median allowable cost. For purposes of this subdivision, "temporary nursing services agency" and "nursing personnel" have the same meaning as provided in section 1 of this act.
(5) For the fiscal year ending June 30, 2022, the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2020, that are not otherwise included in the rates issued.
(6) There shall be no increase to rates based on inflation or any inflationary factor for the fiscal years ending June 30, 2022, and June 30, 2023, unless otherwise authorized under subdivision (1) of this subsection.
(7) For purposes of computing minimum allowable patient days, utilization of a facility's certified beds shall be determined at a minimum of ninety per cent of capacity, except for facilities that have undergone a change in ownership, new facilities, and facilities which are certified for additional beds which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure.
(8) Rates determined under this section shall comply with federal laws and regulations.

(b) On and after April 1, 2025, administrative and general-related costs shall be adjusted for nursing homes with a percentage of occupied licensed beds below the minimum occupancy percentage of ninety percent for those beds that remain unoccupied for greater than 12 months. The 12-month period shall be the period of October 1 to September 30 annually. If the facility does not delicense unoccupied beds or does not increase occupancy percentages to greater than ninety percent, then the facility's reimbursement for administrative and general-related costs shall be reduced to ninety percent of the median of the cost maximums for the administrative and general component.

(c) On and after July 1, 2024, the Department of Social Services shall establish peer group medians and prices for nursing home facilities by using data from the nursing home facilities' most recently filed annual cost reports. Peer groups shall be based on the bed capacity and location of the nursing home facility. The department shall classify the nursing home facilities into mutually exclusive peer groups to establish a price-based component for the administrative and general component of reimbursement and pay based on the median of the peer group spending. The department will consult with stakeholders including the Department of Public Health regarding the establishment of peer groupings to ensure geographic access and available capacity. Nursing home facilities that meet the definition of licensure as a specialized long-term care facility or units with specialized rates, such as ventilator or AIDS units, shall be classified into mutually exclusive peer group classifications. Once nursing home facilities have been classified into peer groups, nursing home facility costs shall remain in that peer group until such prices are rebased. The department shall use the bed complement of the nursing home facility on the final day of the reporting period of the most recent audited cost report filing. A peer group with fewer than five nursing home facilities shall be collapsed into the adjacent peer group with the same bed size. If the peer group with fewer than five nursing home facilities is a peer group and there is a

choice of two peer groups with which to merge, the peer group with fewer than five nursing home facilities shall be collapsed into the peer group with the larger population. The department shall limit the total amount for administrative and general costs for nursing home facilities owned by the same owner and within the same peer group to the median of the total administrative and general costs of all nursing home facilities not owned by the same owner. Peer group medians and prices established pursuant to this section shall be budget neutral.

[(c)] (d) The Commissioner of Social Services may implement policies as necessary to carry out the provisions of this section while in the process of adopting the policies as regulations, provided that prior to implementation the policies are posted (1) on the eRegulations System established pursuant to section 4-173b , and (2) the Department of Social Services' Internet web site.

Agency Legislative Proposal – 2023 Session
Document Name:

Document Name	Reimbursement and Certificate of Need proposal

Naming Format: AGENCY ACRONYM PROPOSAL NUMBER - TOPIC
Please insert a copy of the fully drafted bill at the end of this document (required for review)

Legislative Liaison	David Seifel 860-249-3286 David.Seifel@ct.gov
Division Requesting This Proposal	Reimbursement & CON, Division of Health Services
Drafter	Nicole Godburn, Krista Pender, Paula Pfistner & Melanie Dillon

Title of Proposal	An Act Concerning Medicaid Reimbursement to Community Living Arrangements (CLA), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Residential Care Homes and Nursing Facilities
Statutory Reference, if any	Sections 1 and 2: 17b-244 and 17b-340 (g) (inflation language update) Section 3: 17b-340i (inflation language update) Sections 4 and 5: 17b-340d and 17b-340 (f) (technical revision) Section 230 of Public Act 22-118 (repeal)
Brief Summary and Statement of Purpose	Sections 1: Update to include definition for "change of ownership" and "provider". Section 2 and 3: Inflation language update. Sections 4 and 5: DSS identified the need to make a technical revision to CGS 17b-340. Also provides rebasing NF rates no more frequently than every 2 years and no less frequently than every 4 years. Inflation language update.

SECTION-BY-SECTION SUMMARY
Summarize sections in groups where appropriate

Section 1 of the proposal defines the following terms: "change in ownership", and "provider" as those terms are used in §§ 17b-244 and 17b-340 (g). Allow for fair rent increases within available appropriations.

Section 2 and 3 of the proposal Updating inflation language.

