Agency Legislative Proposal - 2017 Session

1) RCH Rates –DSS proposal- 2017

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Social Services

Liaison: Krista Ostaszewski; Alvin Wilson
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Lead agency division requesting this proposal: Reimbursement & CON

Agency Analyst/Drafter of Proposal: Rich Wysocki

Title of Proposal: AAC Improvements to the rate setting process for Residential Care Homes

Statutory Reference: 17b-340 (h)

Proposal Summary:

This proposal would be the first phase to implementing new Residential Care Home (RCH) rate setting methodology for stand-alone (unaffiliated) Residential Care Homes.

The drafted language carves out standalone RCHs, by further defining RCH's in Section 1 subsection (a) as "owned and operated by a related party, company or family association, as defined in this subsection, that also owns or operates a nursing home".

Section 2 subsection(h)(2) is now specific to standalone RCHs.

- As noted above, this is the first phase toward moving forward with new rate setting methodology beginning in 2020. The Department intends to work with RCHs moving forward to further define the rate setting methodology that can be added into statute in future legislative sessions.
    - Foundational steps needed to implement new rate-setting methodology include a simplified and streamlined cost reporting process for stand-alone RCH's. Possible changes could include:
        - Removing all Nursing Home affiliated questions/requests.
        - An in-depth desk review by Myers and Stauffer LC to ensure rates are based on actual costs. A simplified cost report would also allow Myers and Stauffer to request back up support materials from RCH's in an expedient manner. (Myers and Stauffer are bogged down with adjustments and reclassifications

of current cost-reports) These steps to simplify, improve accuracy and efficiency could reduce the number of RCH audits.

- Cost reports are currently 40 pages- possible simplification could reduce cost reports to approximately 10 pages.

PROPOSAL BACKGROUND

- **Reason for Proposal**

Why is a new RCH rate methodology needed?

Cost Reports that are used as the foundation to create rates for all RCHs are currently the same. RCH's not affiliated with nursing homes (stand-alone RCHs) have to complete the same cost reports as affiliated RCHs. These cost reports are complex and include many questions related to Nursing Homes that are not applicable to stand-alone RCH's.

When stand-alone RCH's attempt to complete current cost reports they are described as confusing. Such cost reports are returned to the department with incomplete or incorrect responses. This causes much back and forth between Myers and Stauffer, the Department and the RCHs to adjust and reclassify cost reports in an attempt to address the inconsistencies.

A simplified cost reporting process (that removes nursing home related questions) would ensure more accurate cost reports, resulting in a more accurate rate reimbursement for RCH's.

- **Origin of Proposal** **_X__ New Proposal** **___ Resubmission**

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal None
State: Potential Savings- as new methodology would better reflect actual costs of the RCHs.
Federal: None
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Sec. 1. Subsection (a) of section 17b-340 of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017)*:

