Document Name	**DSS - Various Revisions**

Legislative Liaison	David Seifel 860-249-3286 David.Seifel@ct.gov Matthew Festa Matthew.Festa@ct.gov Jalmar De Dios 860-424-5308 Jalmar.dedios@ct.gov
Division Requesting This Proposal	**OLCRAH**
Drafter	**Graham Shaffer, OLCRAH**

Title of Proposal	**An Act Concerning Various Revisions to the Department of Social Services Statutes**
Statutory Reference, if any	Sec. 1: CGS 52-362d(d) Sec. 2: CGS 46b-215e(a) Sec. 3: 19a-697 Sec. 4: PA 24-82 Sec. 5: 17b-244 Sec. 6: 17a-247b(c)
Brief Summary and	Section 1: Update statute to allow DSS to develop a child support enforcement system that supports administrative enforcement in interstate cases (AEI)

Statement of Purpose	Sec. 2: Update statute to conform with Federal Law related to modification of child support orders Sec. 3 requires ALSAs to post PSE contact info in their facility Sec. 4 repeals an annual reporting requirement for staggering SNAP benefits Sec. 5: GDP Deflator Sec. 6: Access to DDS Abuse and Neglect Registry

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

Section 1: DSS is currently working to replace its outdated child support enforcement computer system. Once complete, our federal counterparts will need to test our new system and certify that it meets all requirements of federal law. The Department's existing system does not meet certain requirements concerning automated administrative enforcement in interstate cases, or AEI. Federal law requires a IV-D agency to assist another state with certain asset seizures based on overdue support, even if the underlying support order is not registered in the state to whom the request is made. The problem is that existing law in CT requires an out-of-state support order to be registered in CT before the DSS Office of Child Support Services (OCSS) and SES can take such enforcement action. As OCSS needs to develop a child support enforcement system that supports this AEI process, this legislative change will remove a hurdle to doing so by allowing OCSS and Support Enforcement Services (SES) to provide AEI supports to other states even where the underlying support order is not registered in CT.

Section 2: The Department's federal partners have notified the agency that we are out of conformity with federal law regarding modification of child support orders. As our federal partners have explained all child support orders must be based on the obligor's current ability to pay. Accordingly, federal law does not allow states to treat incarceration as voluntary unemployment. Thus, an incarcerated individual should not be limited from a downward modification of a child support order if they have no current ability to pay the order due to their incarceration. While DSS does have a

process in place to facilitate downward modifications of existing child support orders due to incarceration, currently, Connecticut law provides: "Downward modification of an existing support order based solely on a loss of income due to incarceration or institutionalization *shall not* be granted in the case of a child support obligor who is incarcerated or institutionalized for an offense against the custodial party or the child subject to such support order." Our federal partners have notified the agency that this exception for individuals incarcerated for an offense against the custodial party or child is not permitted and that we must amend state law to remove the exception in order to come into compliance with federal law. As such, DSS is requesting the below change in state law to conform with federal law.

Sec. 3: Currently, ALSAs are required to post in their facility the patient bill of rights. DSS believes that as a part of that posting, they should also be required to post the contact information for the Department's Protective Services for the Elderly division.

Sec. 4: Legislation passed in 2024 requires DSS to stagger SNAP benefits beginning in March, 2026. As part of that statute, DSS is required to submit an annual report regarding the staggering of benefits, beginning in April 2026. Once DSS implements the staggering of benefits, there will be minimal information to report. As such, DSS suggests repealing the 'annual' requirement and reporting just one time immediately after the staggering is implemented.

Sec. 5: Amends 17b-244 rate adjustments for an increase to allowable operating costs based on the Gross Domestic Product (GDP) Deflator when funding is specifically appropriated and rate adjustments for fair rent additions placed in service based on the useful life of the asset and in accordance with regulation

Sec. 6: Will allow providers for the Autism Waiver to access the DDS Neglect and Abuse Registry so that they may consult the registry prior to hiring staff.

BACKGROUND

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

Please consider the following, if applicable:

How does this proposal connect to the 10-year vision for the agency's mission?	
How will we measure if the proposal successfully accomplishes its goals?	
Have there been changes in federal/state laws or regulations that make this legislation necessary?	
Has this proposal or a	

similar proposal been implemented in other states? If yes, to what result?	
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	**Support Enforcement Services, Judicial Branch (Sec. 1)**
Agency Contact (name, title)	**Paul Bourdoulous**
Date Contacted	
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

[X] 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

[X] 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 (d) of section 52-362d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

(d) Whenever an order of the Superior Court or a family support magistrate of this state, or an order of another state that has been registered in this state, for support of a minor child or children is issued and such payments have been ordered through the IV-D agency, or when a request from another state for assistance enforcing an order that has not been registered in this state is received by the IV-D agency and such request meets the requirements of 42 USC 666(a)(14), and the obligor against whom such support order was issued owes overdue support under such order in the amount of five hundred dollars or more, the IV-D agency, as defined in subdivision (12) of subsection (b) of section 46b-231, or Support Enforcement Services of the Superior Court may notify (1) any state or local agency or officer with authority (A) to hold assets or property for such obligor including, but not limited to, any property unclaimed or presumed abandoned under part III of chapter 32, or (B) to distribute benefits to such obligor including, but not limited to, unemployment compensation and workers' compensation, (2) any person having or expecting to have custody or control of or authority to distribute any amounts due such obligor under any judgment or settlement, (3) any financial institution holding assets of such obligor, and (4) any public or private entity administering a public or private retirement fund in which such obligor has an interest that such obligor owes overdue support in a IV-D support case. Upon receipt of such notice, such agency, officer, person, institution or entity shall withhold delivery or distribution of any such property, benefits, amounts, assets or funds until receipt of further notice from the IV-D agency.

Sec. 2: Subsections (a) to (c), inclusive, of Section 46b-215e of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Initial or modified support order when child support obligor is institutionalized or incarcerated. Procedure in IV-D support cases when child support obligor is incarcerated

for more than ninety days. (a) Notwithstanding any provision of the general statutes, whenever a child support obligor is institutionalized or incarcerated, the Superior Court or a family support magistrate shall establish an initial order for current support, or modify an existing order for current support, upon proper motion, based upon the obligor's present income and substantial assets, if any, in accordance with the child support guidelines established pursuant to section 46b-215a. **[**Downward modification of an existing support order based solely on a loss of income due to incarceration or institutionalization shall not be granted in the case of a child support obligor who is incarcerated or institutionalized for an offense against the custodial party or the child subject to such support order**]**.

(b) In IV-D support cases, as defined in section 46b-231, when the child support obligor is institutionalized or incarcerated for more than ninety days, any existing support order, as defined in section 46b-231, shall be modified to zero dollars effective upon the date that a support enforcement officer files an affidavit in the Family Support Magistrate Division. The affidavit shall include: (1) The beginning and expected end dates of such obligor's institutionalization or incarceration; and (2) a statement by such officer that (A) a diligent search failed to identify any income or assets that could be used to satisfy the child support order while the obligor is incarcerated or institutionalized, and (B) **[**the offense for which the obligor is institutionalized or incarcerated was not an offense against the custodial party or the child subject to such support order, and (C)**]** a notice in accordance with subsection (c) of this section was provided to the custodial party and an objection form was not received from such party.

