Agency Legislative Proposal - 2020 Session

Document Name: TPL Prompt Pay Requirement To Adjudicate Medicaid Claims

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Connecticut Department of Social Services ("CTDSS")

Liaison: Alvin Wilson
Phone: 860-424-5105
E-mail: **alvin.wilson@ct.gov**

Lead agency division requesting this proposal: Office of Quality Assurance

Agency Analyst/Drafter of Proposal: Eric Lecko

Title of Proposal: Third Party Liability ("TPL") Prompt Pay Requirement To Adjudicate state medical assistance plan claims

Statutory Reference: Title 42 CFR Part 433, Subpart D - Third Party Liability, §433.139 (d) (2); Connecticut General Statute Section 17b-265

Proposal Summary:

A legally liable third party defined under Connecticut General Statute 17b-265 (a), who upon receipt of a claim submitted by CTDSS or its agent for payment of a health care item or service covered under the state medical assistance plan, shall adjudicate the claim and either make payment, or request information necessary to determine its legal obligation to pay the claim, within ninety days of receipt of claim. The legally liable third party shall have an uncontestable obligation to pay the submitted claim within one hundred and twenty days of receipt of claim.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Prompt payment standards are common practice in Connecticut's health insurance industry. However, Connecticut has no statutes that require a health insurance company (a legally liable third party) to adjudicate within a reasonable time period, those claims submitted by CTDSS (or its agent) for CTDSS-paid health care items or services. When the Connecticut state medical assistance plan bills a health insurance company for a state assistance plan health care item or service, the processing of these claims can be delayed, sometimes indefinitely, or simply

ignored. The health insurance company takes no action either to deny or pay the claim. Annually, Connecticut Medicaid costs that should have been paid for by health insurance companies go un-recovered. During the last month of SFY 2019, there were $53.5 M in Medicaid claims, (previously billed to health insurance companies over the preceding 12 months) outstanding and not yet adjudicated by health insurance companies. TPL prompt payment requirements have been enacted in eight (8) states: LA, OH, ME, MI, MO, NC, NJ, FL, and TN. Across these eight states, the standard ranges from a 60-day prompt pay standard up to a 180-day standard. Congress is exploring a package of TPL amendments, including a 60-day prompt payment standard, which would require States to update their statutes and comply with the 60-day standard. Connecticut could realize significant savings by enacting TPL prompt payment legislation. The CTDSS TPL Contractor, Health Management Systems ,Inc. ("HMS"), performs TPL recovery work in other states that have enacted prompt pay legislation. HMS has seen health insurance recoveries increase between ten percent (10%) to fifty percent (50%) in these states. CTDSS believes a prompt pay standard could result in an annual increase of 10-20% in recoveries within one year following effective date of the legislation. In SFY 2019, CTDSS TPL health insurance recoveries were $21.6M. Prompt pay legislation could result in an annual increase of $2.1M to $4.3M in Medicaid cost savings.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

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)*
State CTDSS projects Medicaid health insurance recoveries to increase by $2.1M to $4.3M annually, one year following effective date of the legislation.
Federal
Additional notes on fiscal impact

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs. CTDSS maintains a comprehensive Medicaid health insurance recovery system that would be used to track the proposal impact over time and measure and evaluate outcomes

Insert fully drafted bill here

§ 17b-265. Department subrogated to right of recovery of applicant or recipient. Utilization of personal health insurance. Insurance coverage of medical assistance recipients. Limitations

Currentness

(a) In accordance with 42 USC 1396k, the Department of Social Services shall be subrogated to any right of recovery or indemnification that an applicant or recipient of medical assistance or any legally liable relative of such applicant or recipient has against an insurer or other legally liable third party including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974,[1] service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, for the cost of all health care items or services furnished to the applicant or recipient, including, but not limited to, hospitalization, pharmaceutical services, physician services, nursing services, behavioral health services, long-term care services and other medical services, not to exceed the amount expended by the department for such care and treatment of the applicant or recipient. In the case of such a recipient who is an enrollee in a care management organization under a Medicaid care management contract with the state or a legally liable relative of such an enrollee, the department shall be subrogated to any right of recovery or indemnification which the enrollee or legally liable relative has against such a private insurer or other third party for the medical costs incurred by the care management organization on behalf of an enrollee.

(b) An applicant or recipient or legally liable relative, by the act of the applicant's or recipient's receiving medical assistance, shall be deemed to have made a subrogation assignment and an assignment of claim for benefits to the department. The department shall inform an applicant of such assignments at the time of application. Any entitlements from a contractual agreement with an applicant or recipient, legally liable relative or a state or federal program for such medical services, not to exceed the amount expended by the department, shall be so assigned. Such entitlements shall be directly reimbursable to the department by third party payors. The Department of Social Services may assign its right to subrogation or its entitlement to benefits to a designee or a health care provider participating in the Medicaid program and providing services to an applicant or recipient, in order to assist the provider in obtaining payment for such services. In accordance with subsection (b) of section 38a-472, a provider that has received an assignment from the department shall notify the recipient's health insurer or other legally liable third party including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement

Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, of the assignment upon rendition of services to the applicant or recipient. Failure to so notify the health insurer or other legally liable third party shall render the provider ineligible for payment from the department. The provider shall notify the department of any request by the applicant or recipient or legally liable relative or representative of such applicant or recipient for billing information. This subsection shall not be construed to affect the right of an applicant or recipient to maintain an independent cause of action against such third party tortfeasor.

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

(d) When a recipient of medical assistance has personal health insurance in force covering care or other benefits provided under such program, payment or part-payment of the premium for such insurance may be made when deemed appropriate by the Commissioner of Social Services. Effective January 1, 1992, the commissioner shall limit reimbursement to medical assistance providers for coinsurance and deductible payments under Title XVIII of the Social Security Act[2] to assure that the combined Medicare and Medicaid payment to the provider shall not exceed the maximum allowable under the Medicaid program fee schedules.

(e) No self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974,[3] service benefit plan, managed care plan, or any plan offered or administered by a health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, shall contain any provision that has the effect of denying or limiting enrollment benefits or excluding coverage because services are rendered to an insured or beneficiary who is eligible for or who received medical assistance under this chapter. No insurer, as defined in section 38a-497a, shall impose requirements on the state Medicaid agency, which has been assigned the rights of an

individual eligible for Medicaid and covered for health benefits from an insurer, that differ from requirements applicable to an agent or assignee of another individual so covered.

(f) The Commissioner of Social Services shall not pay for any services provided under this chapter if the individual eligible for medical assistance has coverage for the services under an accident or health insurance policy.

(g) – A legally liable third party, upon receipt of a claim submitted by the department or its agent for payment of a health care item or service covered under the state medical assistance plan, shall within ninety days of receipt of the claim make payment on the claim, request information necessary to determine its legal obligation to pay the claim, or issue a written reason for denial of the claim. Failure to pay or deny a claim within one hundred and twenty days after receipt of the claim creates an uncontestable obligation to pay the claim.

Agency Legislative Proposal - 2020 Session

Document Name: Health Insurance TPL Refund Statute of Limitations

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Department of Social Services
Liaison: Alvin Wilson **Phone:** 860-424-5105 **E-mail:** **alvin.wilson@ct.gov**
Lead agency division requesting this proposal: Department of Social Services ("CTDSS")
Agency Analyst/Drafter of Proposal: Eric Lecko

Title of Proposal: Health Insurance Third Party Liability ("TPL") Refund Statute of Limitations
Statutory Reference: : 42 CFR 433.139 (d), Connecticut General Statute 17b-265
Proposal Summary: A legally liable third party defined under Connecticut General Statute 17b-265 (a), who has reimbursed CTDSS for a CTDSS-paid health care item or service covered under the state medical assistance plan, shall upon determining it is not liable and at risk for cost of the health care item or service, request any refund from CTDSS within twelve (12) months of the date of its initial payment.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

CTDSS submits bills to health insurance companies (legally liable third parties) for CTDSS-paid health care services or items and receives reimbursement from them. A health insurance company may realize later that it incorrectly paid for the health care service or item, and will request CTDSS to refund its payment. There are legitimate reasons for this TPL refund; e.g. a client's health insurance policy termed prior to the individual receiving the health care service or item. However, no Connecticut statute exists limiting the time period in which a health insurance company may seek refund from CTDSS. This subjects the state agency to unpredictable refund requests at a cost to CTDSS and CTDSS TPL contractor staff. The solution is to establish a reasonable time period for health insurance companies to request a refund from CTDSS. Four (4) states have enacted a TPL refund statute of limitations: OH, MN, NJ, and TN.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

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)*
State
Federal
Additional notes on fiscal impact

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

◊ EVIDENCE BASE

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs.