Sections 4 and 5: DSS identified a reference to subsection (f) in 17b-340 (a) that needs to be changed to 17b-340d (a)(3) and language from subsection (f) of section 17b-340 that should have been moved to 17b-340d as those sections are still necessary for setting nursing facility reimbursement rates. The proposed language replaces the reference to subsection (f)(2) of 17b-340 with a referenced to 17b-340d (a)(3) and adds the relevant language from 17b-340 (f) to subsection (a) of section 17b-340d. The proposed language in subsection (a) (9) provides for rebasing NF rates no more frequently than every two years and no less frequently than every four years, as determined by the commissioner.

BACKGROUND

Origin of Proposal **[X] New Proposal** **[ ] Resubmission**

If this is a resubmission, please share the prior bill number, the reason the bill did not move forward, and any changes made or conversations had since it was last proposed:

Please consider the following, if applicable:

Have there been changes in federal/state laws or regulations that make this legislation necessary?	No
Has this proposal or a similar proposal been	No. Inflation factors are handled differently in every state. This is only a technical language update.

implemented in other states? If yes, to what result?	
Have certain constituencies called for this proposal?	*With regard to the technical revision of 17b-340d & 17b-340 (f), Yes. The nursing home associations raised the question with the Department directly. The nursing home associations also raised the question with CMS during the state plan amendment public comment period.*

INTERAGENCY IMPACT

[ ] Check here if this proposal does NOT impact other agencies

1. Agency Name	
Agency Contact (name, title)	
Date Contacted	
Status	**[ ] Approved [ ] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT
Include the section number(s) responsible for the fiscal impact and the anticipated impact

[ ] Check here if this proposal does NOT have a fiscal impact

State	
Municipal (Include any municipal mandate that can be found within legislation)	

Federal	
Additional notes	

MONITORING & EVALUATION PLAN
If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[ ] Check here if this proposal does NOT lead to any measurable outcomes

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Section 1: Section 17b-244 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

(a) As used in this section and section 17b-340(g):

(1) "Change in ownership" means a sale to a new provider, a transfer of ownership from the existing provider to another provider, or any other transaction by which a community living arrangement or intermediate care facility for individuals with intellectual disabilities is divested from a provider;

(2) "Provider" means the owner and operator of a community living arrangement or intermediate

care facility for individuals with intellectual disabilities.

[(a)] (b) 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 individuals with intellectual disabilities, shall be determined annually by the Commissioner of Social Services, except that rates effective April 30, 1989, shall remain in effect through October 31, 1989. Any facility with real property other than land placed in service prior to July 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding July 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request by such facility, allow actual debt service, comprised of principal and interest, on the loan or loans in lieu of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, whether actual debt service is higher or lower than such allowed property costs, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. In the case of facilities financed through the Connecticut Housing Finance Authority, the commissioner shall allow actual debt service, comprised of principal, interest and a reasonable repair and replacement reserve on the loan or loans in lieu of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, whether actual debt service is higher or lower than such allowed property costs, provided such debt service terms and amounts are determined by the commissioner at the time the loan is entered into to be reasonable in relation to the useful life and base value of the property. The commissioner may allow fees associated with mortgage refinancing provided such refinancing will result in state reimbursement savings, after comparing costs over the terms of the existing proposed loans. 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. For fiscal year ending June 30, 1993, the inflation factor used to determine rates shall be two-thirds of the gross national product percentage increase from the midpoint of the cost year to the midpoint of the rate year. For the fiscal years ending June 30, 1996, and June 30, 1997, no inflation factor shall be applied in determining rates. The Commissioner of Social Services 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. Any increase in grants, gifts, fund-raising or endowment income used for the payment of operating costs by a private facility in the fiscal year ending June 30, 1992, shall be excluded by the commissioner from the income of the facility in determining the rates to be paid to the facility for the fiscal year ending June 30, 1993, provided any operating costs funded by such increase shall not obligate the state to increase expenditures in subsequent fiscal years. 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 individuals with intellectual disabilities, shall be determined annually by the Commissioner of Developmental Services in accordance with section 17b-244a. For the fiscal year ending June 30, 2008, no facility shall receive a rate that is more than two per cent greater than the rate in effect for the facility on June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, no facility shall receive a rate that is more than two per cent greater than the rate in effect for the facility on June 30, 2008, except any facility that would have been issued a lower rate effective July 1, 2008, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2008. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except that (1) the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2009, if a capital improvement required by the Commissioner of Developmental Services for the health or safety of the residents was made to the facility during the fiscal years ending June 30, 2010, or June 30, 2011, and (2) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except that (A) the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2011, if a capital improvement required by the Commissioner of Developmental Services for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2012, and (B) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the department, shall be issued such lower rate. Any facility that has a significant decrease in land and building costs shall receive a reduced rate to reflect such decrease in land and building costs. The rate paid to a facility may be increased if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2014, or June 30, 2015, only to the extent such increases are within available appropriations. For the fiscal years ending June 30, 2016, and June 30, 2017, rates shall not exceed those in effect for the period ending June 30, 2015, except the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2015, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2016, or June 30, 2017, to the extent such rate increases are within available appropriations. For the fiscal years ending June 30, 2016, and June 30, 2017, and each succeeding fiscal year, any facility that would have been issued a lower rate, due to interim rate status, a change in allowable fair rent or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2018, and June 30, 2019, rates shall not exceed those in effect for the period ending June 30, 2017, except the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2017, if a capital improvement approved by the Department of

Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2018, or June 30, 2019, to the extent such rate increases are within available appropriations. For the fiscal years ending June 30, 2020, and June 30, 2021, rates shall not exceed those in effect for the fiscal year ending June 30, 2019, except the rate paid to a facility may be higher than the rate paid to the facility for the fiscal year ending June 30, 2019, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2020, or June 30, 2021, to the extent such rate increases are within available appropriations. For the fiscal years ending June 30, 2022, and June 30, 2023, rates shall be based upon rates in effect for the fiscal year ending June 30, 2021, inflated by the gross domestic product deflator applicable to each rate year, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report years ending September 30, 2020, and September 30, 2021, that are not otherwise included in rates issued, or if a rate adjustment for a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2022, or June 30, 2023.

[(b)] (c) Notwithstanding the provisions of subsection (a) of this section, state rates of payment for the fiscal years ending June 30, 2018, June 30, 2019, June 30, 2020, and June 30, 2021, for residential care homes and community living arrangements that receive the flat rate for residential services under section 17-311-54 of the regulations of Connecticut state agencies shall be set in accordance with section 298 of public act 19-117. For the fiscal years ending June 30, 2022, and June 30, 2023, rates shall be based upon rates in effect for the fiscal year ending June 30, 2021, inflated by the gross domestic product deflator applicable to each rate year.

(d) For the fiscal year ending June 30, 2024 and each subsequent fiscal year, the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report years that are not otherwise included in rates issued.

[(c)] (e) The Commissioner of Social Services and the Commissioner of Developmental Services shall adopt regulations in accordance with the provisions of chapter 54[1] to implement the provisions of this section.

Section 2: Subsection (h) of section 17b-340 of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

(h) (1) For the fiscal year ending June 30, 1993, any intermediate care facility for individuals with intellectual disabilities with an operating cost component of its rate in excess of one hundred forty per cent of the median of operating cost components of rates in effect January 1,

1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any intermediate care facility for individuals with intellectual disabilities with an operating cost component of its rate that is less than one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to thirty per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred forty per cent of the median of operating cost components in effect January 1, 1992. Any facility with real property other than land placed in service prior to October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding October 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request, allow actual debt service, comprised of principal and interest, in excess of property costs allowed pursuant to section 17-311-52 of the regulations of Connecticut state agencies, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. For the fiscal year ending June 30, 1995, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, no rate shall exceed three hundred seventy-five dollars per day unless the commissioner, in consultation with the Commissioner of Developmental Services, determines after a review of program and management costs, that a rate in excess of this amount is necessary for care and treatment of facility residents. For the fiscal year ending June 30, 2002, rate period, the Commissioner of Social Services shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2000 costs to include a three and one-half per cent inflation factor. For the fiscal year ending June 30, 2003, rate period, the commissioner shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2001 costs to include a one and one-half per cent inflation factor, except that such increase shall be effective November 1, 2002, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until October 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate updated effective November 1, 2002, in accordance with applicable statutes and regulations. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year

ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until September 30, 2004. Effective October 1, 2004, each facility shall receive a rate that is five per cent greater than the rate in effect September 30, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is four per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (1) The federal financial participation matching funds associated with the rate increase are no longer available; or (2) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than three per cent greater than the rate in effect for the facility on September 30, 2006, except any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal year ending June 30, 2008, each facility shall receive a rate that is two and nine-tenths per cent greater than the rate in effect for the period ending June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, than for the rate period ending June 30, 2007, due to interim rate status, or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2009, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2014, and June 30, 2015, rates shall not exceed those in effect for the period ending June 30, 2013, except the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2013, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2014, or June 30, 2015, to the extent such rate increases are within available appropriations. Any facility that would have