(c) Prior to filing an affidavit under subsection (b) of this section, the support enforcement officer shall provide notice to the custodial party in accordance with section 52-57 or by certified mail, return receipt requested. The notice shall state in clear and simple language that: (1) Such child support order shall be modified unless the custodial party objects not later than fifteen calendar days after receipt of such notice on the grounds that **[**(A)**]** the obligor has sufficient income or assets to comply with the support order, **[**or (B) the obligor is incarcerated or institutionalized for an offense against the custodial party or the child subject to such support order;**]** and (2) the custodial party may object to the proposed modification by delivering a signed objection form, or other written notice or motion, indicating the nature of the objection or grounds of the motion, to the support enforcement officer not later than fifteen calendar days after receipt of such notice. Upon receipt of any objection or motion, the support enforcement officer shall

promptly arrange with the clerk of the Family Support Magistrate Division to enter the appearance of the custodial party, set the matter for a hearing, send a file-stamped copy of the objection or motion to the IV-D agency of the state to whom the support order is payable, and notify all parties of the hearing date set. The court or family support magistrate shall promptly hear the objection or motion and determine whether the child support order should be modified in accordance with subsection (b) of this section.

Sec. 3. Subsection (b) of section 19a-697 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(b) A managed residential community shall post in a prominent place in the managed residential community the resident's bill of rights, including those rights set forth in subsection (a) of this section. The posting of the resident's bill of rights shall include contact information for (1) the Department of Public Health and the Office of the State Long-Term Care Ombudsman, including the names, addresses and telephone numbers of persons within such agencies who handle questions, comments or complaints concerning managed residential community, and (2) making a report to the Department of Social Services concerning the suspected abuse, neglect, exploitation or abandonment of an elderly person, or that an elderly person may be in need of protective services.

Sec. 4. Section 9 of Public Act 24-82 is repealed and the following is substitute in lieu thereof (*Effective July 1, 2025*):

(d) Not later than December 31, 2024, the Commissioner of Social Services shall enter into a contract with an outside vendor to update the system utilized by the Department of Social Services to administer the supplemental nutrition assistance program for the purpose of enabling the department to stagger the distribution of program benefits so that benefits are distributed, in accordance with federal law, to cohorts of program beneficiaries designated by the commissioner at multiple intervals during each month. Not later than March 1, 2026, the commissioner shall commence staggering the distribution of such benefits to such cohorts of beneficiaries each month, in accordance with federal law. Not later than April 1, 2026, [and annually thereafter,] the commissioner shall report, in accordance with the provisions of section 11-4a, to the joint standing

committee of the General Assembly having cognizance of matters relating to human services regarding the staggering of distribution benefits pursuant to this subsection.

Sec. 5: Section 17b-244 of the general statutes is amended as follows (*Effective July 1, 2026*).

(a) The room and board component of the rates to be paid by the state to private facilities and facilities operated by regional education service centers which are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid program as intermediate care facilities for 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. For the fiscal year ending June 30, 2024, rates shall not exceed those in effect for the fiscal year ending June 30, 2023, except the rate paid to a facility may be higher than the rate paid to the facility for the fiscal year ending June 30, 2023, 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, 2024, to the extent such rate increases are within available appropriations. Notwithstanding any other provisions of this chapter or section 17-313b-5 of the regulations of state agencies, any subsequent increase to allowable operating costs, excluding fair rent, shall be inflated by the gross domestic product deflator when funding is specifically appropriated for such purposes in the enacted budget. The rate of inflation shall be computed by comparing the most recent rate year to the average of the gross domestic product deflator for the previous four fiscal quarters ending March thirty-first. Any increase to rates based on inflation shall be applied prior to the application of any other budget adjustment factors that may impact such rates.

(b) 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. Notwithstanding any other provisions of this chapter, any subsequent increase to allowable operating costs, excluding fair rent, shall be inflated by the gross domestic product deflator when funding is specifically appropriated for such purposes in the enacted budget. The rate of inflation shall be computed by comparing the most recent rate year to the average of the gross domestic product deflator for the previous four fiscal quarters ending March thirty-first. Any increase to rates based on inflation shall be applied prior to the application of any other budget adjustment factors that may impact such rates.

Sec. 6: Subsection (c) of Section 17a-247b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The department shall make information in the registry available only to: (1) Authorized agencies, for the purpose of protective service determinations; (2) employers who employ employees to provide services to an individual who receives services or funding from the department or the Medicaid waiver program for autism spectrum disorder administered by the Department of Social Services, as described in section 17a-215c; (3) the Departments of Children and Families, Mental Health and Addiction Services, Social Services and Administrative Services and the Office of Labor Relations, for the purpose of determining whether an applicant for employment with the Departments of Children and Families, Developmental Services, Mental Health and Addiction Services and Social Services appears on the registry; or (4) charitable organizations that recruit volunteers to support programs for persons with intellectual disability or autism spectrum disorder, upon application to and approval by the commissioner, for purposes of conducting background checks on such volunteers.

Document Name	DSS - FQHC Change In Scope Amendment

Legislative Liaison	David Seifel 860-249-3286 David.Seifel@ct.gov
Division Requesting This Proposal	Reimbursement & CON, Division of Health Services, OLCRAH
Drafter	Matthew Antonetti

Title of Proposal	An Act Concerning Medicaid Reimbursement to Federally Qualified Health Centers
Statutory Reference, if any	Sections 17b-245d (c) (change in scope limitation)
Brief Summary and Statement of Purpose	Limits FQHC Change in Scope rate adjustments when solely based on expansions or reductions of existing clinics or new sites with no change to the content of a healthcare encounter.

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

Utilizing certain phraseology contained within regulation related to FQHC rate adjustments based on enhancements to the content of a medical encounter, FQHCs may currently submit encounter rate increase requests based upon the expansion of existing clinics or addition of new sites, without the introduction of new clinical services. Such basis for an encounter rate increase is counterintuitive to establishing the requisite change in the FQHC's 'scope' of services provided in a given healthcare encounter, and economies of scale dictate that an increase in the capacity to furnish those healthcare services already being delivered by the FQHC would, intrinsically, result in positive fiscal impact and not present a basis to increase the reimbursement for an FQHC's underlying encounter.

Encounter rate adjustments are intended to recognize increased costs as a result of enhancements to the content (be it though specialized clinical services and testing, etc.) of any patient encounter.

Unfortunately, current regulation provides an avenue for encounter rate increase requests based solely on an increase in the "volume", e.g., number of, patient encounters without any associated enhancements to the content of the underlying patient encounter, itself.