Insert fully drafted bill here

§ 17b-265. Department subrogated to right of recovery of applicant or recipient. Utilization of personal health insurance. Insurance coverage of medical assistance recipients. Limitations

Currentness

(a) In accordance with 42 USC 1396k, the Department of Social Services shall be subrogated to any right of recovery or indemnification that an applicant or recipient of medical assistance or any legally liable relative of such applicant or recipient has against an insurer or other legally liable third party including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974,[1] service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, for the cost of all health care items or services furnished to the applicant or recipient, including, but not limited to, hospitalization, pharmaceutical services, physician services, nursing services, behavioral health services, long-term care services and other medical services, not to exceed the amount expended by the department for such care and treatment of the applicant or recipient. In the case of such a recipient who is an enrollee in a care management organization under a Medicaid care management contract with the state or a legally liable relative of such an enrollee, the department shall be subrogated to any right of recovery or indemnification which the enrollee or legally liable relative has against such a private insurer or other third party for the medical costs incurred by the care management organization on behalf of an enrollee.

(b) An applicant or recipient or legally liable relative, by the act of the applicant's or recipient's receiving medical assistance, shall be deemed to have made a subrogation assignment and an assignment of claim for benefits to the department. The department shall inform an applicant of such assignments at the time of application. Any entitlements from a contractual agreement with an applicant or recipient, legally liable relative or a state or federal program for such medical services, not to exceed the amount expended by the department, shall be so assigned. Such entitlements shall be directly reimbursable to the department by third party payors. The Department of Social Services may assign its right to subrogation or its entitlement to benefits to a designee or a health care provider participating in the Medicaid program and providing services to an applicant or recipient, in order to assist the provider in obtaining payment for such services. In accordance with subsection (b) of section 38a-472, a provider that has received an assignment from the department shall notify the recipient's health insurer or other legally liable third party including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, of the assignment upon rendition of services to the applicant or recipient. Failure to so notify the health insurer or other legally liable third party shall render the provider ineligible for payment from the department. The provider shall notify the department of any request by the applicant or recipient or legally liable relative or representative of such applicant or recipient for billing information. This subsection shall not be construed to affect the right of an applicant or recipient to maintain an independent cause of action against such third party tortfeasor.

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

(d) When a recipient of medical assistance has personal health insurance in force covering care or other benefits provided under such program, payment or part-payment of the premium for such insurance may be made when deemed appropriate by the Commissioner of Social Services. Effective January 1, 1992, the commissioner shall limit reimbursement to medical assistance providers for coinsurance and deductible

payments under Title XVIII of the Social Security Act[2] to assure that the combined Medicare and Medicaid payment to the provider shall not exceed the maximum allowable under the Medicaid program fee schedules.

(e) No self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974,[3] service benefit plan, managed care plan, or any plan offered or administered by a health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, shall contain any provision that has the effect of denying or limiting enrollment benefits or excluding coverage because services are rendered to an insured or beneficiary who is eligible for or who received medical assistance under this chapter. No insurer, as defined in section 38a-497a, shall impose requirements on the state Medicaid agency, which has been assigned the rights of an individual eligible for Medicaid and covered for health benefits from an insurer, that differ from requirements applicable to an agent or assignee of another individual so covered.

(f) The Commissioner of Social Services shall not pay for any services provided under this chapter if the individual eligible for medical assistance has coverage for the services under an accident or health insurance policy.

(g) – reserved

(h) – A legally liable third party who has reimbursed the department for a health care item or service paid for and covered under the state medical assistance plan, shall, upon determining it is not liable and at risk for cost of the health care item or service, request any refund from the department within twelve months from the date of its initial payment.

Agency Legislative Proposal - 2020 Session

Document Name: 082719_DSS_PaternityDeterminations

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

State Agency: **Department of Social Services**

Liaison: Alvin Wilson
Phone: 860-424-5105
E-mail: alvin.wilson@ct.gov

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

Agency Analyst/Drafter of Proposal: Graham Shaffer, Legal Unit

Title of Proposal: An Act Concerning Paternity Determinations

Statutory Reference: Connecticut General Statutes §§ 46b-171, 46b-172, 46b-172a

Proposal Summary

This proposal clarifies how a court or family support magistrate should evaluate a motion to open and set aside a judgment or acknowledgement of paternity. The amendments made by the proposal codify the analysis already established by a number of Superior Court decisions. The proposal ensures that the best interest of the child is taken into consideration prior to granting such a motion.

Background

Chapter 815y of the General Statutes includes provisions for establishing the paternity of a child born out of wedlock. There are three sections of the statutes that govern the authority of the Superior Court, family support magistrate and Probate Court when reviewing a motion to overturn an acknowledgement of paternity.

Section 46b-160 to 46b-171, inclusive, set forth procedures to be used by the Superior Court or family support magistrate when the mother of the child seeks a judgment of paternity from the court.

Section 46b-172 authorizes the use of a written acknowledgment of paternity that may be used by the mother and putative father to establish the child's paternity, and provides that, when executed, the acknowledgement has the same force and effect as a judgment of the Superior Court.

Section 46b-172a sets forth procedures to be used by the Probate Court when the putative father (or, upon his death, any party deemed by the Probate Court to have a sufficient interest in the putative father's paternity) wishes to obtain a judgment of paternity in his favor.

Once paternity is established by one of these methods, these statutes provide little guidance on how a court or family support magistrate should handle a challenge to the previous acknowledgment or judgment of paternity. Where an acknowledgment executed pursuant to section 46b-172 is the basis for paternity, subsection (a)(2) of that statute allows for a sixty-day rescission period, and provides that, after this period expires, the acknowledgment of paternity may only be challenged "on the basis of fraud, duress or material mistake of fact which may include evidence that [the man who executed the acknowledgment] is not the father, with the burden of proof upon the challenger."

Although the statute does not prescribe an analysis that also takes into consideration the best interests of the child, courts and family support magistrates reviewing challenges to acknowledgments of paternity brought outside the rescission period have nevertheless taken the child's interests into consideration, and have developed a number of factors to be weighed when assessing the child's interest. *See, e.g., Colonghi v. Arcarese*, Superior Court, judicial district of Middlesex at Middletown, Docket No. FA-13-4016846 (January 10, 2014, *Quinn, J.T.R.*) (2014 WL 341888).

Where a judgment establishing paternity was entered by a court or family support magistrate, sections 46b-160 to 46b-171, inclusive, and 46b-172a do not address how such court or magistrate should review a motion to open the judgment and set it aside, though the statutes do contemplate that such a judgment may be set aside. *See* Conn. Gen. Stat. § 46b-171(b) (requiring the Department of Social Services to refund any child support paid to the state by a man previously adjudged father when the judgment of paternity is opened and such man is determined not to be the child's father). In the absence of clarity on this point, courts have ruled that the provisions of General Statutes § 52-212a and Practice Book § 17-4 concerning the opening of civil judgments apply, meaning that a paternity judgment may be opened within four months of the entrance of the judgment, and only upon a showing of fraud, duress, or material mistake of fact after this four-month period. *See, e.g., State v. Dansby*, Superior Court, judicial district of Waterbury, Docket No. FA-89-92582 (June 24, 2005, *Wihbey, F.S.M.*) (29 Conn. L. Rptr. 768).

This legislative proposal codifies the rules already followed by many Connecticut courts and family support magistrates when a judgment or acknowledgment of paternity is challenged outside the window for doing so (e.g., four months on a motion to open or set aside a judgment of paternity, and sixty days on a challenge to an acknowledgment of paternity). It establishes a two-part test in all such cases. First, the court or family support magistrate must determine whether the judgment or acknowledgment was due to fraud, duress, or a material mistake of fact. If the court or magistrate finds fraud, duress or a material mistake of fact occurred, it next must determine that setting aside the previous judgment or acknowledgment would be in the best interest of the child, after considering a number of factors.

In addition, the legislative proposal codifies a jurisdictional rule established by the Appellate Court in *Cardona v. Negron*, 53 Conn. App. 152, 727 A.2d 1150 (1999), which held that, absent a showing of fraud, duress, or material mistake of fact, courts and family support magistrates have no authority to order genetic testing in a case where an acknowledgment or judgment of paternity has become final.

History of proposal

This proposal was submitted to OPM during the 2018 legislative session, but was not formally presented to the General Assembly because the family support magistrates did not support it at that time. The family support magistrates' lack of support was based on their belief that the proposal was unnecessary. Central to this belief was their assumption that the family support magistrates and judges of the Superior Court have inherent authority to open a judgment or acknowledgment of paternity if doing so is in the best interest of the child. At that time, a case presenting the question of whether this inherent authority exists was pending before the Appellate Court. The family support magistrates' indicated they believed the Department's proposal was premature because, if the Appellate Court upheld the lower court's ruling that such inherent authority does exist, the proposal would be unnecessary.