been issued a lower rate for the fiscal year ending June 30, 2014, or the fiscal year ending June 30, 2015, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2016, and June 30, 2017, rates shall not exceed those in effect for the period ending June 30, 2015, except the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2015, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2016, or June 30, 2017, to the extent such rate increases are within available appropriations. For the fiscal years ending June 30, 2016, and June 30, 2017, and each succeeding fiscal year, any facility that would have been issued a lower rate, due to interim rate status, a change in allowable fair rent or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2018, and June 30, 2019, rates shall not exceed those in effect for the period ending June 30, 2017, except the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2017, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2018, or June 30, 2019, only to the extent such rate increases are within available appropriations. For the fiscal years ending June 30, 2020, and June 30, 2021, rates shall not exceed those in effect for the fiscal year ending June 30, 2019, except the rate paid to a facility may be higher than the rate paid to the facility for the fiscal year ending June 30, 2019, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2020, or June 30, 2021, only to the extent such rate increases are within available appropriations. For the fiscal year ending June 30, 2022, rates shall not exceed those in effect for the fiscal year ending June 30, 2021, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities that have documented fair rent additions placed in service in the cost report year ending September 30, 2020, that are not otherwise included in rates issued. For the fiscal year ending June 30, 2023, rates shall not exceed those in effect for the fiscal year ending June 30, 2022, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2021, that are not otherwise included in rates issued. For the fiscal years ending June 30, 2022, and June 30, 2023, a facility may receive a rate increase for a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents during the fiscal year ending June 30, 2022, or June 30, 2023, only to the extent such rate increases are within available appropriations. Any facility that has a significant decrease in land and building costs shall receive a reduced rate to reflect such decrease in land and building costs. For the fiscal years ending June 30, 2012, June 30, 2013, June 30, 2014, June 30, 2015, June 30, 2016, June 30, 2017, June 30, 2018, June 30, 2019, June 30, 2020, June 30, 2021, June 30, 2022, and June 30, 2023, the Commissioner of Social Services may provide fair rent increases to any facility that has undergone a material change in

circumstances related to fair rent and has an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. Notwithstanding the provisions of this section, the Commissioner of Social Services may, within available appropriations, increase or decrease rates issued to intermediate care facilities for individuals with intellectual disabilities to reflect a reduction in available appropriations as provided in subsection (a) of this section. For the fiscal years ending June 30, 2014, and June 30, 2015, the commissioner shall not consider rebasing in determining rates. Notwithstanding the provisions of this subsection, effective July 1, 2021, and July 1, 2022, the commissioner shall, within available appropriations, increase rates for the purpose of wage and benefit enhancements for employees of intermediate care facilities. Facilities that receive a rate adjustment for the purpose of wage and benefit enhancements but do not provide increases in employee salaries as described in this subsection on or before July 31, 2021, and July 31, 2022, respectively, may be subject to a rate decrease in the same amount as the adjustment by the commissioner. There shall be no increase to rates based on inflation or any inflationary factor for the fiscal years ending June 30, 2022, and June 30, 2023. Notwithstanding any other statute or regulation, any subsequent increase to rates based on inflation as authorized for any succeeding fiscal year shall be adjusted as determined by the commissioner. The rate of inflation shall be computed based on the percentage increase, if any, in the most recent calendar year average in the gross domestic product deflator over the average for the previous calendar year. Any increase to rates based on inflation shall be applied prior to the application of any other budget adjustment factors that may impact said rates.

(2) The Commissioner of Social Services shall determine whether and to what extent a change in ownership of a facility shall occasion the rebasing of the facility's costs. There shall be no inflation adjustment during a year in which a facility's rates are rebased. For the fiscal year ending June 30, 2024, and each subsequent fiscal year, the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report years that are not otherwise included in rates issued.

Section 3: Subsection (i) of section 17b-340 of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

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

less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Beginning with the fiscal year ending June 30, 1997, a residential care home with allowable fair rent less than three dollars and ten cents per day shall be reimbursed as having allowable fair rent equal to three dollars and ten cents per day. Property additions placed in service during the cost year ending September 30, 1996, or any succeeding cost year shall receive a fair rent allowance for such additions as an addition to three dollars and ten cents per day if the fair rent for the facility for property placed in service prior to September 30, 1995, is less than or equal to three dollars and ten cents per day. Beginning with the fiscal year ending June 30, 2016, a residential care home shall be reimbursed the greater of the allowable accumulated fair rent reimbursement associated with real property additions and land as calculated on a per day basis or three dollars and ten cents per day if the allowable reimbursement associated with real property additions and land is less than three dollars and ten cents per day. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. Beginning with the fiscal year ending June 30, 1997, minimum allowable patient days for rate computation purposes for a residential care home with twenty-five beds or less shall be eighty-five per cent of licensed capacity. Beginning with the fiscal year ending June 30, 2002, for the purposes of determining the allowable salary of an administrator of a residential care home with sixty beds or less the department shall revise the allowable base salary to thirty-seven thousand dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies. The rates for the fiscal year ending June 30, 2002, shall be based upon the increased allowable salary of an administrator, regardless of whether such amount was expended in the 2000 cost report period upon which the rates are based. Beginning with the fiscal year ending June 30, 2000, and until the fiscal year ending June 30, 2009, inclusive, the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall be increased by two per cent, and beginning with the fiscal year ending June 30, 2002, the inflation adjustment for rates made in accordance with subsection (c) of said section shall be increased by one per cent. Beginning with the fiscal year ending June 30, 1999, for the purpose of determining the allowable salary of a related party, the department shall revise the maximum salary to twenty-seven thousand eight hundred fifty-six dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies and beginning with the fiscal year ending June 30, 2001, such allowable salary shall be computed on an hourly basis and the maximum number of hours allowed for a related party other than the proprietor shall be increased from forty hours to forty-eight hours per work week. For the fiscal year ending June 30, 2005, each facility shall receive a rate that is two and one-quarter per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective upon receipt of all the

necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is determined in accordance with applicable law and subject to appropriations, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (1) The federal financial participation matching funds associated with the rate increase are no longer available; or (2) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than four per cent greater than the rate in effect for the facility on September 30, 2006, except for any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate, except (A) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (B) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except that (i) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (ii) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2013, the Commissioner of Social Services may, within available appropriations, provide a rate increase to a residential care home. Any facility that would have been issued a lower rate for the fiscal year ending June 30, 2013, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, the Commissioner of Social Services may provide fair rent increases to any facility that has undergone a material change in circumstances related to fair rent and has an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. For the fiscal years ending June 30, 2014, and June 30, 2015, for those facilities that have a calculated rate greater than the rate in effect for the fiscal year ending June 30, 2013, the commissioner may increase facility rates based upon available appropriations up to a stop gain

as determined by the commissioner. No facility shall be issued a rate that is lower than the rate in effect on June 30, 2013, except that any facility that would have been issued a lower rate for the fiscal year ending June 30, 2014, or the fiscal year ending June 30, 2015, due to interim rate status or agreement with the commissioner, shall be issued such lower rate. For the fiscal year ending June 30, 2014, and each fiscal year thereafter, a residential care home shall receive a rate increase for any capital improvement made during the fiscal year for the health and safety of residents and approved by the Department of Social Services, provided such rate increase is within available appropriations. For the fiscal year ending June 30, 2015, and each succeeding fiscal year thereafter, costs of less than ten thousand dollars that are incurred by a facility and are associated with any land, building or nonmovable equipment repair or improvement that are reported in the cost year used to establish the facility's rate shall not be capitalized for a period of more than five years for rate-setting purposes. For the fiscal year ending June 30, 2015, subject to available appropriations, the commissioner may, at the commissioner's discretion: Increase the inflation cost limitation under subsection (c) of section 17-311-52 of the regulations of Connecticut state agencies, provided such inflation allowance factor does not exceed a maximum of five per cent; establish a minimum rate of return applied to real property of five per cent inclusive of assets placed in service during cost year 2013; waive the standard rate of return under subsection (f) of section 17-311-52 of the regulations of Connecticut state agencies for ownership changes or health and safety improvements that exceed one hundred thousand dollars and that are required under a consent order from the Department of Public Health; and waive the rate of return adjustment under subsection (f) of section 17-311-52 of the regulations of Connecticut state agencies to avoid financial hardship. For the fiscal years ending June 30, 2016, and June 30, 2017, rates shall not exceed those in effect for the period ending June 30, 2015, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in cost report years ending September 30, 2014, and September 30, 2015, that are not otherwise included in rates issued. For the fiscal years ending June 30, 2016, and June 30, 2017, and each succeeding fiscal year, any facility that would have been issued a lower rate, due to interim rate status, a change in allowable fair rent or agreement with the department, shall be issued such lower rate. For the fiscal year ending June 30, 2018, rates shall not exceed those in effect for the period ending June 30, 2017, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2016, that are not otherwise included in rates issued. For the fiscal year ending June 30, 2019, rates shall not exceed those in effect for the period ending June 30, 2018, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2017, that are not otherwise included in rates issued. For the fiscal year ending June 30, 2020, rates shall not exceed those in effect for the fiscal year ending June 30, 2019, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2018, that are not otherwise included in rates issued. For the