(a) For purposes of this subsection, (1) a "related party" includes, but is not limited to, any company related to a chronic and convalescent nursing home through family association, common ownership, control or business association with any of the owners, operators or officials of such nursing home; (2) "company" means any person, partnership, association, holding company, limited liability company or corporation; (3) "family association" means a relationship by birth, marriage or domestic partnership; and (4) "profit and loss statement" means the most recent annual statement on profits and losses finalized by a related party before the annual report mandated under this subsection. The rates to be paid by or for persons aided or cared for by the state or any town in this state to licensed chronic and convalescent nursing homes, to chronic disease hospitals associated with chronic and convalescent nursing homes, to rest homes with nursing supervision, to licensed residential care homes, as defined by section 19a-490, that are owned and operated by a related party, company or family association, as defined in this subsection, that also owns or operates a nursing home pursuant to 19a-490 and to residential facilities for persons with intellectual disability that are licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program[1] as intermediate care facilities for individuals with intellectual disabilities, for room, board and services specified in licensing regulations issued by the licensing agency shall be determined annually, except as otherwise provided in this subsection, after a public hearing, by the Commissioner of Social Services, to be effective July first of each year except as otherwise provided in this subsection. Such rates shall be determined on a basis of a reasonable payment for such necessary services, which basis shall take into account as a factor the costs of such services. Cost of such services shall include reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons employed as managers or chief administrators or required to be licensed as nursing home administrators, and compensation for services rendered by proprietors at prevailing wage rates, as determined by application of principles of accounting as prescribed by said commissioner. Cost of such services shall not include amounts paid by the facilities to employees as salary, or to attorneys or consultants as fees, where the responsibility of the employees, attorneys, or consultants is to persuade or seek to persuade the other employees of the facility to support or oppose unionization. Nothing in this subsection shall prohibit inclusion of amounts paid for legal counsel related to the negotiation of collective bargaining agreements, the settlement of grievances or normal administration of labor relations. The commissioner may, in the commissioner's discretion, allow the inclusion of extraordinary and unanticipated costs of providing services that were incurred to avoid an immediate negative impact on the health and safety of patients. The commissioner may, in the commissioner's discretion, based upon review of a facility's costs, direct care staff to patient ratio and any other related information, revise a facility's rate for any increases or decreases to total licensed capacity of more than ten beds or changes to its number of licensed rest home with nursing supervision beds and chronic and convalescent nursing home beds. The commissioner may, in the commissioner's discretion, revise the rate of a facility that is closing. An interim rate issued for the period during which a facility is closing shall be based on a review of facility costs, the expected duration of the close-down period, the anticipated impact on Medicaid costs, available appropriations and the relationship of the rate requested by the facility to the average Medicaid rate for a close-down period. The commissioner may so revise a facility's rate established for the

fiscal year ending June 30, 1993, and thereafter for any bed increases, decreases or changes in licensure effective after October 1, 1989. Effective July 1, 1991, in facilities that have both a chronic and convalescent nursing home and a rest home with nursing supervision, the rate for the rest home with nursing supervision shall not exceed such facility's rate for its chronic and convalescent nursing home. All such facilities for which rates are determined under this subsection shall report on a fiscal year basis ending on September thirtieth. Such report shall be submitted to the commissioner by February fifteenth. Each for-profit chronic and convalescent nursing home that receives state funding pursuant to this section shall include in such annual report a profit and loss statement from each related party that receives from such chronic and convalescent nursing home fifty thousand dollars or more per year for goods, fees and services. No cause of action or liability shall arise against the state, the Department of Social Services, any state official or agent for failure to take action based on the information required to be reported under this subsection. The commissioner may reduce the rate in effect for a facility that fails to submit a complete and accurate report on or before February fifteenth by an amount not to exceed ten per cent of such rate. If a licensed residential care home as defined in this subsection, fails to submit a complete and accurate report, the department shall notify such home of the failure and the home shall have thirty days from the date the notice was issued to submit a complete and accurate report. If a licensed residential care home as defined in this subsection, fails to submit a complete and accurate report not later than thirty days after the date of notice, such home may not receive a retroactive rate increase, in the commissioner's discretion. The commissioner shall, annually, on or before April first, report the data contained in the reports of such facilities to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies. For the cost reporting year commencing October 1, 1985, and for subsequent cost reporting years, facilities shall report the cost of using the services of any nursing pool employee by separating said cost into two categories, the portion of the cost equal to the salary of the employee for whom the nursing pool employee is substituting shall be considered a nursing cost and any cost in excess of such salary shall be further divided so that seventy-five per cent of the excess cost shall be considered an administrative or general cost and twenty-five per cent of the excess cost shall be considered a nursing cost, provided if the total nursing pool costs of a facility for any cost year are equal to or exceed fifteen per cent of the total nursing expenditures of the facility for such cost year, no portion of nursing pool costs in excess of fifteen per cent shall be classified as administrative or general costs. The commissioner, in determining such rates, shall also take into account the classification of patients or boarders according to special care requirements or classification of the facility according to such factors as facilities and services and such other factors as the commissioner deems reasonable, including anticipated fluctuations in the cost of providing such services. The commissioner may establish a separate rate for a facility or a portion of a facility for traumatic brain injury patients who require extensive care but not acute general hospital care. Such separate rate shall reflect the special care requirements of such patients. If changes in federal or state laws, regulations or standards adopted subsequent to June 30, 1985, result in increased costs or expenditures in an amount exceeding one-half of one per cent of allowable costs for the most recent cost reporting year, the commissioner shall adjust rates and provide payment for any such increased reasonable costs or expenditures within a reasonable period of time retroactive to the date of enforcement. Nothing in this section shall be construed to require