Over the past year, utilizing this "volume" reference in regulation, multiple FQHCs have sought encounter rate increases based solely on expansion of sites or facilities with no substantive enhancements to the content of any underlying care provided during a patient encounter. Such ongoing requests introduce substantial fiscal instability and uncertainty to the state budget, not anticipated when establishing budgetary projections related to Medicaid spending.

Statutory revisions are requested to preserve the financial stability of the state's overall Medicaid budget allocations in alignment with the basic

principle of adjusted FQHC patient encounter rates dependent on enhancements to the services contained within such patient encounters.

BACKGROUND

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

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?	No.
Have certain constituencies called for this proposal?	*No.*

INTERAGENCY IMPACT

[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)	
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 17b-245d is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

Sec. 17b-245d. Information to be provided by federally qualified health centers. Adjustment of encounter rates. (a) On or before February 1, 2013, and on January first annually thereafter, each federally qualified health center shall file with the Department of Social Services the following documents for the previous state fiscal year: (1) Medicaid cost report; (2) audited financial statements; and (3) any additional information reasonably required by the department. Any federally qualified health center that does not use the state fiscal year as its fiscal year shall have six months from the completion of such health center's fiscal year to file said documents with the department.

(b) Each federally qualified health center shall provide to the Department of Social Services a copy of its original scope of project, as approved by the federal Health Resources and Services Administration, and all subsequently approved amendments to its original scope of project. Each federally qualified health center shall notify the department, in writing, of all approvals for additional amendments to its scope of project, and provide to the department a copy of such amended scope of project, not later than thirty days after such approvals.

(c) If there is an increase or a decrease in the scope of services furnished by a federally qualified health center, the federally qualified health center shall notify the Department of Social Services, in writing, of any such increase or decrease not later than thirty days after such increase or decrease and provide any additional information reasonably requested by the department not later than thirty days after the request. Notwithstanding section 17b-262-1001 of the regulations of state agencies, a change in volume of services as a result of an expansion or reduction of an existing clinic, or the addition or discontinuance of a satellite or new site or change in operational costs attributable to capital expenditures, including new service facilities or regulatory compliance, shall not constitute a change in the scope of services furnished by a federally qualified health center for which a federally qualified health center's encounter rate may be adjusted.

(d) The Commissioner of Social Services may impose a civil penalty of five hundred dollars per day on any federally qualified health center that fails to provide any information required pursuant to this section not later than thirty days after the date such information is due.

(e) The department may adjust a federally qualified health center's encounter rate based upon an increase or decrease in the scope of services furnished by the federally qualified health center, in accordance with 42 USC 1396a(bb)(3)(B), following receipt of the written notification described in subsection (c) of this section or based upon the department's review of documents filed in accordance with subsections (a) and (b) of this section.

(f) The Commissioner of Social Services shall implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Document Name	DSS - Facility Appeals of Hearing Decisions to Superior Court

Legislative Liaison	David Seifel 860-249-3286 David.Seifel@ct.gov
Divisions Requesting This Proposal	OLCRAH, Quality Assurance and Reimbursement & CON, Division of Health Services
Drafter	Matthew Antonetti, Nicole Godburn, John Jakuboswki

Title of Proposal	An Act Concerning Appeals of Certain Agency Hearings
Statutory Reference, if any	Section 1: Amends subsection (b) of section 17b-238 to delete reference to arbitration proceedings for appeals of agency decisions concerning FQHC rates and replace with the ability to file appeals to the superior court as provided in chapter 54 (UAPA). Section 2: Amends subsection (i) of section 17b-99a to delete reference to arbitration proceedings for appeals of audit hearings and replace with the ability to file appeals to the superior court as provided in chapter 54 (UAPA).
Brief Summary and Statement of Purpose	To (1) update appeal processes to remove the concept of an appeal to an arbitration panel and replace with appeal to Superior Court; and (2) remove the concept of "volume" in FQHC Change in Scope requests when the "volume" of encounters increases, based on expansions of existing clinics or new sites.

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

Section 1: Amends subsection (b) of section 17b-238 to delete reference to arbitration proceedings for appeals of agency decisions concerning FQHC rates and replace with the ability to file appeals to the superior court as provided in chapter 54 (UAPA). Section 2: Amends subsection (i) of section 17b-99a to delete reference to arbitration proceedings for appeals of audit hearings and replace with the ability to file appeals to the superior court as provided in chapter 54 (UAPA).

BACKGROUND

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

Contained within HB 5373 of 2024 Session. Met with opposition from FQHCs. No language changes from prior submission.

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?	No.
Have certain constituencies called for this proposal?	

INTERAGENCY IMPACT

[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)	
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: Subsection (b) to Section 17b-238 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective upon Passage*):

(b) Any institution or agency to which payments are to be made under sections 17b-239 to 17b-246, inclusive, and sections 17b-340 and 17b-343 which is aggrieved by any decision of said commissioner may, within ten days after written notice thereof from the commissioner, obtain, by written request to the commissioner, a rehearing on all items of aggrievement. On and after July 1, 1996, a rehearing shall be held by the commissioner or his designee, provided a detailed written description of all such items is filed within ninety days of written notice of the commissioner's decision. The rehearing shall be held within thirty days of the filing of the detailed written description of each specific item of aggrievement. The commissioner shall issue a final decision within sixty days of the close of evidence or the date on which final briefs are filed, whichever occurs later. Any designee of the commissioner who presides over such rehearing shall be impartial and shall not be employed within the Department of Social Services office of certificate of need and rate setting. Any such items not resolved at such rehearing to the satisfaction of either such institution or agency or said commissioner **[**shall be submitted to binding arbitration to an arbitration board consisting of one member appointed by the institution or agency, one member appointed by the commissioner and one member appointed by the Chief Court Administrator from among the retired judges of the Superior Court, which retired judge shall be compensated for his services on such board in the same manner as a state referee is compensated for his services under section 52-434. The proceedings of the arbitration board and any decisions rendered by such board shall be conducted in accordance with the provisions of the Social Security Act, 49 Stat. 620 (1935), 42 USC 1396, as amended from time to time, and chapter 54**]** may be appealed in accordance with section 4-183. Such appeals shall be privileged cases to be heard by the court as soon after the return day as shall be practicable.

Section 2: Section (i) of section 17b-99a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

(i) Any facility aggrieved by a final report issued pursuant to 588 subsection (h) of this section may request a rehearing. A rehearing shall be held by the commissioner or the commissioner's designee, provided a detailed written description of all items of aggrievement in the final report is filed by the facility not later than ninety days following the date of written notice of the commissioner's decision. The rehearing shall be held not later than thirty days following the date of filing of the detailed written description of each specific item of aggrievement. The commissioner shall issue a final decision not later than sixty days following the close of evidence or the date on which final briefs are filed, whichever occurs later. Any items not resolved at such rehearing to the satisfaction of the facility or the commissioner **[**shall be submitted to binding arbitration by an arbitration board consisting of one member appointed by the facility, one member appointed by the commissioner and one member appointed by the Chief Court Administrator from among the retired judges of the Superior Court, which retired judge shall be compensated for his services on such board in the same manner as a state referee is compensated for his services under section 52-434. The proceedings of the arbitration board and any decisions rendered by such board shall be conducted in accordance with the provisions of the Social Security Act, 42 USC 1396, as amended from time to time, and chapter 54**]** may be appealed in accordance with section 4-183. Such appeals shall be privileged cases to be heard by the court as soon after the return day as shall be practicable.