However, on May 15, 2018, the Appellate Court overturned the lower court's ruling in the case in question. *See Asia A.M. v. Geoffrey M., Jr.,* 182 Conn. App. 22, 188 A.3d 762, 764 (2018). In that case, which dealt with an attempt to open and set aside an acknowledgment of paternity executed pursuant to section 46b-172, the Appellate Court held that "[b]eyond the sixty day rescission period, and absent a finding of fraud, duress, or material mistake of fact, [a] magistrate [does] not have the authority to grant [a] motion to open the judgment" of paternity. *Id.* at 38.

The proposal was formally submitted during the 2019 legislative session and was not opposed by the magistrates, given the ruling in *Asia A.M.* The bill was voted out of the Judiciary Committee, but died on the Senate floor.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

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

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

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

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

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Agency Name: Probate Court
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)

State

Federal
Additional notes on fiscal impact

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

Insert fully drafted bill here

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

Section 1. Subsection (b) of section 46b-171 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) (1) Except as provided in subdivisions (2) and (3) of this subsection, a judgment of paternity entered by the Superior Court or family support magistrate pursuant to this chapter may not be opened or set aside unless a motion to open or set aside is filed not later than four months after the date on which the judgment was entered, and only upon a showing of reasonable cause, or that a valid defense to the petition for a judgment of paternity existed, in whole or in part, at the time judgment was rendered, and that the person seeking to open or set aside the judgment was prevented by mistake, accident or other reasonable cause from making a valid defense. The court or a family support magistrate may not order genetic testing to determine paternity unless such court or magistrate determines that the person seeking to open or set aside the judgment of paternity pursuant to this subdivision has made such a showing of reasonable cause or established the existence of a valid defense.

(2) The Superior Court or a family support magistrate may consider a motion to open or set aside a judgment of paternity filed more than four months after such judgment was entered if such court or magistrate determines that the judgment was entered due to fraud, duress or material mistake of fact, with the burden of proof on the person seeking to open or set aside such judgment. A court or family support magistrate may not order genetic testing to determine paternity unless such court or magistrate determines that the person seeking to open or set aside the judgment of paternity under this subdivision has met such burden.

(3) If the court or family support magistrate, as the case may be, determines that the person seeking to open or set aside a judgment of paternity under subdivision (2) of this subsection has met his or her burden of demonstrating fraud, duress or material mistake of fact, such court or magistrate shall set aside the judgment only upon determining that doing so is in the best interest of the child. In evaluating the best interest of the child, the court or magistrate may consider, but shall not be limited to, the following factors:

(A) Any genetic information available to the court or family support magistrate concerning paternity;

(B) The past relationship between the child and (i) the person previously adjudged father of the child, and (ii) such person's family;

(C) The child's future interests in knowing the identity of his or her biological father;

(D) The child's potential emotional and financial support from his or her biological father; and

(E) Any potential harm the child may suffer by disturbing the judgment of paternity, including loss of a parental relationship and loss of financial support.

[(b)**]** (5) Whenever the Superior Court or family support magistrate **[**reopens**]** opens a judgment of paternity **[**entered**]** pursuant to this **[**section**]** subsection in which (A) a person was found to be the father of a child who is or has been supported by the state, and (B) the court or family support magistrate finds that the person adjudicated the father is not the father of the child, the Department of Social Services shall refund to

such person any money paid to the state by such person during the period such child was supported by the state.

Sec. 2. Subsection (a) of section 46b-172 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) (1) In lieu of or in conclusion of proceedings under section 46b64 160, a written acknowledgment of paternity executed and sworn to by the putative father of the child when accompanied by (A) an attested waiver of the right to a blood test, the right to a trial and the right to an attorney, (B) a written affirmation of paternity executed and sworn to by the mother of the child, and (C) if the person subject to the acknowledgment of paternity is an adult eighteen years of age or older, a notarized affidavit affirming consent to the voluntary acknowledgment of paternity, shall have the same force and effect as a judgment of the Superior Court. It shall be considered a legal finding of paternity without requiring or permitting judicial ratification, and shall be binding on the person executing the same whether such person is an adult or a minor, subject to subdivision (2) of this subsection. Such acknowledgment shall not be binding unless, prior to the signing of any affirmation or acknowledgment of paternity, the mother and the putative father are given oral and written notice of the alternatives to, the legal consequences of, and the rights and responsibilities that arise from signing such affirmation or acknowledgment. The notice to the mother shall include, but shall not be limited to, notice that the affirmation of paternity may result in rights of custody and visitation, as well as a duty of support, in the person named as father. The notice to the putative father shall include, but not be limited to, notice that such father has the right to contest paternity, including the right to appointment of counsel, a genetic test to determine paternity and a trial by the Superior Court or a family support magistrate and that acknowledgment of paternity will make such father liable for the financial support of the child until the child's eighteenth birthday. In addition, the notice shall inform the mother and the father that DNA testing may be able to establish paternity with a high degree of accuracy and may, under certain circumstances, be available at state expense. The notices shall also explain the right to rescind the acknowledgment, as set forth in subdivision (2) of this subsection, including the address where such notice of rescission should be sent, and shall explain that the acknowledgment cannot be challenged after sixty days, except in court upon a showing of fraud, duress or material mistake of fact.

(2) The mother and the acknowledged father shall have the right to rescind such affirmation or acknowledgment in writing within the earlier of (A) sixty days, or (B) the date of an agreement to support such child approved in accordance with subsection (b) of this section or an order of support for such child entered in a proceeding under subsection (c) of this section.

(3) (A) An acknowledgment executed in accordance with subdivision (1) of this subsection may be challenged in court or before a family support magistrate after the rescission period only on the basis of fraud, duress or material mistake of fact which may include evidence that he is not the father, with the burden of proof upon the challenger. A court or family support magistrate may not order genetic testing to determine paternity unless the court or magistrate, as the case may be, determines that the challenger has met such burden.

(B) If the court or family support magistrate, as the case may be, determines that the challenger has met his or her burden under subparagraph (A) of this subdivision, the acknowledgment of paternity shall be set aside only if such court or magistrate determines that doing so is in the best interest of the child. In evaluating the best interest of the child, the court or magistrate may consider, but shall not be limited to, the following factors:

(i) Any genetic information available to the court concerning paternity;

(ii) The past relationship between the child and (I) the person who executed an acknowledgment of paternity, and (II) such person's family;

(iii) The child's future interests in knowing the identity of his or her biological father;

(iv) The child's potential emotional and financial support from his or her biological father; and

(v) Any potential harm the child may suffer by disturbing the acknowledgment of paternity, including loss of a parental relationship and loss of financial support.

(C) During the pendency of any **[**such**]** challenge to a previous acknowledgment of paternity, any responsibilities arising from such acknowledgment shall continue except for good cause shown.

[(3)**]** (4) All written notices, waivers, affirmations and acknowledgments required under subdivision (1) of this subsection, and rescissions authorized under subdivision (2) of this subsection, shall be on forms prescribed by the Department of Public Health, provided such acknowledgment form includes the minimum requirements specified by the Secretary of the United States Department of Health and Human Services. All acknowledgments and rescissions executed in accordance with this subsection shall be filed in the paternity registry established and maintained by the Department of Public Health under section 19a-42a.

[(4)**]** (5) An acknowledgment of paternity signed in any other state according to its procedures shall be given full faith and credit by this state.

Sec. 3. Section 46b-172a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) Any person claiming to be the father of a child who was born out of wedlock and for whom paternity has not yet been established may file a claim for paternity with the Probate Court for the district in which either the mother or the child resides, on forms provided by such court. The claim may be filed at any time during the life of the child, whether before, on or after the date the child reaches the age of eighteen, or after the death of the child, but not later than sixty days after the date of notice under section 45a-716. The claim shall contain the claimant's name and address, the name and last-known address of the mother and the month and year of the birth or expected birth of the child. Not later than five days after the filing of a claim for paternity, the court shall cause a certified copy of such claim to be served upon the mother or prospective mother of such child by personal service or service at her usual place of abode, and to the Attorney General by first class mail. The Attorney General may file an appearance and shall be and remain a party to the action if the child is receiving or has received aid or care from the state, or if the child is receiving child support enforcement services, as defined in subdivision (2) of subsection (b) of section 46b-231. The claim for paternity shall be admissible in any action for paternity under section 46b-160, and shall estop the claimant from denying his paternity of such child and shall contain language that he acknowledges liability for contribution to the support and education of the child after the child's birth and for contribution to the pregnancy-related medical expenses of the mother.