the Department of Social Services to adjust rates and provide payment for any increases in costs resulting from an inspection of a facility by the Department of Public Health. Such assistance as the commissioner requires from other state agencies or departments in determining rates shall be made available to the commissioner at the commissioner's request. Payment of the rates established pursuant to this section shall be conditioned on the establishment by such facilities of admissions procedures that conform with this section, section 19a-533 and all other applicable provisions of the law and the provision of equality of treatment to all persons in such facilities. The established rates shall be the maximum amount chargeable by such facilities for care of such beneficiaries, and the acceptance by or on behalf of any such facility of any additional compensation for care of any such beneficiary from any other person or source shall constitute the offense of aiding a beneficiary to obtain aid to which the beneficiary is not entitled and shall be punishable in the same manner as is provided in subsection (b) of section 17b-97. For the fiscal year ending June 30, 1992, rates for licensed residential care homes and intermediate care facilities for individuals with intellectual disabilities may receive an increase not to exceed the most recent annual increase in the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items. Rates for newly certified intermediate care facilities for individuals with intellectual disabilities shall not exceed one hundred fifty per cent of the median rate of rates in effect on January 31, 1991, for intermediate care facilities for individuals with intellectual disabilities certified prior to February 1, 1991. Notwithstanding any provision of this section, the Commissioner of Social Services may, within available appropriations, provide an interim rate increase for a licensed chronic and convalescent nursing home or a rest home with nursing supervision for rate periods no earlier than April 1, 2004, only if the commissioner determines that the increase is necessary to avoid the filing of a petition for relief under Title 11 of the United States Code;[2] imposition of receivership pursuant to sections 19a-542 and 19a-543; or substantial deterioration of the facility's financial condition that may be expected to adversely affect resident care and the continued operation of the facility, and the commissioner determines that the continued operation of the facility is in the best interest of the state. The commissioner shall consider any requests for interim rate increases on file with the department from March 30, 2004, and those submitted subsequently for rate periods no earlier than April 1, 2004. When reviewing an interim rate increase request the commissioner shall, at a minimum, consider: (A) Existing chronic and convalescent nursing home or rest home with nursing supervision utilization in the area and projected bed need; (B) physical plant long-term viability and the ability of the owner or purchaser to implement any necessary property improvements; (C) licensure and certification compliance history; (D) reasonableness of actual and projected expenses; and (E) the ability of the facility to meet wage and benefit costs. No interim rate shall be increased pursuant to this subsection in excess of one hundred fifteen per cent of the median rate for the facility's peer grouping, established pursuant to subdivision (2) of subsection (f) of this section, unless recommended by the commissioner and approved by the Secretary of the Office of Policy and Management after consultation with the commissioner. Such median rates shall be published by the Department of Social Services not later than April first of each year. In the event that a facility granted an interim rate increase pursuant to this section is sold or otherwise conveyed for value to an unrelated entity less than five years after the effective date of such rate increase, the rate increase shall be deemed rescinded and the department shall recover an amount equal to the difference between payments made for all

affected rate periods and payments that would have been made if the interim rate increase was not granted. The commissioner may seek recovery of such payments from any facility with common ownership. With the approval of the Secretary of the Office of Policy and Management, the commissioner may waive recovery and rescission of the interim rate for good cause shown that is not inconsistent with this section, including, but not limited to, transfers to family members that were made for no value. The commissioner shall provide written quarterly reports to the joint standing committees of the General Assembly having cognizance of matters relating to aging, human services and appropriations and the budgets of state agencies, that identify each facility requesting an interim rate increase, the amount of the requested rate increase for each facility, the action taken by the commissioner and the secretary pursuant to this subsection, and estimates of the additional cost to the state for each approved interim rate increase. Nothing in this subsection shall prohibit the commissioner from increasing the rate of a licensed chronic and convalescent nursing home or a rest home with nursing supervision for allowable costs associated with facility capital improvements or increasing the rate in case of a sale of a licensed chronic and convalescent nursing home or a rest home with nursing supervision, pursuant to subdivision (15) of subsection (f) of this section, if receivership has been imposed on such home.