Document Name	DSS - Nursing Home Exception to the Bed Moratorium for Access to Medicaid

Legislative Liaison	David Seifel 860-249-3286 David.Seifel@ct.gov Matthew Festa Matthew.Festa@ct.gov Jalmar De Dios 860-424-5308 Jalmar.Dedios@ct.gov
Division Requesting This Proposal	Division of Health Services – Reimbursement & Certificate of Need ("CON")
Drafter	Nicole Godburn, Nick Mazzatto, Betsy Bujwid

Title of Proposal	An Act Concerning Exception to the Nursing Home Bed Moratorium
Statutory Reference, if any	Sec. 17b-354. Moratorium on requests for additional nursing home beds. Exceptions. Continuing care facility. Medicaid nursing facility bed relocation. Construction. Financing. Regulations.
Brief Summary and Statement of Purpose	The proposed statutory language allows for the addition of new nursing home beds into a geographic area to address access concerns. State right sizing and rebalancing goals were implemented years ago to assist the state with excess bed capacity. What was not predicted when right sizing goals were implemented was the impact of a global pandemic.

	Between 2021 to 2024, 14 nursing homes have closed and over 3,000 beds have been delicensed and, delicensing of beds continues. In accordance with statute, DSS defines nursing home access as bed need in the towns within a fifteen-mile radius of the town in which the proposed beds are located and availability of beds in the service area; bed need is defined in statute as at 97.5% occupancy in the area. The Department proposes that area need be defined as 96% occupancy during a minimum of two consecutive quarters. While statewide occupancy is 86% as of September 2024, and DSS continues to support right-sizing efforts and continues to encourage nursing homes to delicense beds, the Department is being proactive should an area of the state experience too great of a contraction in available beds. For example, using the 15-mile criteria, Stratford area beds are 90% occupied and Brooklyn area nursing home beds are 89% occupied, which is greater than the statewide percentage of 86.2%. The proposed language would allow the Department to look at the state from geographic criteria versus a statewide view and to identify geographic need before the state has an access concern. This language allows DSS to be proactive in developing criteria to look at geographic need and to allow a process for expansion of nursing home beds should a region of the state experience access issues.

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

Section 1: Sec. 17b-354. Moratorium on requests for additional nursing home beds. Exceptions. Continuing care facility. Medicaid nursing facility bed relocation. Construction. Financing. Regulations. Section 2: Sec. 17b-354. Moratorium on requests for additional nursing home beds. Exceptions. Continuing care facility. Medicaid nursing facility bed relocation. Construction. Financing. Regulations.

BACKGROUND

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

Please consider the following, if applicable:

How does this proposal connect to the 10-year vision for the agency's mission?	N/A
How will we measure if the proposal successfully	Increase nursing home bed access in areas of the state with more than 96% area occupancy for minimum two consecutive quarters.

accomplishes its goals?	
Have there been changes in federal/state laws or regulations that make this legislation necessary?	N/A
Has this proposal or a similar proposal been implemented in other states? If yes, to what result?	No. Skilled Nursing Facilities ("SNF") are handled differently in every state.
Have certain constituencies called for this proposal?	N/A

INTERAGENCY IMPACT

List each affected agency. Copy the table as needed.

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

1. Agency Name	Department of Public Health
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)	
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

Increased access to areas of the state with more than 96% nursing home occupancy. Geographic area is defined in statute as 15-mile radius of the town in which the beds are proposed to be located. This legislation would allow the Department to be proactive and look at nursing home access based on geography versus statewide. This allows the Department the ability to identify early – before access issues – regions of the state that may encounter access issues and to be proactive in addressing those concerns.

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Section 1: Sec. 17b-354. Moratorium on requests for additional nursing home beds. Exceptions. Continuing care facility. Medicaid nursing facility bed relocation. Construction. Financing. Regulations.

(a) The Department of Social Services shall not accept or approve any requests for additional nursing home beds, except (1) beds restricted to use by patients with acquired immune deficiency syndrome or by patients requiring neurological rehabilitation; (2) beds associated with a continuing care facility, as described in section 17b-520, provided such beds are not used in the Medicaid program. For the purpose of this subsection, beds associated with a continuing care facility are not subject to the certificate of need provisions pursuant to sections 17b-352 and 17b-353; (3) Medicaid certified beds either to be relocated from one licensed nursing facility to another licensed nursing facility to meet a priority need identified in the strategic plan developed pursuant to subsection (c) of section 17b-369 or new beds added to an existing facility or a new facility with preference given to, nontraditional, small-house style nursing home facility that incorporates the goals for nursing facilities referenced in the department's strategic plan for long-term care as provided in section 17b-355, to address priority need reflected by area census trends,; (4) licensed Medicaid nursing facility beds to be relocated from one or more existing nursing facilities to a new nursing facility, including a replacement facility, provided (A) no new Medicaid certified beds are added, (B) at least one currently licensed facility is closed in the transaction as a result of the relocation, (C) the relocation is done within available appropriations, (D) the facility participates in the Money Follows the Person demonstration project pursuant to section 17b-369, (E) the availability of beds in the area of need will not be adversely affected, (F) the certificate of need approval for such new facility or facility relocation and the associated capital expenditures are obtained pursuant to sections 17b-352 and 17b-353, and (G) the facilities included in the bed relocation and closure shall be in accordance with the strategic plan developed pursuant to subsection (c) of section 17b-369; and (5) proposals to build a nontraditional, small-house style nursing home designed to enhance the quality of life for nursing facility residents, provided that the nursing facility agrees to reduce its total number of licensed

beds by a percentage determined by the Commissioner of Social Services in accordance with the department's strategic plan for long-term care.

Section 2: Sec. 17b-355. Certificate of need for capital expenditures; transfer of ownership or control; criteria.