fiscal year ending June 30, 2021, rates shall not exceed those in effect for the fiscal year ending June 30, 2020, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2019, that are not otherwise included in rates issued. For the fiscal year ending June 30, 2022, the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities that have documented fair rent additions placed in service in the cost report year ending September 30, 2020, that are not otherwise included in rates issued. For the fiscal year ending June 30, 2023, the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2021, that are not otherwise included in rates issued. For the fiscal years ending June 30, 2022, and June 30, 2023, a facility may receive a rate increase for a capital improvement approved by the Department of Social Services, for the health or safety of the residents during the fiscal year ending June 30, 2022, or June 30, 2023, only to the extent such rate increases are within available appropriations. For the fiscal year ending June 30, 2022, and June 30, 2023, rates shall be based upon rates in effect for the fiscal year ending June 30, 2021, inflated by the gross domestic product deflator applicable to each rate year, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report years ending September 30, 2020, and September 30, 2021, that are not otherwise included in rates issued. Notwithstanding any other statute or regulation, any subsequent increase to rates based on inflation as authorized for any succeeding fiscal year shall be adjusted as determined by the commissioner. The rate of inflation shall be computed based on the percentage increase, if any, in the most recent calendar year average in the gross domestic product deflator over the average for the previous calendar year. Any increase to rates based on inflation shall be applied prior to the application of any other budget adjustment factors that may impact said rates. 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. There shall be no inflation adjustment during a year in which a facility's rates are rebased.

Section 4: Subsection (a) of section 17b-340 is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

(a) For purposes of this subsection, (1) a "related party" includes, but is not limited to, any company related to a chronic and convalescent nursing home through family association, common ownership, control or business association with any of the owners, operators or officials of such nursing home; (2) "company" means any person, partnership, association, holding company, limited liability company or corporation; (3) "family association" means a relationship by birth, marriage or domestic partnership; and (4) "profit and loss statement" means the most recent annual statement on profits and losses finalized by a related party before the annual report mandated under this subsection. The rates to be paid by or for persons aided or cared for by the state or any town in this state to licensed chronic and convalescent nursing homes, to

chronic disease hospitals associated with chronic and convalescent nursing homes, to rest homes with nursing supervision, to licensed residential care homes, as defined by section 19a-490, and to residential facilities for persons with intellectual disability that are licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as intermediate care facilities for individuals with intellectual disabilities, 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 by the Commissioner of Social Services, to be effective July first of each year except as otherwise provided in this subsection. Such rates shall be determined on a basis of a reasonable payment for such necessary services, which basis shall take into account as a factor the costs of such services. Cost of such services shall include reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons employed as managers or chief administrators or required to be licensed as nursing home administrators, and compensation for services rendered by proprietors at prevailing wage rates, as determined by application of principles of accounting as prescribed by said commissioner. Cost of such services shall not include amounts paid by the facilities to employees as salary, or to attorneys or consultants as fees, where the responsibility of the employees, attorneys, or consultants is to persuade or seek to persuade the other employees of the facility to support or oppose unionization. Nothing in this subsection shall prohibit inclusion of amounts paid for legal counsel related to the negotiation of collective bargaining agreements, the settlement of grievances or normal administration of labor relations. The commissioner may, in the commissioner's discretion, allow the inclusion of extraordinary and unanticipated costs of providing services that were incurred to avoid an immediate negative impact on the health and safety of patients. The commissioner may, in the commissioner's discretion, based upon review of a facility's costs, direct care staff to patient ratio and any other related information, revise a facility's rate for any increases or decreases to total licensed capacity of more than ten beds or changes to its number of licensed rest home with nursing supervision beds and chronic and convalescent nursing home beds. The commissioner may, in the commissioner's discretion, revise the rate of a facility that is closing. An interim rate issued for the period during which a facility is closing shall be based on a review of facility costs, the expected duration of the close-down period, the anticipated impact on Medicaid costs, available appropriations and the relationship of the rate requested by the facility to the average Medicaid rate for a close-down period. The commissioner may so revise a facility's rate established for the fiscal year ending June 30, 1993, and thereafter for any bed increases, decreases or changes in licensure effective after October 1, 1989. Effective July 1, 1991, in facilities that 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 September thirtieth. Such report shall be submitted to the commissioner by February fifteenth. Each for-profit chronic and convalescent nursing home that receives state funding pursuant to this section shall include in such annual report a profit and loss statement from each related party that receives from such chronic and convalescent nursing home fifty thousand dollars or more per year for goods, fees and services. No cause of action or liability shall