Sec. 2. Subsection (h) of section 17b-340 of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017)*:

(h) (1)~~][~~For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate in excess of one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate that is less than one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to sixty-five per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred thirty per cent of the median of operating cost components in effect January 1, 1992. Beginning with the fiscal year ending June 30, 1993, for the purpose of determining allowable fair rent, a residential care home with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Beginning with the fiscal year ending June 30, 1997, a residential care home with allowable fair rent less than three dollars and ten cents per day shall be reimbursed as having allowable fair rent equal to three dollars and ten cents per day. Property additions placed in service during the cost year ending September 30, 1996, or any succeeding cost year shall receive a fair rent allowance for such additions as an addition to three dollars and ten cents per day if the fair rent for the facility for property placed in service prior to September 30, 1995, is less than or equal to three dollars and ten cents per day. Beginning with the fiscal year ending June 30, 2016, a residential care home shall be reimbursed the greater of the allowable accumulated fair rent reimbursement associated with real property additions and land as calculated on a per day basis or three dollars and ten cents per day if the allowable reimbursement associated with real

property additions and land is less than three dollars and ten cents per day. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. Beginning with the fiscal year ending June 30, 1997, minimum allowable patient days for rate computation purposes for a residential care home with twenty-five beds or less shall be eighty-five per cent of licensed capacity. Beginning with the fiscal year ending June 30, 2002, for the purposes of determining the allowable salary of an administrator of a residential care home with sixty beds or less the department shall revise the allowable base salary to thirty-seven thousand dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies. The rates for the fiscal year ending June 30, 2002, shall be based upon the increased allowable salary of an administrator, regardless of whether such amount was expended in the 2000 cost report period upon which the rates are based. Beginning with the fiscal year ending June 30, 2000, and until the fiscal year ending June 30, 2009, inclusive, the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall be increased by two per cent, and beginning with the fiscal year ending June 30, 2002, the inflation adjustment for rates made in accordance with subsection (c) of said section shall be increased by one per cent. Beginning with the fiscal year ending June 30, 1999, for the purpose of determining the allowable salary of a related party, the department shall revise the maximum salary to twenty-seven thousand eight hundred fifty-six dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies and beginning with the fiscal year ending June 30, 2001, such allowable salary shall be computed on an hourly basis and the maximum number of hours allowed for a related party other than the proprietor shall be increased from forty hours to forty-eight hours per work week. For the fiscal year ending June 30, 2005, each facility shall receive a rate that is two and one-quarter per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is determined in accordance with applicable law and subject to appropriations, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (A) The federal financial participation matching funds associated with the rate increase are no longer available; or (B) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or

agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than four per cent greater than the rate in effect for the facility on September 30, 2006, except for any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate, except (i) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (ii) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except that (I) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (II) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2013, the Commissioner of Social Services may, within available appropriations, provide a rate increase to a residential care home. Any facility that would have been issued a lower rate for the fiscal year ending June 30, 2013, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, the Commissioner of Social Services may provide fair rent increases to any facility that has undergone a material change in circumstances related to fair rent and has an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. For the fiscal years ending June 30, 2014, and June 30, 2015, for those facilities that have a calculated rate greater than the rate in effect for the fiscal year ending June 30, 2013, the commissioner may increase facility rates based upon available appropriations up to a stop gain as determined by the commissioner. No facility shall be issued a rate that is lower than the rate in effect on June 30, 2013, except that any facility that would have been issued a lower rate for the fiscal year ending June 30, 2014, or the fiscal year ending June 30, 2015, due to interim rate status or agreement with the commissioner, shall be issued such lower rate. For the fiscal year ending June 30, 2014, and each fiscal year thereafter, a residential care home shall receive a rate increase for any capital improvement made during the fiscal year for the health and safety of residents and approved by the Department of Social Services, provided such rate increase is within available appropriations. For the fiscal year ending June 30, 2015, and each succeeding fiscal year thereafter, costs of less than ten thousand dollars that are incurred by a facility and are associated with any land, building or nonmovable equipment repair or improvement that are reported in the cost year used to establish the facility's rate shall not be capitalized for a period of more than five years for rate-setting purposes. For the fiscal year ending June 30, 2015, subject to available appropriations, the commissioner may, at the commissioner's discretion: Increase the inflation cost limitation under subsection (c) of section