In determining whether a request submitted pursuant to sections 17b-352 to 17b-354, inclusive, will be granted, modified or denied, the Commissioner of Social Services shall consider the following: The financial feasibility of the request and its impact on the applicant's rates and financial condition, the contribution of the request to the quality, accessibility and cost-effectiveness of the delivery of long-term care in the region, whether there is clear public need for the request, the relationship of any proposed change to the applicant's current utilization statistics and the effect of the proposal on the utilization statistics of other facilities in the applicant's service area, the business interests of all owners, partners, associates, incorporators, directors, sponsors, stockholders and operators and the personal background of such persons, and any other factor which the Department of Social Services deems relevant. In considering whether there is clear public need for any request for the relocation of beds to a replacement facility or for new beds added to an existing facility or a new facility, the commissioner shall consider whether there is a demonstrated bed need in the towns within a fifteen-mile radius of the town in which the beds are proposed to be located and whether the availability of beds in the applicant's service area will be adversely affected. Any proposal to relocate nursing home beds from an existing facility to a new facility shall not increase the number of Medicaid certified beds and shall result in the closure of at least one currently licensed facility. The commissioner may request that any applicant seeking to replace an existing facility reduce the number of beds in the new facility by a percentage that is consistent with the department's strategic plan for long-term care. If an applicant seeking to replace an existing facility with a new facility owns or operates more than one nursing facility, the commissioner may request that the applicant close two or more facilities before approving the proposal to build a new facility. The commissioner shall also consider whether an application to establish a new or replacement nursing facility proposes a nontraditional, small-house style nursing facility and incorporates goals for nursing facilities referenced in the department's strategic plan for long-term care, including, but

not limited to, (1) promoting person-centered care, (2) providing enhanced quality of care, (3) creating community space for all nursing facility residents, and (4) developing stronger connections between the nursing facility residents and the surrounding community. **[**Bed**]** Demonstrated bed need shall be based on the recent occupancy percentage of area nursing facilities with occupancy above ninety-six percent for a minimum of two consecutive quarters. **[**and the**]** The Department may consider projected bed need **[**for no more than five years**]** into the future at occupancy above ninety-six **[**seven and one-half**]** per cent **[**occupancy**]** using the latest statewide Strategic Rebalancing Plan as published by the Department **[**official population projections by town and age as published by the Office of Policy and Management and the latest available state-wide nursing facility utilization statistics by age cohort from the Department of Public Health**]**. The commissioner may also consider area specific utilization and reductions in utilization rates to account for the increased use of less institutional alternatives.

Document Name	DSS - Forensic Audits

Legislative Liaison	David Seifel 860-249-3286 David.Seifel@ct.gov Matthew Festa Matthew.Festa@ct.gov Jalmar De Dios 860-424-5308 Jalmar.dedios@ct.gov
Division Requesting This Proposal	OLCRAH, CON, QA
Drafter	OLCRAH

Title of Proposal	An Act Concerning Forensic Audits
Statutory Reference, if any	CGS Section 17b-99a
Brief Summary and Statement of Purpose	To more clearly define "forensic audit" and outline when DSS shall conduct that auditing process. To require a civil monetary penalty for not complying with such audit.

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

- This proposal will more clearly define a 'forensic audit' and outline when DSS shall: (i) conduct such forensic audits; (ii) require facility compliance with the audit process and be subject to civil penalties for failure to provide data necessary for any such forensic audit; and (iii) be subject to audit costs (capped at $100,000) should a forensic audit identify material issues with a facility's internal financial management or integrity of a facility's financial statements.
- This proposal is intended to incentivize facilities to proactively engage in responsible financial management and fiscal accounting and subject a facility to certain costs should DSS be required to take affirmative steps to examine a facility's financial management/stability to protect the health and wellbeing of the vulnerable residents residing in, and dependent on the quality of care and daily services provided by, such facilities.
- Subsection (a)(1) defines forensic audit
- Subsection (m) defines when DSS shall conduct such audit and requirements of the facility
- Subsection (n) outlines what costs DSS shall be able to recover from the facility

BACKGROUND

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

This concept was part of HB 5046 in 2024. It was ultimately removed from the final version of that bill.

Please consider the following, if applicable:

How does this proposal connect to the 10-year vision for the agency's mission?	This proposal gives DSS the ability to further provide added protections for our members to ensure safe, reliable quality of care. Forensic audits are rare and necessary when there is a serious financial concern. This legislation is necessary to support the Department's continued effort to ensure the health and safety of our members and to proactively incentivize facilities to maintain responsible financial management. Post COVID-19 the Department has experienced an unprecedented number of changes in ownership, closure of facilities, and increased CMS interventions for poor health care outcomes. Medicaid is the largest payor of nursing homes (73%), and the Department has an interest in ensuring Medicaid spend it directed to patient cares. Medicaid reimburses not only for direct care but also infrastructure costs to maintain good facilities. When buildings and care decline, there is a concern that funding needs to be better targeted. Forensic audits are rare, but one tool in the toolbox to help the Department in its oversight of Medicaid spend and patient care.
How will we measure if the proposal successfully accomplishes its goals?	Hopefully, over time, DSS will see a reduction in requests for financial hardship relief as financial management improves.
Have there been changes in federal/state laws or regulations that make this	N/A

legislation necessary?	
Has this proposal or a similar proposal been implemented in other states? If yes, to what result?	No
Have certain constituencies called for this proposal?	N/A

INTERAGENCY IMPACT

List each affected agency. Copy the table as needed.

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

1. Agency Name	**DPH**
Agency Contact (name, title)	**Miriam Miller**
Date Contacted	**January, 2024**
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

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

State	NA – Cost of a forensic audit is passed to the facility.
Municipal (Include any municipal mandate that can be found within legislation)	NA
Federal	NA
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

Sec. 10. Section 17b-99a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) For purposes of this section, (A) "extrapolation" means the determination of an unknown value by projecting the results of the review of a sample to the universe from which the sample was drawn, (B) "facility" means any facility described in this subsection and for which rates are established pursuant to section 17b-340 or 17b-340d, [and] (C) "universe" means a defined population of claims submitted by a facility during a specific time period, and (D) "forensic audit" means an examination of financial records for information or evidence that may be used to determine compliance with applicable law.

(2) The Commissioner of Social Services shall conduct any audit, including a forensic audit, of a licensed chronic and convalescent nursing home, chronic disease hospital associated with a chronic and convalescent nursing home, a rest home with nursing supervision, a licensed residential care home, as defined in section 19a-490, and a residential facility for persons with intellectual disability which is licensed pursuant to section 17a-227 and certified to participate in the Medicaid program as an intermediate care facility for individuals with intellectual disabilities in accordance with the provisions of this section.

(b) Not less than thirty days prior to the commencement of any such audit, the commissioner shall provide written notification of the audit to such facility, unless the commissioner makes a good-faith determination that (1) the health or safety of a recipient of services is at risk; or (2) the facility is engaging in vendor fraud under sections 53a-290 to 53a-296, inclusive.

(c) Any clerical error, including, but not limited to, recordkeeping, typographical, scrivener's or computer error, discovered in a record or document produced for any such audit, shall not of itself constitute a wilful violation of the rules of a medical assistance program administered by the Department of Social Services unless proof of intent to commit fraud or otherwise violate program rules is established. In determining which

facilities shall be subject to audits, the Commissioner of Social Services may give consideration to the history of a facility's compliance in addition to other criteria used to select a facility for an audit.

(d) A finding of overpayment or underpayment to such facility shall not be based on extrapolation unless (1) there is a determination of sustained or high level of payment error involving the facility, (2) documented educational intervention has failed to correct the level of payment error, or (3) the value of the claims in aggregate exceeds two hundred thousand dollars on an annual basis.