(b) If a claim for paternity is filed by the father of any minor child who was born out of wedlock, the Probate Court shall schedule a hearing on such claim, send notice of the hearing to all parties involved and proceed accordingly.

(c) The child shall be made a party to the action and shall be represented by a guardian ad litem appointed by the court in accordance with section 45a-708. Payment shall be made in accordance with such section from funds appropriated to the Judicial Department, except that, if funds have not been included in the budget of the Judicial Department for such purposes, such payment shall be made from the Probate Court Administration Fund.

(d) In the event that the mother or the claimant father is a minor, the court shall appoint a guardian ad litem to represent him or her in accordance with the provisions of section 45a-708. Payment shall be made in accordance with said section from funds appropriated to the Judicial Department, except that, if funds have not been included in the budget of the Judicial Department for such purposes, such payment shall be made from the Probate Court Administration Fund.

(e) By filing a claim under this section, the putative father submits to the jurisdiction of the Probate Court.

(f) Once alleged parental rights of the father have been adjudicated in his favor under subsection (b) of this section, or acknowledged as provided for under section 46b-172, as amended by this act, his rights and responsibilities shall be equivalent to those of the mother, including those rights defined under section 45a-606. Thereafter, disputes involving custody, visitation or support shall be transferred to the Superior Court under chapter 815j, except that the Probate Court may enter a temporary order for custody, visitation or support until an order is entered by the Superior Court.

(g) Failing perfection of parental rights as prescribed by this section, any person claiming to be the father of a child who was born out of wedlock (1) who has not been adjudicated the father of such child by a court of competent jurisdiction, **[**or**]** (2) who has not acknowledged in writing that he is the father of such child, **[**or**]** (3) who has not contributed regularly to the support of such child, or (4) whose name does not appear on the birth certificate, shall cease to be a legal party in interest in any proceeding concerning the custody or welfare of the child, including, but not limited to,

guardianship and adoption, unless he has shown a reasonable degree of interest, concern or responsibility for the child's welfare.

(h) Notwithstanding the provisions of this section, after the death of the father of a child who was born out of wedlock, a party deemed by the court to have a sufficient interest may file a claim for paternity on behalf of such father with the Probate Court for the district in which either the putative father resided or the party filing the claim resides. If a claim for paternity is filed pursuant to this subsection, the Probate Court shall schedule a hearing on such claim, send notice of the hearing to all parties involved and proceed accordingly.

(i) (1) Except as provided in subdivisions (2) and (3) of this subsection, a judgment of paternity entered under this section may not be opened or set aside unless a motion to open or set aside is filed with the Probate Court district that entered such judgment not later than four months after the date on which it was entered, and only upon a showing of reasonable cause, or that a valid defense to the claim for a judgment of paternity existed, in whole or in part, at the time judgment was entered, and that the person seeking to open or set aside such judgment was prevented by mistake, accident or other reasonable cause from making a valid defense. The Probate Court may not order genetic testing to determine paternity unless and until the court determines that the person seeking to open or set aside the judgment of paternity pursuant to this subdivision has made such a showing of reasonable cause or established the existence of a valid defense.

(2) The Probate Court in the district where a judgment of paternity was entered pursuant to this section may consider a motion to open or set aside such judgment filed more than four months after such judgment was rendered if such court determines that the judgment was rendered due to fraud, duress or material mistake of fact, with the burden of proof on the person seeking to open or set aside such judgment. Such court may not order genetic testing to determine paternity unless and until the court determines that the person seeking to open or set aside the judgment of paternity under this subdivision has met such burden.

(3) If such court determines that the person seeking to open or set aside a judgment of paternity under subdivision (2) of this subsection has met his or her burden of demonstrating fraud, duress or material mistake of fact, such court shall set aside the judgment only upon determining that doing so is in the best interest of the

child. In evaluating the best interest of the child, the court may consider, but shall not be limited to, the following factors:

(A) Any genetic information available to the court concerning paternity;

(B) The past relationship between the child and (i) the person previously adjudged father of the child, and (ii) such person's family;

(C) The child's future interests in knowing the identity of his or her biological father;

(D) The child's potential emotional and financial support from his or her biological father; and

(E) Any potential harm the child may suffer by disturbing the judgment of paternity, including loss of a parental relationship and loss of financial support.

(4) Upon the filing of any motion to open and set aside a judgment of paternity filed pursuant to this subsection, the Probate Court shall schedule a hearing on the motion and provide notice of the hearing and a copy of the motion to all interested parties, including the Attorney General.

(5) During the pendency of any motion to open or set aside a judgment of paternity filed pursuant to this subsection, any responsibilities arising from such earlier judgment shall continue, except for good cause shown.

Agency Legislative Proposal - 2020 Session

Document Name: 090319_DSS_DelinquentObligors

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

State Agency: **Department of Social Services**

Liaison: Alvin Wilson
Phone: 860-424-5105
E-mail: **alvin.wilson@ct.gov**

Lead agency division requesting this proposal: OCSS

Agency Analyst/Drafter of Proposal: Graham Shaffer, Legal

Title of Proposal: AAC A List of the 100 Most Delinquent Child Support Obligors

Statutory Reference: Conn. Gen. Stat. § 17b-179(*l*)

Proposal Summary

Connecticut General Statutes § 17b-179(*l*) requires the Department of Social Services (the Department) to create, maintain, and publish on its website a list of the one hundred most delinquent child support obligors based on the information contained in the federally-mandated state case registry of all child support orders established or modified in the State. To date, the Department has not published such a list on its website for a number of reasons.

First, since the requirement to create and publish this list was enacted by Public Act 14-177, no funds have ever been appropriated for programming changes to the state case registry, known as the Connecticut Child Support Enforcement System (CCSES), that would be necessary to allow the Department to identify the one hundred most delinquent child support obligors. The Department has previously estimated that the cost of making these programming changes to its antiquated system would likely exceed $100,000, and simply has never been able to identify funding for this project within available appropriations, particularly given that CCSES will be replaced in the coming years.

Furthermore, although implementing regulations are not required by section 17b-179(*l*), it became apparent to the Department that such regulations would be necessary to ensure that, for instance, an obligor whose name and address are to be published on the Internet is first afforded due process, including a right to a hearing, and that custodial parents and children who are at risk of abuse or harm due to the publication of an obligor's personal information also have a voice in the process. Such a regulation was publically noticed in 2016. *See*

https://eregulations.ct.gov/eRegsPortal/Search/RMRView/PR2015-154. Subsequently, the Department received comments from Connecticut Legal Services, some of which cast doubt on the legality of publically disclosing information from the state case registry, particularly given that the support orders entered into the registry are not limited to IV-D support cases.

Finally, and perhaps most importantly, the requirement is antithetical to the Department's modern approach to operating the IV-D program, and places Connecticut at the extreme of child support enforcement when compared to its peers. As the agency leading the John S. Martinez Fatherhood Initiative of Connecticut, the Department seeks to encourage fathers to participate in their children's lives and upbringing, rather than shaming or threatening fathers into a role of responsibility, which experience has demonstrated often drives a wedge between families and can actually reduce support collection.

Furthermore, the Department has surveyed IV-D programs in other states, and the responses collected to date (from 39 of 50 states) indicate that few states publish the names and identifying information of delinquent child support obligors. **Notably, among Connecticut's geographic neighbors in New York, New Jersey and the rest of New England, no state publishes the names of delinquent child support obligors.** While six states (Texas, New Mexico, Louisiana, Indiana, Illinois, and Arizona) do publish the names of some delinquent child support obligors online, the criteria for determining whether an obligor's name is published is often more restrictive than under Connecticut's law. For instance, in Indiana, an obligor's name is only published if a county prosecutor determines that the obligor is actively evading his or her support obligations, and sends the obligor's name to the state IV-D agency for publication. This has resulted in fewer than ten names being published each year since 2014. *See* https://www.in.gov/dcs/3333.htm. Similarly, New Mexico only publishes the name of a delinquent obligor if there is an outstanding bench warrant for his or her arrest; in other words, New Mexico only publishes information that is otherwise publically available through court documents and proceedings. *See* https://www.hsd.state.nm.us/bench-warrant-program.aspx. Arizona weeds out obligors who have filed for bankruptcy or are receiving public assistance, and therefore have a demonstrated inability to pay. *See* https://des.az.gov/services/child-and-family/child-support/wanted-child-support-evaders.

The response received from the IV-D director in Iowa was instructive. Iowa discontinued the practice of publishing the names of delinquent child support obligors many years ago because it found that the amount of work that was involved in maintaining the list outweighed the very small amounts that were collected as a result of its publication.