~~17-311-52 of the regulations of Connecticut state agencies, provided such inflation allowance factor does not exceed a maximum of five per cent; establish a minimum rate of return applied to real property of five per cent inclusive of assets placed in service during cost year 2013; waive the standard rate of return under subsection (f) of section 17-311-52 of the regulations of Connecticut state agencies for ownership changes or health and safety improvements that exceed one hundred thousand dollars and that are required under a consent order from the Department of Public Health; and waive the rate of return adjustment under subsection (f) of section 17-311-52 of the regulations of Connecticut state agencies to avoid financial hardship.~~**]** For the fiscal years ending June 30, 2016, and June 30, 2017, rates shall not exceed those in effect for the period ending June 30, 2015, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in cost report years ending September 30, 2014, and September 30, 2015, that are not otherwise included in rates issued. For the fiscal years ending June 30, 2016, and June 30, 2017, and each succeeding fiscal year, any facility that would have been issued a lower rate, due to interim rate status, a change in allowable fair rent or agreement with the department, shall be issued such lower rate.

(2) The Commissioner of Social Services shall annually establish rates for licensed residential care homes that are not owned and operated by a related party, company or family association, as defined in subsection (a) that also owns or operates a nursing home pursuant to 19a-490. All such facilities under this subsection shall report on a fiscal year basis ending on September thirtieth. Such report shall be submitted to the commissioner by February fifteenth. No cause of action or liability shall arise against the state, the Department of Social Services, any state official or agent for failure to take action based on the information required to be reported under this subsection. The commissioner may reduce the rate in effect for a facility that fails to submit a complete and accurate report on or before February fifteenth by an amount not to exceed ten per cent of such rate.

[(2)**]** (3) The commissioner shall, upon determining that a loan to be issued to a residential care home by the Connecticut Housing Finance Authority is reasonable in relation to the useful life and property cost allowance pursuant to section 17-311-52 of the regulations of Connecticut state agencies, allow actual debt service, comprised of principal, interest and a repair and replacement reserve on the loan, in lieu of allowed property costs whether actual debt service is higher or lower than such allowed property costs.

Agency Legislative Proposal - 2017 Session

2) Pharmacy-DSS Proposal-2017

State Agency: Department of Social Services
Liaison: Krista Ostaszewski; Alvin Wilson E-mail: krista.ostaszewski@ct.gov; Alvin.Wilson@ct.gov Phone: 860-424-5612; 860-424-5105
Lead agency division requesting this proposal: Division of Health Services – Pharmacy Unit
Agency Analyst/Drafter of Proposal: Patricia McCooey, OLCRAH and Herman Kranc, Manager Pharmacy Unit

Title of Proposal: AAC Reimbursement for Covered Outpatient Drugs in the Medicaid Program
Statutory Reference Conn. Gen. Stat. Section 17b-280;
Proposal Summary On February 1, 2016, CMS published a regulation to implement a provision in the Affordable Care ACT that mandates all states (except for those with Medicaid managed-care arrangements) to implement a new reimbursement system for covered outpatient drugs in Medicaid. The regulation requires that such reimbursement methodology must be implemented by April 1, 2017. The reimbursement methodology for covered outpatient drugs under Medicaid mandated by state statute is no longer permitted under this CMS regulation. Medicaid generally reimburse pharmacies based on a two-part formula consisting of the ingredient cost and a professional fee. Ingredient Cost: Connecticut has used a formula based on Average Wholesale Price, as required by state statute (Conn. Gen. Stat. Sec. 17b-280) for the ingredient cost. The CMS regulation now requires states to base the ingredient cost on the "actual acquisition cost" (AAC). States were given the option to implement an AAC model or reimbursement based on various pricing methodologies, including national surveys, such as the National Average Drug Acquisition Cost (NADAC). CT has decided to move forward with utilizing the NADAC survey results (sponsored by CMS) as our pricing list for AAC. NADAC's AAC are published monthly and

can be found on CMS' website. States must implement an AAC-based reimbursement methodology on or before April 1, 2017.