arise against the state, the Department of Social Services, any state official or agent for failure to take action based on the information required to be reported under this subsection. The commissioner may reduce the rate in effect for a facility that fails to submit a complete and accurate report on or before February fifteenth by an amount not to exceed ten per cent of such rate. If a licensed residential care home fails to submit a complete and accurate report, the department shall notify such home of the failure and the home shall have thirty days from the date the notice was issued to submit a complete and accurate report. If a licensed residential care home fails to submit a complete and accurate report not later than thirty days after the date of notice, such home may not receive a retroactive rate increase, in the commissioner's discretion. The commissioner shall, annually, on or before April first, report the data contained in the reports of such facilities on the department's Internet web site. 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 personnel supplied by a temporary nursing services agency by separating said cost into two categories, the portion of the cost equal to the salary of the employee for whom the nursing personnel supplied by a temporary nursing services agency 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 costs of a facility for nursing personnel supplied by a temporary nursing services agency in 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 such 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 the commissioner deems reasonable, including anticipated fluctuations in the cost of providing such services. The commissioner may establish a separate rate for a facility or a portion of a facility for traumatic brain injury patients who require extensive care but not acute general hospital care. Such separate rate shall reflect the special care requirements of such patients. If changes in federal or state laws, regulations or standards adopted subsequent to June 30, 1985, result in increased costs or expenditures in an amount exceeding one-half of one per cent of allowable costs for the most recent cost reporting year, the commissioner shall adjust rates and provide payment for any such increased reasonable costs or expenditures within a reasonable period of time retroactive to the date of enforcement. Nothing in this section shall be construed to require the Department of Social Services to adjust rates and provide payment for any increases in costs resulting from an inspection of a facility by the Department of Public Health. Such assistance as the commissioner requires from other state agencies or departments in determining rates shall be made available to the commissioner at the commissioner's request. Payment of the rates established pursuant to this section shall be conditioned on the establishment by such facilities of admissions procedures that 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 the beneficiary is not entitled and shall be punishable in the same manner as is provided in subsection (b) of section 17b-97. Notwithstanding any provision of this section, the Commissioner of Social Services may, within available appropriations, provide an interim rate increase for a licensed chronic and convalescent nursing home or a rest home with nursing supervision for rate periods no earlier than April 1, 2004, only if the commissioner determines that the increase is necessary to avoid the filing of a petition for relief under Title 11 of the United States Code;[1] imposition of receivership pursuant to sections 19a-542 and 19a-543; or substantial deterioration of the facility's financial condition that may be expected to adversely affect resident care and the continued operation of the facility, and the commissioner determines that the continued operation of the facility is in the best interest of the state. The commissioner shall consider any requests for interim rate increases on file with the department from March 30, 2004, and those submitted subsequently for rate periods no earlier than April 1, 2004. When reviewing an interim rate increase request the commissioner shall, at a minimum, consider: (A) Existing chronic and convalescent nursing home or rest home with nursing supervision utilization in the area and projected bed need; (B) physical plant long-term viability and the ability of the owner or purchaser to implement any necessary property improvements; (C) licensure and certification compliance history; (D) reasonableness of actual and projected expenses; and (E) the ability of the facility to meet wage and benefit costs. No interim rate shall be increased pursuant to this subsection in excess of one hundred fifteen per cent of the median rate for the facility's peer grouping, established pursuant to subdivision [(2) of subsection (f) of this section] subsection (3) of section 17b-340d of the Connecticut General Statutes, unless recommended by the commissioner and approved by the Secretary of the Office of Policy and Management after consultation with the commissioner. Such median rates shall be published by the Department of Social Services not later than April first of each year. In the event that a facility granted an interim rate increase pursuant to this section is sold or otherwise conveyed for value to an unrelated entity less than five years after the effective date of such rate increase, the rate increase shall be deemed rescinded and the department shall recover an amount equal to the difference between payments made for all affected rate periods and payments that would have been made if the interim rate increase was not granted. The commissioner may seek recovery of such payments from any facility with common ownership. With the approval of the Secretary of the Office of Policy and Management, the commissioner may waive recovery and rescission of the interim rate for good cause shown that is not inconsistent with this section, including, but not limited to, transfers to family members that were made for no value. The commissioner shall provide written quarterly reports to the joint standing committees of the General Assembly having cognizance of matters relating to aging, human services and appropriations and the budgets of state agencies, that identify each facility requesting an interim rate increase, the amount of the requested rate increase for each facility, the action taken by the commissioner and the secretary pursuant to this subsection, and estimates of the additional cost to the state for each approved interim rate increase. Nothing in this subsection shall prohibit the commissioner from increasing the rate of a licensed chronic and convalescent nursing home or a rest home with nursing supervision for allowable costs associated with facility capital improvements or increasing the rate in case of a sale of a licensed chronic and convalescent nursing home or a rest home with

nursing supervision if receivership has been imposed on such home. For purposes of this section, "temporary nursing services agency" and "nursing personnel" have the same meaning as provided in section 1 of public act 22-57.