For all of these practical, legal, financial and strategic reasons, the Department believes that the requirement to publish a list of delinquent child support obligors, as set forth in section 17b-179(*l*) of the General Statutes, should be repealed.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

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

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

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)

State

Federal
Additional notes on fiscal impact

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

Insert fully drafted bill here

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

Section 1. Subsection (*l*) of section 17b-179 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

(*l*) The Office of Child Support Services shall arrange to provide a single centralized automated system for the reporting of collections on all accounts established for the collection of all IV-D support orders. Such reporting shall be made available to the Family Support Magistrate Division and to all state agencies which have a cooperative agreement with the IV-D agency. Such automated system shall include a state case registry which complies with federal law and regulations. The state case registry shall contain information on each support order established or modified in this state. **[**The Office of Child Support Services, utilizing information contained in the state case registry, shall establish, maintain and periodically update a list of all delinquent child support obligors. The list shall, at a minimum, contain the name, residential address and amount of the delinquent child support owed by a child support obligor, exclusive of any amount of child support owed for which an appeal is pending. The Office of Child Support Services shall publish on the Department of Social Services'

Internet web site, the names, residential addresses and amounts of delinquent child support owed by the one hundred individuals having the highest delinquent child support obligations. For purposes of this subsection, "delinquent child support obligor" means an obligor who (1) owes overdue child support, accruing after the entry of a court order, in an amount which exceeds ninety days of periodic payments on a current child support or arrearage payment order, or (2) has failed to make court ordered medical or dental insurance coverage available within ninety days of the issuance of a court order or fails to maintain such coverage pursuant to a court order for a period of ninety days.**]**

Agency Legislative Proposal - 2020 Session

Document Name: Eligibility Requirements for Participating in CHCPD

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Department of Social Services

Liaison: Alvin Wilson
Phone: 860-424-5105
E-mail: **alvin.wilson@ct.gov**

Lead agency division requesting this proposal: Community Options Unit

Agency Analyst/Drafter of Proposal: Paul Chase; Melanie Dillon

Title of Proposal: An Act Concerning the Connecticut Home Care Program for Persons with Disabilities (CHCPD)

Statutory Reference: CGS 17b-617

Proposal Summary:

The state funded pilot program for disabled individuals ages 18-64 was established in 2007 and intended to provide these individuals with the same services as are provided under the state funded portion of the Connecticut Home Care Program for Elders. The program is currently limited to 100 participants. Since the inception of the program in 2007, DSS has not allowed individuals who are eligible or active on Medicaid to participate in the program since they may obtain services through the Medicaid State Plan or a Medicaid Waiver. Section 17b-617 provides the asset limits for the program but does not specifically state that individuals who are eligible for or active on Medicaid shall not be eligible to participate in the pilot program. This proposal amends the statute to clearly state that individuals who are eligible for Medicaid under Title XIX or a Medicaid Waiver shall not be eligible for the CHCPD.

PROPOSAL BACKGROUND

◊ Reason for Proposal

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

The Community Options unit has denied or discontinued Medicaid eligible individuals from the program. If the individual requests a hearing after receiving notice of the denial or discontinuance, the Department would most likely lose the hearing because the statute does not state that Medicaid eligible individuals are not eligible for this program.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share: *(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* *(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* *(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* *(4) What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: N/A **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)*
State
Federal

Additional notes on fiscal impact

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Since the Department currently limits the program to non-Medicaid eligible individuals, this would make the statutory language consistent with Department policy and the Department would be able to rely on the statutory language in the event the individual requests a fair hearing contesting the denial or discontinuance.

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs.

Sec. 1. Section 17b-617 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective upon passage*);

(a) The Commissioner of Social Services shall, within available appropriations, establish and operate a state-funded pilot program to allow not more than one hundred persons with disabilities (1) who are age eighteen to sixty-four, inclusive, (2) who are inappropriately institutionalized or at risk of inappropriate institutionalization, [and] (3) whose assets do not exceed the asset limits of the state-funded home care program for the elderly, established pursuant to subsection (i) of section 17b-342, to be eligible to receive the same services that are provided under the state-funded home care program for the elderly, and (4) who are not currently eligible for medical assistance under section 17b-261 or a Medicaid waiver pursuant to 42 USC 1396n (c). At the discretion of the Commissioner of Social Services, such persons may also be eligible to receive services that are necessary to meet needs attributable to disabilities in order to allow such persons to avoid institutionalization.

(b) Any person participating in the pilot program whose income exceeds two hundred per cent of the federal poverty level shall contribute to the cost of care in accordance with the methodology established for recipients of medical assistance pursuant to sections 5035.20 and 5035.25 of the department's uniform policy manual.

(c) The annualized cost of services provided to an individual under the pilot program shall not exceed

fifty per cent of the weighted average cost of care in nursing homes in the state.

(d) If the number of persons eligible for the pilot program established pursuant to this section exceeds one hundred persons or if the cost of the program exceeds available appropriations, the commissioner shall establish a waiting list designed to serve applicants by order of application date.

Agency Legislative Proposal - 2020 Session

Document Name: No Hire Clause

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Connecticut Department of Social Services ("CTDSS")

Liaison: Alvin Wilson
Phone: 860-424-5105
E-mail: Alvin.wilson@ct.gov

Lead agency division requesting this proposal:

Agency Analyst/Drafter of Proposal: Melanie Dillon, Staff Attorney

Title of Proposal:

Statutory Reference: Connecticut General Statute Section 20-679

Proposal Summary:
In the 2019 legislative session, Connecticut passed a covenant not to compete in contracts between agency and consumers for the provision of homemaker, companion, personal care services and home health services. There is concern that Medicaid consumers and private consumers may be charged a fee or be liable for damages incurred should the consumer decide to privately hire the homemaker or caregiver. These fees can range anywhere from $5,000 to $10,000 depending upon the terms of the contract. If a consumer is on Medicaid, the consumer would not have the ability to pay this type of fee. This proposal seeks to restrict "no hire" provisions in homemaker-companion agency and home health agency contracts with consumers.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share: *(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* *(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* *(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* *(4) What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Consumer Protection; Department of Public Health **Agency Contact (*name, title, phone*):** **Date Contacted:** Need to contact both DCP and DPH legislative liaisons to discuss. 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)*
State
Federal
Additional notes on fiscal impact

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs.

Insert fully drafted bill here

New Section:

Any contract or agreement between a homemaker-companion agency or a home health agency and any person receiving homemaker, companion or home health services from the homemaker-companion agency or home health provider shall not include a "no-hire clause." For the purpose of this section, a "no-hire clause" is a provision that restricts the individual receiving the services from hiring the caregiver following the termination of the contract and charges the individual a fee for hiring the caregiver. Any such provision is against public policy and shall be void and unenforceable.

Agency Legislative Proposal - 2020 Session

Document Name: Health Information Exchange Board of Directors

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Dept. of Social Services
Liaison: Alvin Wilson **Phone:** 860-424-5105 **E-mail:** **alvin.wilson@ct.gov**
Lead agency division requesting this proposal: Division of Health Services
Agency Analyst/Drafter of Proposal:

Title of Proposal: AAC the State-Wide Health Information Exchange Board of Directors
Statutory Reference: 17b-59g(c)
Proposal Summary: The Proposal would add the Commissioner of DSS to the Health Information Exchange Board of Directors

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

◊ **Origin of Proposal** ☐ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Office of Healthcare Strategy **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)*
State
Federal
Additional notes on fiscal impact

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs.

Insert fully drafted bill here

Section 1. Subsection (c) of Section 17b-59g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*).

(c) Any entity established or incorporated pursuant to subsection (b) of this section shall have its powers vested in and exercised by a board of directors. The board of directors shall be comprised of the following members who shall each serve for a term of two years:

(1) One member who shall have expertise as an advocate for consumers of health care, appointed by the Governor;

(2) One member who shall have expertise as a clinical medical doctor, appointed by the president pro tempore of the Senate;

(3) One member who shall have expertise in the area of hospital administration, appointed by the speaker of the House of Representatives;

(4) One member who shall have expertise in the area of corporate law or finance, appointed by the minority leader of the Senate;

(5) One member who shall have expertise in group health insurance coverage, appointed by the minority leader of the House of Representatives;

(6) The Chief Information Officer and the Secretary of the Office of Policy and Management, or their designees, who shall serve as ex-officio, voting members of the board; [and]

(7) The health information technology officer, designated in accordance with section 19a-754a, who shall serve as chairperson of the board[.]; and

(8) The Commissioner of the Department of Social Services, or their designee, who shall serve as an ex officio, voting member of the board.