Professional Fee: As part of CMS regulations, states must also now develop a "professional dispensing fee" to reflect pharmacists' professional services and costs to dispense a drug to a Medicaid client. Currently the state's professional fee is $1.40. The new dispensing fee will be based on actual pharmacy financials. DSS is participating in a regional survey with other New England states through the New England States Consortium Systems Organization (NESCSO) to determine this fee. The contractor for this regional survey is Myers and Stauffer. Along with the survey to pharmacies, Myers and Stauffer are also reviewing pharmacy financial statements and are performing random audits. The survey will be completed by the end of December. (This survey is being conducted at no cost to the participating states. CMS approved the survey for the regional New England states as states are a member of NESCSO).

In addition to the move to AAC pricing for most covered outpatient drugs, the regulations require states to submit a comprehensive amendment to their Medicaid state plans. As part of this State Plan Amendment, DSS is required to set forth its pricing methodology for drugs not subject to AAC, including specialty drugs not dispensed through a retail pharmacy, clotting factors and 340B purchased drugs. The Department also proposed to eliminate the statutory language allowing for an enhanced dispensing fee for drugs purchased by a pharmacy enrolled in the 340B program or under contract to provide services under the 340B program. 340B pharmacies currently receive a dispensing fee ($13) that is considerably higher than the state's dispensing fee to retail pharmacies ($1.40). The CMS regulations require states to specify a 340B drug pricing methodology that is consistent with overall AAC requirements.

PROPOSAL BACKGROUND

- **Reason for Proposal**

This change is necessary to conform state law to the requirements of the CMS Covered Outpatient Drug final Rule with Comment (CMS-2345-FC)(81FR 5170), published on February 1, 2016. Key provisions in the regulation take effect on April 1, 2017.

If the Department does not update our reimbursement methodology to align with CMS regulation by April 1, 2017, we would be considered out of compliance with CMS regulatory requirements. This would be put federal match dollars at risk. For context, in SFY 16 gross total pharmacy expenditures under CT Medicaid were approximately $1.24 billion.

- **Origin of Proposal** **_X_ New Proposal** **___ Resubmission**

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency) NONE

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

State

The fiscal impact of the changes in methodology are not known at this time. Professional fee will increase significantly. New methodology will raise reimbursement for some drugs and decrease reimbursement for others. The NADAC file will be updated on a monthly basis. If an AAC methodology is not implemented by April 1, 2017, DSS will be out of compliance with CMS regulation, putting federal match (50 – 90%, depending on the coverage group and/or service) at risk.

Federal

Federal match at risk if Department does not implement new methodology by April 1, 2017. For context, in SFY 16 gross total pharmacy expenditures under CT Medicaid were approximately $1.24 billion.

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The change in reimbursement methodology will require some changes to the MMIS system. The changes will also require considerable staff time to develop and implement the State Plan Amendment and system changes.

Section 17b-280 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

Sec. 17b-280. (Formerly Sec. 17-134bb). Reimbursement rate for legend drugs. Dispensing fee. Reimbursement for over-the-counter drugs and products. Enhanced dispensing fee. ~~(a) The state shall reimburse for all legend drugs provided under medical assistance programs administered by the Department of Social Services at the lower of (1) the rate established by the Centers for Medicare and Medicaid Services as the federal acquisition cost, (2) the average wholesale price minus sixteen per cent, or (3) an equivalent percentage as established under the Medicaid state plan. The state shall pay a professional fee of one dollar and seventy cents to licensed pharmacies for each prescription dispensed to a recipient of benefits under a medical assistance program administered by the Department of Social Services in accordance with federal regulations. On and after September 4, 1991, payment for legend and nonlegend drugs provided to Medicaid recipients shall be based upon the actual package size dispensed.~~ Effective on or after April 1, 2017, the Commissioner of Social Services may, with the approval of the Secretary of the Office of Policy and Management, revise the reimbursement methodology and professional dispensing fees for covered outpatient drugs under the Medicaid program to meet the requirements of federal regulations implementing changes to Section 1927 of the Social Security Act.