(e) A facility, in complying with the requirements of any such audit, shall be allowed not less than thirty days to provide documentation in connection with any discrepancy discovered and brought to the attention of such facility in the course of any such audit.

(f) The commissioner shall produce a preliminary written report concerning any audit conducted pursuant to this section and such preliminary report shall be provided to the facility that was the subject of the audit not later than sixty days after the conclusion of such audit.

(g) The commissioner shall, following the issuance of the preliminary report pursuant to subsection (f) of this section, hold an exit conference with any facility that was the subject of any audit pursuant to this subsection for the purpose of discussing the preliminary report. Such facility may present evidence at such exit conference refuting findings in the preliminary report.

(h) The commissioner shall produce a final written report concerning any audit conducted pursuant to this subsection. Such final written report shall be provided to the facility that was the subject of the audit not later than sixty days after the date of the exit conference conducted pursuant to subsection (g) of this section, unless the commissioner and the facility agree to a later date or there are other referrals or investigations pending concerning the facility.

(i) Any facility aggrieved by a final report issued pursuant to subsection (h) of this section may request a rehearing. A rehearing shall be held by the commissioner or the commissioner's designee, provided a detailed written description of all items of aggrievement in the final report is filed by the facility not later than ninety days following the date of written notice of the commissioner's decision. The rehearing shall be held not

later than thirty days following the date of filing of the detailed written description of each specific item of aggrievement. The commissioner shall issue a final decision not later than sixty days following the close of evidence or the date on which final briefs are filed, whichever occurs later. Any items not resolved at such rehearing to the satisfaction of the facility or the commissioner shall be submitted to binding arbitration by an arbitration board consisting of one member appointed by the facility, one member appointed by the commissioner and one member appointed by the Chief Court Administrator from among the retired judges of the Superior Court, which retired judge shall be compensated for his services on such board in the same manner as a state referee is compensated for his services under section 52-434. The proceedings of the arbitration board and any decisions rendered by such board shall be conducted in accordance with the provisions of the Social Security Act, 42 USC 1396, as amended from time to time, and chapter 54.

(j) The submission of any false or misleading fiscal information or data to the commissioner shall be grounds for suspension of payments by the state under sections 17b-239 to 17b-246, inclusive, and sections 17b-340, and 17b-343, in accordance with regulations adopted by the commissioner. In addition, any person, including any corporation, who knowingly makes or causes to be made any false or misleading statement or who knowingly submits false or misleading fiscal information or data on the forms approved by the commissioner shall be guilty of a class D felony.

(k) The commissioner, or any agent authorized by the commissioner to conduct any inquiry, investigation or hearing under the provisions of this section, shall have power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any hearing ordered by the commissioner, the commissioner or such agent having authority by law to issue such process may subpoena witnesses and require the production of records, papers and documents pertinent to such inquiry. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to the person by the commissioner or the commissioner's authorized agent or to produce any records and papers pursuant thereto, the commissioner or the commissioner's agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person resides or wherein the business has been conducted, or to any judge of such court if the same is not in session, setting forth such disobedience to process or refusal to answer, and such court or judge shall cite such person to appear before such court or judge to answer such question or to produce such records and papers.

(l) The commissioner shall provide free training to facilities on the preparation of cost reports to avoid clerical errors and shall post information on the department's Internet web site concerning the auditing process and methods to avoid clerical errors. Not later than April 1, 2015, the commissioner shall establish audit protocols to assist facilities subject to audit pursuant to this section in developing programs to improve compliance with Medicaid requirements under state and federal laws and regulations, provided audit protocols may not be relied upon to create a substantive or procedural right or benefit enforceable at law or in equity by any person, including a corporation. The commissioner shall establish and publish on the department's Internet web site audit protocols for: (1) Licensed chronic and convalescent nursing homes, (2) chronic disease hospitals associated with chronic and convalescent nursing homes, (3) rest homes with nursing supervision, (4) licensed residential care homes, as defined in section 19a-490, and (5) residential facilities for persons with intellectual disability that are licensed pursuant to section 17a-227 and certified to participate in the Medicaid program as intermediate care facilities for individuals with intellectual disabilities. The commissioner shall ensure that the Department of Social Services, or any entity with which the commissioner contracts to conduct an audit pursuant to this section, has on staff or consults with, as needed, licensed health professionals with experience in treatment, billing and coding procedures used by the facilities being audited pursuant to this section.

(m) (1) The commissioner shall not conduct a forensic audit of a facility unless the commissioner (A) provides the facility with an opportunity to meet with Department of Social Services representatives and respond to any financial concerns identified by the commissioner, and (B) makes a good faith determination that a forensic audit of such facility is necessary to evaluate such financial concerns.

(2) If a facility receives a written request by the department to cooperate and assist with a forensic audit, such facility shall cooperate and assist not more than ten business days after the date the facility receives such request and shall ensure that all facility personnel, financial consultants and accountants fully cooperate and assist with a forensic audit as may be necessary, except no facility shall be required to divert facility personnel from residential care duties and responsibilities to cooperate and assist with such forensic audit. Ten days after a facility receives a written request by the department to cooperate and assist with a forensic audit, a facility shall be subject to a civil monetary penalty not to exceed one thousand dollars per day for each business day that the facility

fails to comply with such written request. A facility may request a fair hearing on the assessment of any such civil monetary penalty as an aggrieved person pursuant to section 17b-60.

(3) A facility may be liable to the Department of Social Services for the costs of a forensic audit of a facility identified by the department as experiencing a serious financial loss, including, but not limited to, any reports or subsequent testimony related thereto, provided liability for such costs shall not exceed one hundred thousand dollars. Such costs, not to exceed one hundred thousand dollars, may be assessed against any single facility, or in the aggregate if more than one facility is subject to a particular forensic audit.

(n) The department may recover (1) subject to the provisions of subdivision (3) of subsection (m) of this section, the costs of any forensic audit conducted pursuant to the provisions of this section from a facility if such forensic audit identifies material issues with a facility's internal financial management or the integrity of a facility's financial statements, or (2) civil monetary penalties assessed against a facility in accordance with subdivision (2) of subsection (m) of this section through recoupment of such forensic audit costs or civil monetary penalties against funds that would otherwise be paid to such facility for services rendered to recipients of assistance under the Medicaid program.

Document Name	DSS – Pilot Program Disregard

Legislative Liaison	David Seifel 860-249-3286 David.Seifel@ct.gov Matthew Festa Matthew.Festa@ct.gov Jalmar De Dios 860-424-5308 Jalmar.DeDios@ct.gov
Division Requesting This Proposal	POGA
Drafter	Dan Giacomi

Title of Proposal	An Act Concerning An Income Disregard in the TFA Program.
Statutory Reference, if any	Subsection (d)(1) of section 17b-112 of the general statutes
Brief Summary and Statement of Purpose	This proposal would disregard funds from consideration when determining eligibility for DSS cash assistance and food assistance programs that a DSS client receives while participating in a private direct cash transfer pilot program

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

The commissioner shall disregard any financial assistance received by a family member as part of their participation in a pilot program that has developed a plan to study and evaluate the impact and potential benefits of direct cash transfers. Such disregard shall be applied for the length of time the family member participates in such program, not to exceed sixty cumulative months.