Agency Legislative Proposal - 2020 Session

Document Name: Division of Health Services- HUSKY B copayments and HUSKY Plus

State Agency: Department of Social Services

Liaison: Alvin Wilson
Phone: 860-424-5105
E-mail: alvin.wilson@ct.gov

Lead agency division requesting this proposal: Division of Health Services and Office of Legal Counsel

Agency Analyst/Drafter of Proposal: Trish McCooey

Title of Proposal: An Act Concerning Changes to the HUSKY B Program

Statutory Reference: 17b-294a and 17b-295 (a)

Proposal Summary:

This proposal repeals the requirement that copayments under HUSKY B align with copayment levels within the state employee point-of-enrollment health care plan. It also eliminates the separate "HUSKY Plus" program that provides certain supplemental services, such as long term therapies to members who have medical needs that go beyond the HUSKY B covered benefits.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

The provision of 17b-295 (a) that requires HUSKY B copayments to align with the state employee point-of enrollment health care plan copayments was passed in 2010. Since that time, state employee copayments have risen considerably, notably, physician office visits rose from $10 to $15. The $15 per visit cost is high for low-income HUSKY B families who may need to see outpatient providers on a regular or frequent basis. The Department has not increased the copayments at this time, so this legislative language is requested to align with current practice.

The elimination of HUSKY Plus will bring the physical health side of HUSKY B in line with the behavioral health side. When the HUSKY B program was created in 1998, HUSKY Plus had two components, HUSKY Plus Physical and HUSKY Plus Behavioral. When behavioral health services were carved out of the HUSKY program in 2006, the behavioral health services offered under HUSKY Plus Behavioral were made part of the Behavioral Health Partnership. This

proposal would do the same for HUSKY Plus physical services. The services would become part of the regular HUSKY B benefit package. The separate administrative cost of administering a HUSKY Plus program through its contract with Community Health Network of CT, Inc., (CHNCT) would be eliminated. The Department does not anticipate that there would be a significant increase in utilization as those children who have required the additional services that HUSKY Plus offers (long term physical therapy, speech therapy, occupational therapy and certain types of specialized medical supplies and equipment) are a small part of the HUSKY B population. Over the years, the Department has been able to serve Members who need these supplemental physical services within the appropriations for the program.

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

PROPOSAL IMPACT

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

Agency Name: N/A
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)

State

The proposal is not expected to have a significant impact. The copayments for HUSKY B members would stay the same; thus the proposal would align with current practice. The elimination of the HUSKY Plus program is also anticipated to have minimal fiscal impact.

Federal

Additional notes on fiscal impact

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

Section 1. Section 17b-294a of the general statutes is repealed in its entirety. (*Effective from passage).*

Section 2**.** Subsection (a) of 17b-295 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*).

(a) The commissioner shall impose cost-sharing requirements, including the payment of a premium or copayment, in connection with services provided under HUSKY B, to the extent permitted by federal law. [Copayments under HUSKY B shall be the same as those in effect for active state employees enrolled in a point-of-enrollment health care plan, provided the household's annual combined premiums and copayments do not exceed the maximum annual aggregate cost-sharing requirement.] The cost-sharing requirements imposed by the commissioner shall be in accordance with the following limitations:

(1) The commissioner may increase the maximum annual aggregate cost-sharing requirements, provided such cost-sharing requirements shall not exceed five per cent of the household's gross annual income.

(2) In accordance with federal law, the commissioner may impose a premium requirement on households whose income exceeds two hundred forty-nine per cent of the federal poverty level as a component of the household's cost-sharing responsibility and, for the fiscal years ending June 30, 2012, to June 30, 2016, inclusive, may annually increase the premium requirement based on the percentage increase in the Consumer Price Index for medical care services; and

(3) The commissioner shall monitor copayments and premiums under the provisions of subdivision (1) of this subsection.


STATE OF CONNECTICUT
QUI TRANSTULIT SUSTINET

Agency Legislative Proposal - 2020 Session

Document Name: 082719_DSS_OutdatedStatutes

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

State Agency: **Department of Social Services**

Liaison: Alvin Wilson
Phone: 860-424-5105
E-mail: **alvin.wilson@ct.gov**

Lead agency division requesting this proposal: OLCRAH

Agency Analyst/Drafter of Proposal: Graham Shaffer, Legal

Title of Proposal: An Act Concerning Outdated Department of Social Services Statutes

Statutory Reference: Connecticut General Statutes §§ 17a-485d(c), 17b-59a(b), 17b-349(a) and 38a-479aa(n)

Proposal Summary

This bill is intended to clean up certain statutes that contain outdated, inaccurate or confusing provisions.

- **General Statutes § 17a-485d(c)** – This statute requires DSS "to amend the Medicaid state plan to provide for coverage of optional adult rehabilitation services supplied by providers of mental health services or substance abuse rehabilitation services for adults with serious and persistent mental illness or who alcoholism or other substance abuse disorders," and to adopt regulations to support this state plan amendment. DSS currently covers a comprehensive array of behavioral health services, many of which are equivalent to those contemplated by this statute. This is done through the Behavioral Health Partnership in collaboration with DMHAS and DCF. Accordingly, DSS has never amended the Medicaid state plan to add adult behavioral health services within the rehabilitation benefits services category. However, DSS may add these services and amend the state plan accordingly in the future. Therefore, DSS is requesting that this statute be amended to make any amendment to the state plan and the development of supporting regulations permissive.

- **General Statutes § 17b-59a(b)** – This statutory subsection requires DSS to work with the executive director of the Office of Health Strategy to, among other things, develop uniformity in various activities undertaken by DDS, DPH, DOC, DCF, DVA, and DMHAS. Included among this list of aims is a requirement to "develop . . . uniform regulations for the licensing of human services facilities." The Auditor of Public Accounts recently informed DSS that it interprets this language as requiring DSS to promulgate uniform regulations for the licensing of human services facilities (a term not defined by the statute). While DSS understands how this reading of the statute could be reached, it does not believe it was the intention of the General Assembly to charge DSS with promulgating regulations concerning the licensing of facilities within the purview of the other agencies listed in the statute. Therefore, DSS is requesting that this confusing language be removed from the statute.

- **General Statutes § 17b-349(a)** – This statutory subsection suggests that, like federally qualified health centers, freestanding medical clinics are paid rates based on cost reporting. This is incorrect. Freestanding medical clinics always have been and continue to be paid rates based on a fee schedule. DSS is therefore requesting that this statute be amended to remove references to freestanding medical clinics.

- **General Statutes § 38a-479aa(n)** – This statutory subsection clarifies that preceding subsections in the statute concerning requirements for preferred provider networks do not apply "to a consortium of federal qualified health centers funded by the state, providing services only to recipients of programs administered by the Department of Social Services." It requires DSS to "adopt regulations . . . to establish criteria to certify any such federal qualified health center . . . ." However, no such consortium of federally qualified health centers (FQHCs) exists today. This consortium was a component of Medicaid managed care, and was a reference to Community Health Network of Connecticut, Inc. (CHN), which , at the time, referred Medicaid clients only to the FQHCs in the state. All other entities were actually managed care plans, already subject to Insurance Department statutes and regulations. Because the Medicaid program no longer uses managed care plans (or CHN as a managed care entity referring to FQHCs), this subsection is no longer applicable. DSS is therefore requesting that it be repealed.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

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

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

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)
State
Federal
Additional notes on fiscal impact

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

Insert fully drafted bill here

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

Section 1. Subsection (c) of section 17a-485d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

(c) The Commissioner of Social Services **[**shall**]** <u>may</u> take such action as **[**may be**]** necessary to amend the Medicaid state plan to provide for coverage of optional adult rehabilitation services supplied by providers of mental health services or substance abuse rehabilitation services for adults with serious and persistent mental illness or who have alcoholism or other substance use disorders, that are certified by the Department of Mental Health and Addiction Services. The Commissioner of Social

Services [shall] may adopt regulations, in accordance with the provisions of chapter 54, as it deems necessary to implement optional rehabilitation services under the Medicaid program. The commissioner [shall] may implement policies and procedures to administer such services while in the process of adopting such policies or procedures in regulation form, provided [notice of intention to adopt the regulations is printed in the Connecticut Law Journal within forty-five days of implementation, and any] the commissioner posts such policies and procedures on the eRegulations System prior to adopting the policies and procedures. Any such policies or procedures shall be valid until the time final regulations are effective.

Sec. 2. Subsection (b) of section 17b-59a of the general statues is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

(b) The Commissioner of Social Services, in consultation with the executive director of the Office of Health Strategy, established under section 19a-754a, shall (1) develop, throughout the Departments of Developmental Services, Public Health, Correction, Children and Families, Veterans Affairs and Mental Health and Addiction Services, uniform management information, uniform statistical information, uniform terminology for similar facilities, and uniform electronic health information technology standards, [and uniform regulations for the licensing of human services facilities,] (2) plan for increased participation of the private sector in the delivery of human services, (3) provide direction and coordination to federally funded programs in the human services agencies and recommend uniform system improvements and reallocation of physical resources and designation of a single responsibility across human services agencies lines to facilitate shared services and eliminate duplication.