Effective October 1, 1991, reimbursement for over-the-counter drugs for such recipients shall be limited to those over-the-counter drugs and products published in the Connecticut Formulary, or the cross reference list, issued by the commissioner. The cost of all over-the-counter drugs and products provided to residents of nursing facilities, chronic disease hospitals, and intermediate care facilities for individuals with intellectual disabilities shall be included in the facilities' per diem rate. Notwithstanding the provisions of this subsection, no dispensing fee shall be issued for a prescription drug dispensed to a Medicaid recipient who is a Medicare Part D beneficiary when the prescription drug is a Medicare Part D drug, as defined in Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

~~(b) The Department of Social Services may provide an enhanced dispensing fee to a pharmacy enrolled in the federal Office of Pharmacy Affairs Section 340B drug discount program established pursuant to 42 USC 256b or a pharmacy under contract to provide services under said program.~~

Agency Legislative Proposal - 2017 Session

3) CBS SW Program-DSS proposal- 2017

State Agency:
Department of Social Services

Liaison: Krista Ostaszewski; Alvin Wilson
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Lead agency division requesting this proposal:
Social Work Division

Agency Analyst/Drafter of Proposal:
Lara Stauning, Staff Attorney; Dorian Long, Manager

Title of Proposal
AAC Social Work In-Home Support Program

Statutory Reference
Section 17b-605b

Proposal Summary

This proposal includes a technical modification that renames the Community Based Services Program to the Social Work In-Home Support Program.

This proposal also clarifies that if an individual is eligible for services through one of the Medicaid Home and Community Based Services programs (Community First Choice or a waiver program) then that individual cannot concurrently receive the same services through the Social Work In-Home Support Program (Community Based Services Program).

The one exception to this limitation is if a particular service is not available through a Medicaid Home and Community Based Services Program but is only available through the Social Work In-Home Support program (Community Based Services Program). This clarification is necessary to ensure that individuals do not access services through both a Medicaid Home and Community Based Services Program and the Social Work In-Home Support program (Community Based Services Program) simultaneously.

PROPOSAL BACKGROUND

- **Reason for Proposal**

  - With the addition of the Community First Choice Program (CFC) to the State Medicaid program there has been duplication of the exact same home and community based services for some recipients of both CFC and the Social Work In-Home Support program (Community Based Services Program) available from the Department's Social Work Division.

  - By eliminating duplicative services there is the potential to serve more residents with the Social Work In-Home Supports program (Community Based Services Program).

  - The program is funded through the Social Service Block Grant.

  - As of 11/1/16, a total of 1,115 individuals were receiving services under the CBS program.

  - While the controlling regulations allow for monthly expenditures of up to $650 per participant, average cost per participant to date this past SFY was $493.

  - The Social Work In-Home Support Program (Community Based Services Program) provides non-medical homecare services to maintain low income adults with physical and/or mental disabilities ages 18-64 in the community. The provision of these supportive services prevents adults with a disability from placement in a costly institutional setting. Core services include: adult day care; companion; meals on wheels; homemaker; and personal emergency response system.

- **Origin of Proposal** **_X__ New Proposal** **___ Resubmission**

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) none
State none
Federal none
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 17b-605b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

§ 17b-605b. ~~Community-based services~~ Social Work In-Home Support program for persons with disabilities. Eligibility. Regulations

(a) The Commissioner of Social Services, within available appropriations, may establish and operate a ~~community-based services~~ Social Work In-Home Support program for persons with disabilities (1) who are between the ages of eighteen and sixty-four years, and (2) who meet

the eligibility requirements specified in sections 17b-4(a)-1 to 17b-4(a)-6, inclusive, of the Regulations of Connecticut State Agencies. Such eligibility requirements with respect to income and assets shall not apply to persons eligible for medical assistance under section 17b-597 who were receiving social work in-home support services, formerly known as community-based services on October 1, 2000.