Section 5: Subsection (a) of section 17b-340d is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

(a) The Commissioner of Social Services shall implement an acuity-based methodology for Medicaid reimbursement of nursing home services effective July 1, 2022. Notwithstanding section 17b-340, for the fiscal year ending June 30, 2023, and annually thereafter, the Commissioner of Social Services shall establish Medicaid rates paid to nursing home facilities based on cost years ending on September thirtieth in accordance with the following:

(1) Case-mix adjustments to the direct care component, which will be based on Minimum Data Set resident assessment data as well as cost data reported for the cost year ending September 30, 2019, shall be made effective beginning July 1, 2022, and updated every quarter thereafter. After modeling such case-mix adjustments, the Commissioner of Social Services shall evaluate impact on a facility by facility basis and, not later than October 1, 2021, (A) make recommendations to the Secretary of the Office of Policy and Management, and (B) submit a report on the recommendations, in accordance with the provisions of section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services on any adjustments needed to facilitate the transition to the new methodology on July 1, 2022. This evaluation may include a review of inflationary allowances, case mix and budget adjustment factors and stop loss and stop gain corridors and the ability to make such adjustments within available appropriations.
(2) Beginning July 1, 2022, facilities will be required to comply with collection and reporting of quality metrics as specified by the Department of Social Services, after consultation with the nursing home industry, consumers, employees and the Department of Public Health. Rate adjustments based on performance on quality metrics will be phased in, beginning July 1, 2022, with a period of reporting only.

(3) Geographic peer groupings of facilities shall be established by the Department of Social Services pursuant to regulations adopted in accordance with subsection (b) of this section.

(4) Allowable costs shall be divided into the following five cost components: (A) Direct costs, which shall include salaries for nursing personnel, related fringe benefits and costs for nursing personnel supplied by a temporary nursing services agency; (B) 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; (C) fair rent, which shall be defined in regulations adopted in accordance with subsection (b) of this section; (D) capital-related costs, which shall include property taxes, insurance expenses, equipment leases and equipment depreciation; and (E) administrative and general costs, which shall include maintenance and operation of plant expenses, salaries for administrative and maintenance

personnel and related fringe benefits. For (i) direct costs, the maximum cost shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; (ii) indirect costs, the maximum cost shall be equal to one hundred fifteen per cent of the state-wide median allowable cost; (iii) fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 17b-353; (iv) capital-related costs, there shall be no maximum; and (v) administrative and general costs, the maximum shall be equal to the state-wide median allowable cost. For purposes of this subdivision, "temporary nursing services agency" and "nursing personnel" have the same meaning as provided in section 1 of public act 22-57.

(5) Costs in excess of the maximum amounts established under this subsection shall not be recognized as allowable costs, except that the commissioner may establish rates whereby allowable costs may exceed such maximum amounts for beds, which are restricted to use by patients with acquired immune deficiency syndrome, traumatic brain injury or other specialized services.

[(5)] (6) [For the fiscal year ending] On or after June 30, 2022, the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the most recently filed cost report [year ending September 30, 2020,] that are not otherwise included in the rates issued.

(7) 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. Any facility with a rate of return on real property other than land in excess of eleven per cent shall have such allowance revised to eleven per cent. Any facility or its related realty affiliate which finances or refinances debt through bonds issued by the State of Connecticut Health and Education Facilities Authority shall report the terms and conditions of such financing or refinancing to the Commissioner of Social Services within thirty days of completing such financing or refinancing. The commissioner may revise the facility's fair rent component of its rate to reflect any financial benefit the facility or its related realty affiliate received as a result of such financing or refinancing. The commissioner shall determine allowable fair rent for real property other than land based on the rate of return for the cost year in which such bonds were issued. The financial benefit resulting from a facility financing or refinancing debt through such bonds shall be shared between the state and the facility to an extent determined by the commissioner on a case-by-case basis and shall be reflected in an adjustment to the facility's allowable fair rent.

(8) A facility shall receive cost efficiency adjustments for indirect costs and for administrative and general costs if such costs are below the statewide median costs. The cost efficiency adjustments shall equal twenty-five per cent of the difference between allowable reported costs and the applicable median allowable cost established pursuant to this subdivision.

(9) On and after July 1, 2025, costs shall be rebased no more frequently than every two years and no less frequently than every four years, as determined by the commissioner. There shall be no inflation adjustment during a year in which a facility's rates are rebased. 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.

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

[(6)] (11) There shall be no increase to rates based on inflation or any inflationary factor for the fiscal years ending June 30, 2022, and June 30, 2023, unless otherwise authorized under subdivision (1) of this subsection. Notwithstanding any other statute or regulation, any subsequent increase to rates based on inflation as authorized for any succeeding fiscal year shall be adjusted as determined by the commissioner. The rate of inflation shall be computed based on the percentage increase, if any, in the most recent calendar year average in the gross domestic product deflator over the average for the previous calendar year. Any increase to rates based on inflation shall be applied prior to the application of any other budget adjustment factors that may impact said rates.

[(7)] (12) For purposes of computing minimum allowable patient days, utilization of a facility's certified beds shall be determined at a minimum of ninety per cent of capacity, except for facilities that have undergone a change in ownership, new facilities, and facilities which are certified for additional beds which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure.

[(8)] (13) Rates determined under this section shall comply with federal laws and regulations.