BACKGROUND

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

The language regarding the direct cash transfers was introduced late in the 2024 legislative session.

Please consider the following, if applicable:

How does this proposal connect to the 10-year vision for the agency's mission?	These proposals directly support low-income state residents in achieving economic mobility and well-bring. We have the ability to provide additional support for state residents while also exploring innovative ways to reduce poverty and improve economic wellbeing. As the agency charged with administering a vast array for programs that seek to improve the health and wellbeing of low income state residents, it is critical for DSS to explore innovative approaches to providing support and opportunities for success while maximizing federal and private dollars to help support these goals.
How will we measure if the proposal successfully	The direct cash transfer programs have quantifiable measures/evaluations built in to determine effectiveness. The entire purpose is to test and measure the efficacy of direct cash transfers as a means to economic mobility

accomplishes its goals?	and improved health and well-being among identified populations in need.
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?	Massachusetts and New York, among other states, have recently implemented legislative and regulatory protections for direct cash transfer pilots. Philanthropic and research groups are looking to test this work in states where states have established protections for pilot participants.
Have certain constituencies called for this proposal?	Yes, numerous stakeholders are pushing for these changes. Specific to direct cash transfers – 4CT, The Connecticut Foundation, Dana Farber Cancer Institute, YNHH, The Bridge Project, and others.

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)	
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

Data for the impact of direct cash transfer programs will be part of the pilot evaluations

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Subsection (d)(1) of section 17b-112 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d)(1) Under said program, no family shall be eligible that has total gross earnings exceeding the federal poverty level, however, in the calculation of the benefit amount for eligible families and previously eligible families that become ineligible temporarily because of receipt of workers' compensation benefits by a family member who subsequently returns to work immediately after the period of receipt of such benefits, earned income shall be disregarded up to the federal poverty level. On and after October 1, 2023, the commissioner shall not deny a family assistance under said program on the basis of such family's assets unless such assets exceed six thousand dollars. Except when determining eligibility for a six-month extension of benefits pursuant to subsection (c) of this section, the commissioner shall disregard the first fifty dollars per month of income attributable to current child support that a family receives in determining eligibility and benefit levels for temporary family assistance. Any current child support in excess of fifty dollars per month collected by the department on behalf of an eligible child shall be considered in determining eligibility but shall not be considered when calculating benefits and shall be taken as reimbursement for assistance paid under this section, except that when the current child support collected exceeds the family's monthly award of temporary family assistance benefits plus fifty dollars, the current child support shall be paid to the family and shall be considered when calculating benefits. The commissioner shall disregard any financial assistance received by a family member to the extent the commissioner determines that such financial assistance was provided to the family member as part of their participation in a pilot program that has developed a plan to study and evaluate the impact and potential benefits of direct cash transfers. Such disregard shall be applied for the length of time the family member participates in such program, not to exceed sixty cumulative months.

Document Name	DSS – Federal AHEAD Innovation Model Hospital Global Budget Payment Methodology

Legislative Liaison	David Seifel 860-249-3286 David.Seifel@ct.gov Matthew Festa Matthew.Festa@ct.gov Jalmar De Dios 860-424-5308 Jalmar.dedios@ct.gov
Division Requesting This Proposal	DSS Policy Division and DSS Division of Health Services
Drafter	Mehul Dalal, Chief Policy Advisor Joel Norwood, Deputy Policy Advisor Bill Halsey, Medicaid Director Nicole Godburn, Ratesetting Manager

Title of Proposal	An Act Concerning the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Federal Innovation Model Hospital Global Budget Payment Methodology
Statutory Reference, if any	n/a (new section)
Brief Summary and	This proposal authorizes DSS to implement the AHEAD federal innovation model's hospital global budget payment methodology for hospitals choosing to participate in AHEAD.

Statement of Purpose	

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

Section 1 authorizes DSS to pay hospitals choosing to participate in AHEAD using a global budget methodology that complies with applicable federal requirements and subject to federal approval.

BACKGROUND

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

Please consider the following, if applicable:

How does this proposal connect to the 10-year vision for the agency's mission?	The agency's 10-year vision focuses on further improving population health, prevention, and coordination of care—including through enhanced use of alternative payment methodologies (APM) for healthcare providers. The AHEAD model's APM for hospital global budget payments specifically includes parameters to address all of these key long-term agency goals.
How will we measure if the proposal successfully accomplishes its goals?	As part of the state's participation the AHEAD federal innovation model, the state will monitor and evaluate the success of the new payment model per the terms of our cooperative agreement with CMS. We will specifically measure Medicaid members' health outcomes and costs when they receive services from hospitals participating in the AHEAD model.

Have there been changes in federal/state laws or regulations that make this legislation necessary?	No changes in federal laws, but this proposal is necessary to enable the state to meet its commitments in implementing the AHEAD federal innovation model, which is a federal grant that the state applied for and recently was awarded.
Has this proposal or a similar proposal been implemented in other states? If yes, to what result?	Yes, Maryland, Vermont, and Pennsylvania have all used hospital global budgets. The success of those models in containing cost growth and improving health outcomes (especially Maryland's model, which is the most comprehensive) led the federal Centers for Medicare and Medicaid Services (CMS) to implement the AHEAD model as an option for states.
Have certain constituencies called for this proposal?	While there have not been specific external constituencies calling for this proposal, it implements the administration's broader goals of improving the state's healthcare system to enhance outcomes and contain cost growth.

INTERAGENCY IMPACT

List each affected agency. Copy the table as needed.

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

1. Agency Name	**Office of Health Strategy**
Agency Contact (name, title)	Elisa Neira, Senior Director of Health Equity
Date Contacted	
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

[X] 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	This proposal gives DSS the necessary authority to implement a hospital global budget payment methodology, but does not establish any new expenditure requirements, so there is no fiscal impact for this legislative proposal. As context, the state is receiving $12 million federal grant funds to design the AHEAD federal innovation model. OHS is the lead recipient, DSS is the key subrecipient, and other agencies are also participating in AHEAD. These federal funds support hiring OHS and DSS staff and contractors to design and oversee implementation of the changes. As a condition of receiving these federal grant funds, the state is required to implement the

	AHEAD innovation model. A key component of AHEAD is Medicaid hospital global budget payments instead of fee-for-service payments, for hospitals that choose to participate. There will be separate fiscal analyses for each component of AHEAD, including when DSS requests federal approval to implement the hospital global budget. The legislation itself is general in nature, so does not have a fiscal impact.