~~(b) The Commissioner of Social Services shall determine whether a person eligible for medical assistance under section 17b-597 who is receiving community-based services on October 1, 2000, is eligible for personal care assistance under section 17b-605a. Such person shall not qualify for community-based services in the event such person may be enrolled in the personal care assistance program at the time such person is disqualified from receiving community-based services.~~

(b) Any person participating in a Medicaid Home and Community-Based Services program shall not be also eligible for Social Work In-Home Support, unless a particular service is not otherwise available under a Medicaid Home and Community Based Services program.

(c) The Commissioner of Social Services shall implement the policies and procedures necessary to carry out the provisions of subsection (a) of this section while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal within twenty days after implementation. Such policies and procedures shall be valid until the time final regulations are effective.

Agency Legislative Proposal - 2017 Session

DSS_CS Income Withholding

State Agency: Department of Social Services

Liaison: Alvin Wilson/Krista Ostaszewski/Mike Carone/ Gordon Frassinelli

Lead agency division requesting this proposal: Office of Child Support Services

Agency Analyst/Drafter of Proposal: John Dillon –IV-D Director, BCSE

Title of Proposal: An Act Concerning Improvements to Income Withholding for Child Support

Statutory Reference CGS§§: 52-362

Proposal Summary

This proposal would:

Amend subsection (k) of section 52-362 to require that an employer include any income withholding for an employee when sending a referral to a worker's compensation (WC) carrier.

PROPOSAL BACKGROUND

- **Reason for Proposal**

52-362 Subsection (k) already mandates that employers "notify promptly the dependent or Support Enforcement Services as directed when the obligor terminates employment, makes a claim for workers' compensation benefits…"; however, child support has no means to ensure prompt notification.

Very often SES [of the Judicial Branch] learns that an employee is receiving workers compensation only after the employer withholding payments stops, and child support contacts the employer by mail or phone.

When child support learns that an employee is receiving workers compensation through a private insurance carrier, SES must prepare and send a subsequent IWO to the insurance carrier to withhold child support. Very often this process results in a 4-6 week gap in child support payments, sometime more.

Requiring that an employer forward income withholding orders (IWOs) to worker's compensation carriers will prevent delays in the transfer of IWOs and the collection of child support payments.

- **Origin of Proposal __ New Proposal ___X Resubmission**

PROPOSAL IMPACT

- **Agencies Affected**

Agency Name: Judicial Branch Support Enforcement Services Agency Contact: Doreen DelBianco- Deputy Director- Public Affairs Date Contacted: on going Approve of Proposal _x_YES ___NO ___Talks Ongoing Agency Name: Agency Contact: Date Contacted: on going Approve of Proposal ___ YES ___NO ___Talks Ongoing Agency Name: Agency Contact: Date Contacted: on going Approve of Proposal ___ YES ___NO __Talks Ongoing-no position Agency Name: Agency Contact: Date Contacted: on going Approve of Proposal ___ YES ___NO ___Talks Ongoing
Will there need to be further negotiation? ___YES **_X_**NO

- **Fiscal Impact**

Municipal

State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts**

Income withholding is the most effective means of enforcing court-ordered child support. In SFY 2016, 65% of the approximately $302 million collected through the Title IV-D program was obtained by means of income withholding directly from employers and other payers of income. The additional procedures and remedies proposed herein will close some loopholes in the existing process, expediting payments to families and saving personnel and other resources within the state agencies involved in the child support program.

AN ACT CONCERNING IMPROVEMENTS TO INCOME WITHHOLDING FOR CHILD SUPPORT

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

Sec. 4. Subsection (k) of section 52-362 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(k) The employer shall notify promptly the dependent or Support Enforcement Services as directed when the obligor terminates employment, makes a claim for workers' compensation benefits or makes a claim for unemployment compensation benefits and shall provide the obligor's last-known address and the name and address of the obligor's new employer, if known. When the obligor makes a claim for workers' compensation benefits, the employer shall include a copy of any order for withholding received for the obligor with the employer's first report of occupational illness or injury to the employer's workers' compensation benefits carrier, and such benefits carrier shall withhold funds pursuant to the withholding order and pay any sums withheld as required by subsection (f) of this section.