Sec. 3. Subsection (a) of section 17b-349 of the general statues is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

(a) The rates paid by the state to community health centers [and freestanding medical clinics] participating in the Medicaid program may be adjusted annually on the basis of the cost reports submitted to the Commissioner of Social Services, except that rates effective July 1, 1989, shall remain in effect through June 30, 1990. The Department of Social Services may develop an alternative payment methodology to replace the encounter-based reimbursement system. Such methodology shall be approved by the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. Until such methodology is implemented, the Department of Social Services shall distribute supplemental funding, within available appropriations, to federally qualified health centers based on cost, volume and quality measures as determined by the

Commissioner of Social Services. (1) Beginning with the one-year rate period commencing on October 1, 2012, and annually thereafter, the Commissioner of Social Services may add to a community health center's rates, if applicable, a capital cost rate adjustment that is equivalent to the center's actual or projected year-to-year increase in total allowable depreciation and interest expenses associated with major capital projects divided by the projected service visit volume. For the purposes of this subsection, "capital costs" means expenditures for land or building purchases, fixed assets, movable equipment, capitalized financing fees and capitalized construction period interest and "major capital projects" means projects with costs exceeding two million dollars. The commissioner may revise such capital cost rate adjustment retroactively based on actual allowable depreciation and interest expenses or actual service visit volume for the rate period. (2) The commissioner shall establish separate capital cost rate adjustments for each Medicaid service provided by a center. (3) The commissioner shall not grant a capital cost rate adjustment to a community health center for any depreciation or interest expenses associated with capital costs that were disapproved by the federal Department of Health and Human Services or another federal or state government agency with capital expenditure approval authority related to health care services. (4) The commissioner may allow actual debt service in lieu of allowable depreciation and interest expenses associated with capital items funded with a debt obligation, provided debt service amounts are deemed reasonable in consideration of the interest rate and other loan terms. (5) The commissioner shall implement policies and procedures necessary to carry out the provisions of this subsection while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt such regulations is **[**published in the Connecticut Law Journal not later than twenty days after implementation.**]** <u>posted on the eRegulations System prior to adopting the policies and procedures.</u> Such policies and procedures shall be valid until the time final regulations are effective.

Sec. 4. Subsection (n) of section 38a-479aa is repealed. (*Effective July 1, 2020*).

Agency Legislative Proposal - 2020 Session

Document Name: 092019_NursingFacility_AcuityReimbursement

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Department of Social Services

Liaison: Alvin Wilson / David Seifel
Phone: 860-424-5105 / 860-424-5612
E-mail: alvin.wilson@ct.gov / David.seifel@ct.gov

Lead agency division requesting this proposal: Division of Health Services

Agency Analyst/Drafter of Proposal: Nicole Godburn/Melanie Dillon

Title of Proposal: An Act Concerning Nursing Facility Reimbursement

Statutory Reference: 17b-340

Proposal Summary:

Pursuant to Connecticut General Statutes Section 17b-340d, the Department is currently in the process of transitioning from a cost-based methodology to an acuity-based methodology for Medicaid reimbursement of nursing facility direct care costs. On September 3, 2019, the Department hosted a public meeting to announce the plan for implementation of the system. During that meeting, the Department provided a timeline for the implementation of the new payment methodology. The goal is to implement by July 1, 2020. In order to accomplish this goal, DSS needs to revise the current payment methodology in section 17b-340. Section 17b-340 needs to be revised not only to reflect the new payment system for nursing homes but it would also be helpful to delete the unnecessary language regarding payment rates dating back to 1991. The statute is long and difficult to read given the outdated language that spans almost thirty years. Since legislative history is easily accessible, there is no reason to keep the outdated language in the current version of the statute

PROPOSAL BACKGROUND

◊ Reason for Proposal

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Connecticut General Statute Section § 17b-340d requires the implementation of acuity based Medicaid reimbursement methodologies for Medicaid reimbursement of nursing facility

services. Most other states have already transitioned to acuity based. Medicare implemented a case-mix adjusted prospective payment system on July 1, 1998.

◊ **Origin of Proposal** ☐ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Social Services
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)*

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs.

Section 1. Section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For purposes of this subsection, (1) a "related party" includes, but is not limited to, any company related to a chronic and convalescent nursing home through family association, common ownership, control or business association with any of the owners, operators or officials of such nursing home; (2) "company" means any person, partnership, association, holding company, limited liability company or corporation; (3) "family association" means a relationship by birth, marriage or domestic partnership; and (4) "profit and loss statement" means the most recent annual statement on profits and losses finalized by a related party before the annual report mandated under this subsection. The rates to be paid by or for persons aided or cared for by the state or any town in this state to licensed chronic and convalescent nursing homes, to chronic disease hospitals associated with chronic and convalescent nursing homes, to rest homes with nursing supervision, to licensed residential care homes, as defined by section 19a-490, and to residential facilities for persons with intellectual disability that are licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program[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, i~~]In facilities that have both a chronic and convalescent nursing home and a rest home with nursing supervision, the rate for the rest home with nursing supervision shall not exceed such facility's rate for its chronic and convalescent nursing home. All such facilities for which rates are determined under this subsection shall report on a fiscal year basis ending on September thirtieth. Such report shall be submitted to the commissioner by February fifteenth. Each for-profit chronic and convalescent nursing home that receives state funding pursuant to this section shall include in such annual report a profit and loss statement from each related party that receives from such chronic and convalescent nursing home fifty thousand dollars or more per year for goods, fees and services. No cause of action or liability shall arise against the state, the Department of Social Services, any state official or agent for failure to take action based on the information required to be reported under this subsection. The commissioner may reduce the rate in effect for a facility that fails to submit a complete and accurate report on or before February fifteenth by an amount not to exceed ten per cent of such rate. If a licensed residential care home fails to submit a complete and accurate report, the department shall notify such home of the failure and the home shall have thirty days from the date the notice was issued to submit a complete and accurate report. If a licensed residential care home fails to submit a complete and accurate report not later than thirty days after the date of notice, such home may not receive a retroactive rate increase, in the commissioner's discretion. The commissioner shall, annually, on or before April first, report the data contained in the reports of such facilities on the department's website. [~~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.

(b) [The Commissioner of Social Services shall adopt regulations in accordance with the provisions of chapter 54 to specify other allowable services. For purposes of this section, other allowable services means those services required by any medical assistance beneficiary residing in such home or hospital which are not already covered in the rate set by the commissioner in accordance with the provisions of subsection (a) of this section.] The Commissioner of Social Services may implement policies and procedures as necessary to carry out the provisions of this section while in the process of adopting the policies and procedures as regulations, provided notice of intent to adopt the regulations is published in accordance with the provisions of section 17b-10 not later than twenty days after the date of implementation.

(c) No facility subject to the requirements of this section shall accept payment in excess of the rate set by the commissioner pursuant to subsection (a) of this section for any medical assistance patient from this or any other state. No facility shall accept payment in excess of the reasonable and necessary costs of other allowable services as specified by the commissioner pursuant to the regulations adopted under subsection (b) of this section for any public assistance patient from this or any other state. Notwithstanding the provisions of this subsection, the commissioner may authorize a facility to accept payment in excess of the rate paid for a medical assistance patient in this state for a patient who receives medical assistance from another state.

(d) In any instance where the Commissioner of Social Services finds that a facility subject to the requirements of this section is accepting payment for a medical assistance beneficiary in violation of subsection (c) of this section, the commissioner shall proceed to recover through the rate set for the facility any sum in excess of the stipulated per diem and other allowable costs, as provided for in regulations adopted pursuant to subsections (a) and (b) of this section. The commissioner shall make the recovery prospectively at the time of the next annual rate redetermination.