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

In implementing the AHEAD federal innovation model, the state will be required to monitor outcomes by CMS. In addition, CMS will conduct its own monitoring and evaluation. Specific areas for evaluation as part of the state's implementation of the AHEAD innovation model focus on reducing unnecessary hospital emergency department (ED) visits and unplanned admissions and readmissions, preventing under-service, improving health equity, and containing cost growth.

ANYTHING ELSE WE SHOULD KNOW?

The state has committed to implementing the AHEAD federal innovation model. This legislative proposal is necessary for the state to meet its obligations to the federal government under the AHEAD grant cooperative agreement. Otherwise, the state is at risk of losing federal AHEAD grant funding.

INSERT FULLY DRAFTED BILL HERE

Section 1. (NEW) (*Effective January 1, 2027*): As part of the state's implementation of the States Advancing All-Payer Health Equity Approaches and Development innovation model administered by the U.S. Center for Medicare and Medicaid Innovation, on or after January 1, 2027, subject to applicable federal requirements and federal approval, the Department of Social Services may provide a global budget payment methodology for licensed acute care hospitals, including children's hospitals that choose to participate in this model. For participating hospitals, such global budget payment methodology shall apply instead of the applicable fee-for-service payment methodologies established pursuant to sections 17b-239 and 17b-239d for all service categories included in the global budget payment methodology.

Document Name	Job training stipend

Legislative Liaison	David Seifel 860-249-3286 David.Seifel@ct.gov Matthew Festa Matthew.Festa@ct.gov Jalmar De Dios 860-424-5308 Jalmar.dedios@ct.gov
Division Requesting This Proposal	POGA
Drafter	POGA, OLCRAH

Title of Proposal	AAC Job Training Stipends
Statutory Reference, if any	17b-112 (d)(1)
Brief Summary and Statement of Purpose	This will disregard certain income individuals receive for specific job training programs for DSS SNAP and TANF purposes

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

- Currently, if an individual is receiving DSS benefits such as SNAP or SAGA, and they receive a new source of income, or increased income, it could potentially bring them over the income limits for said program
- This occurrence is known as the "benefits cliff," where many clients often lose DSS benefits
- Ex: if a non-profit organization offered a temporary stipend to certain individuals who participate in specific job training programs, those funds could be counted as income and force people off their DSS benefits.
- This proposal seeks to disregard those such funds for purposes of eligibility for DSS benefits

BACKGROUND

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

Please consider the following, if applicable:

How does this proposal connect to the 10-year vision for the agency's mission?	This proposal will allow the state to continue to address issues our constituency has with the benefits cliff.
How will we measure if the proposal	

successfully accomplishes its goals?	
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?	Yes. Massachusetts and Maryland have seen certain non-profits offering job training programs to certain individuals. Those states have run into challenges with the benefits cliff and have thus enacted statutory language that would create an exception for such income.
Have certain constituencies called for this proposal?	Roca non-profit in Hartford brought this to the Department's attention.

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	There is no anticipated fiscal impact
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. Subsection (d)(1) of section 17b-112 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d)(1) Under said program, no family shall be eligible that has total gross earnings exceeding the federal poverty level, however, in the calculation of the benefit amount for eligible families and previously eligible families that become ineligible temporarily because of receipt of workers' compensation benefits by a family member who subsequently returns to work immediately after the period of receipt of such benefits, earned income shall be disregarded up to the federal poverty level. On and after October 1, 2023, the commissioner shall not deny a family assistance under said program on the basis of such family's assets unless such assets exceed six thousand dollars. Except when determining eligibility for a six-month extension of benefits pursuant to subsection (c) of this section, the commissioner shall disregard the first fifty dollars per month of income attributable to current child support that a family receives in determining eligibility and benefit levels for temporary family assistance. Any current child support in excess of fifty dollars per month collected by the department on behalf of an eligible child shall be considered in determining eligibility but shall not be considered when calculating benefits and shall be taken as reimbursement for assistance paid under this section, except that when the current child support collected exceeds the family's monthly award of temporary family assistance benefits plus fifty dollars, the current child support shall be paid to the family and shall be considered when calculating benefits. The commissioner shall disregard any stipend received by a family member as part of their participation in a job training program, including, but not limited to, payments from programs offered by or through the Office of Workforce Strategy established pursuant to section 4-124w, the Bureau of Rehabilitation Services within the Department of Aging and Disability Services or a private not-for-profit organization that is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended. Such disregard shall be applied for the length of time the family member participates in such program, not to exceed thirty-six cumulative months.

Agency Legislative Proposal – 2025 Session
Document Name: DSS - Covered CT OON

Document Name	DSS - Covered CT OON

Legislative Liaison	David Seifel Matt Festa Jalmar De Dios
Division Requesting This Proposal	DHS
Drafter	POGA, DHS

Title of Proposal	An Act Concerning Covered Connecticut
Statutory Reference, if any	19a-754c (f)
Brief Summary and Statement of Purpose	To provide DSS with flexibility in administering the Covered CT program.
How does this proposal relate to the agency's mission?	

Agency Legislative Proposal – 2025 Session
Document Name: DSS - Covered CT OON

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

This proposal will provide flexibility in how DSS administers the program and allows the agency to explore avenues to control costs without undermining the program. The Department seeks the authority to make modest changes to out-of-network coverage policies within the federal/state framework of the Covered CT program, while retaining flexibility for implementation of such changes in the event that federal approval is conditional or delayed.

BACKGROUND

Origin of Proposal [X] New Proposal [ ] Resubmission

Please consider the following, if applicable:

Have there been changes in federal/state laws or regulations that make this legislation necessary?	Recently enacted Public Act No. 24-138 requires the elimination of subsidies within the Covered Connecticut program for members that go out of network to seek care.
Has this proposal or a similar proposal been implemented in other states? If	Other states with similar waiver programs only subsidize in-network services.

yes, to what result?	
Have certain constituencies called for this proposal?	ConnectiCare supported the 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	Access Health CT will need to update their system
Agency Contact (name, title)	
Date Contacted	
Status	**[ ] Approved [ ] Talks Ongoing**
Open Issues, if any	Full scope of system impact and cost not fully assessed.

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	Cost Savings

Municipal (Include any municipal mandate that can be found within legislation)	
Federal	Theoretical Cost Savings
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

There is a federal monitoring and evaluation plan that will monitor whether this change creates a barrier to access.

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Subsection (f) of Section 19a-754c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(f) Notwithstanding any provision of this section, the Commissioner of Social Services may seek federal approval to limit cost-sharing subsidies in the Covered Connecticut program **[**shall only include in-network health care providers and in-network services, unless the health carrier's network is deemed by the Insurance Commissioner to be inadequate**]**. The Commissioner may implement such changes to cost-sharing subsidies upon obtaining any necessary federal approval. **[**Benefits described in subsection (b) of this section and cost-sharing available to all eligible individuals pursuant to subdivision (1) of subsection (b) of this section shall only apply if such eligible individuals use in-network health care providers or in-network facilities.**]**