[~~(e) Except as provided in this subsection, the provisions of subsections (c) and (d) of this section shall not apply to any facility subject to the requirements of this section, which on October 1, 1981, (1) was accepting payments from the commissioner in accordance with the provisions of subsection (a) of this section, (2) was accepting medical assistance payments from another state for at least twenty per cent of its patients, and (3) had not notified the commissioner of any intent to terminate its provider agreement, in accordance with section 17b-271, provided no patient residing in any such facility on May 22, 1984, shall be removed from such facility for purposes of meeting the requirements of this subsection. If the commissioner finds that the number of beds available to medical assistance patients from this state in any such facility is less than fifteen per cent the provisions of subsections (c) and (d) of this section shall apply to that number of beds which is less~~

~~than said percentage.~~]

[(f)] (e) [~~For the fiscal year ending June 30, 1992, the rates paid by or for persons aided or cared for by the state or any town in this state to facilities for room, board and services specified in licensing regulations issued by the licensing agency, except intermediate care facilities for individuals with intellectual disabilities and residential care homes, shall be based on the cost year ending September 30, 1989. For the fiscal years ending June 30, 1993, and June 30, 1994, such rates shall be based on the cost year ending September 30, 1990. Such rates shall be determined by the Commissioner of Social Services in accordance with this section and the regulations of Connecticut state agencies promulgated by the commissioner and in effect on April 1, 1991, except that~~] For fiscal years ending June 30th the Commissioner of Social Services shall establish Medicaid rates paid to nursing facilities based on cost years ending September 30th in accordance with the following :

(1) Allowable costs shall be divided into the following five cost components: Direct costs, which shall include salaries for nursing personnel, related fringe benefits and nursing pool costs; indirect costs, which shall include professional fees, dietary expenses, housekeeping expenses, laundry expenses, supplies related to patient care, salaries for indirect care personnel and related fringe benefits; fair rent, which shall be defined in accordance with subsection (f) of section 17-311-52 of the regulations of Connecticut state agencies; capital-related costs, which shall include property taxes, insurance expenses, equipment leases and equipment depreciation; and administrative and general costs, which shall include maintenance and operation of plant expenses, salaries for administrative and maintenance personnel and related fringe benefits. [~~The commissioner may provide a rate adjustment for nonemergency transportation services required by nursing facility residents. Such adjustment shall be a fixed amount determined annually by the commissioner based upon a review of costs and other associated information.~~] Allowable costs shall not include costs for ancillary services payable under Part B of the Medicare program. For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred fifteen per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 19a-638; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to the state-wide median allowable cost.

~~[(2) Two geographic peer groupings of facilities shall be established for each level of care, as defined by the Department of Social Services for the determination of rates, for the purpose of determining allowable direct costs. One peer grouping shall be comprised of those facilities located in Fairfield County. The other peer grouping shall be comprised of facilities located in all other counties.]~~

(2) Case-mix adjustments to the direct care component shall be made or phased in effective beginning July 1, 2020 and updated every quarter thereafter.

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

~~[(3) For the fiscal year ending June 30, 1992, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred thirty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the Office of Health Care Access pursuant to section 19a-638; for capital-related costs, there shall be no maximum; and for administrative and general costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1993, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the Office of Health Care Access pursuant to section 19a-638; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred fifteen per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1994, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the Office of Health Care Access pursuant to section 19a-638; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred ten per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1995, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the Office of Health Care Access pursuant to section 19a-638; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred five per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, except for the fiscal years ending June 30, 2000, and June 30, 2001, for facilities with an interim rate in one or both periods, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred fifteen per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 19a-638; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to the state-wide median allowable cost. For the fiscal~~

years ending June 30, 2000, and June 30, 2001, for facilities with an interim rate in one or both periods, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 19a-638; for capital related costs, there shall be no maximum; and for administrative and general costs, the maximum shall be equal to the state wide median allowable cost and such medians shall be based upon the same cost year used to set rates for facilities with prospective rates. Costs in excess of the maximum amounts established under this subsection shall not be recognized as allowable costs, except that the Commissioner of Social Services (A) may allow costs in excess of maximum amounts for any facility with patient days covered by Medicare, including days requiring coinsurance, in excess of twelve per cent of annual patient days which also has patient days covered by Medicaid in excess of fifty per cent of annual patient days; (B) may establish a pilot program whereby costs in excess of maximum amounts shall be allowed for beds in a nursing home which has a managed care program and is affiliated with a hospital licensed under chapter 368v;[5] and (C) may establish rates whereby allowable costs may exceed such maximum amounts for beds approved on or after July 1, 1991, which are restricted to use by patients with acquired immune deficiency syndrome or traumatic brain injury.]

(4) [For the fiscal year ending June 30, 1992, (A) no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1991; (B) no facility whose rate, if determined pursuant to this subsection, would exceed one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is five and one-half per cent more than the rate it received for the rate year ending June 30, 1991; and (C) no facility whose rate, if determined pursuant to this subsection, would be less than one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is six and one-half per cent more than the rate it received for the rate year ending June 30, 1991. For the fiscal year ending June 30, 1993, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1992, or six per cent more than the rate it received for the rate year ending June 30, 1992. For the fiscal year ending June 30, 1994, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1993, or six per cent more than the rate it received for the rate year ending June 30, 1993. For the fiscal year ending June 30, 1995, no facility shall receive a rate that is more than five per cent less than the rate it received for the rate year ending June 30, 1994, or six per cent more than the rate it received for the rate year ending June 30, 1994. For the fiscal years ending June 30, 1996, and June 30, 1997, no facility shall receive a rate that is more than three per cent more than the rate it received for the prior rate year. For the fiscal year ending June 30, 1998, a facility shall receive a rate increase that is not more than two per cent more than the rate that the facility received in the prior year. For the fiscal year ending June 30, 1999, a facility shall receive a rate increase that is not more than three per cent more than the rate that the

facility received in the prior year and that is not less than one per cent more than the rate that the facility received in the prior year, exclusive of rate increases associated with a wage, benefit and staffing enhancement rate adjustment added for the period from April 1, 1999, to June 30, 1999, inclusive. For the fiscal year ending June 30, 2000, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 1999, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2000, shall receive a rate increase equal to one per cent applied to the rate the facility received for the fiscal year ending June 30, 1999, exclusive of the facility's wage, benefit and staffing enhancement rate adjustment. For the fiscal year ending June 30, 2000, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2000, shall receive a rate increase that is more than one per cent more than the rate the facility received in the fiscal year ending June 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 2000, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2001, shall receive a rate increase equal to two per cent applied to the rate the facility received for the fiscal year ending June 30, 2000, subject to verification of wage enhancement adjustments pursuant to subdivision (14) of this subsection. For the fiscal year ending June 30, 2001, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2001, shall receive a rate increase that is more than two per cent more than the rate the facility received for the fiscal year ending June 30, 2000. For the fiscal year ending June 30, 2002, each facility shall receive a rate that is two and one half per cent more than the rate the facility received in the prior fiscal year. For the fiscal year ending June 30, 2003, each facility shall receive a rate that is two per cent more than the rate the facility received in the prior fiscal year, except that such increase shall be effective January 1, 2003, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until December 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate increased two per cent effective June 1, 2003. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until December 31, 2004, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective January 1, 2005, each facility shall receive a rate that is one per cent greater than the rate in effect December 31, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in this subdivision, but in no event earlier than July 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, for the fiscal year ending June 30,

2006, the department shall compute the rate for each facility based upon its 2003 cost report filing or a subsequent cost year filing for facilities having an interim rate for the period ending June 30, 2005, as provided under section 17-311-55 of the regulations of Connecticut state agencies. For each facility not having an interim rate for the period ending June 30, 2005, the rate for the period ending June 30, 2006, shall be determined beginning with the higher of the computed rate based upon its 2003 cost report filing or the rate in effect for the period ending June 30, 2005. Such rate shall then be increased by eleven dollars and eighty cents per day except that in no event shall the rate for the period ending June 30, 2006, be thirty two dollars more than the rate in effect for the period ending June 30, 2005, and for any facility with a rate below one hundred ninety five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not be greater than two hundred seventeen dollars and forty three cents per day and for any facility with a rate equal to or greater than one hundred ninety five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one half per cent. For each facility with an interim rate for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven dollars and eighty cents per day plus the per day cost of the user fee payments made pursuant to section 17b-320 divided by annual resident service days, except for any facility with an interim rate below one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not be greater than two hundred seventeen dollars and forty-three cents per day and for any facility with an interim rate equal to or greater than one hundred ninety five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one half per cent. Such July 1, 2005, rate adjustments shall remain in effect unless (i) the federal financial participation matching funds associated with the rate increase are no longer available; or (ii) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, each facility shall receive a rate that is three per cent greater than the rate in effect for the period ending June 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the rate period ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. For the fiscal year ending June 30, 2008, each facility shall receive a rate that is two and nine-tenths per cent greater than the rate in effect for the period ending June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, than for the rate period ending June 30, 2007, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2009, due to interim rate status or agreement with the department shall be issued such lower rate. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement

with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2013, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, or the fiscal year ending June 30, 2013, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal year ending June 30, 2014, the department shall determine facility rates based upon 2011 cost report filings subject to the provisions of this section and applicable regulations except: (I) A ninety per cent minimum occupancy standard shall be applied; (II) no facility shall receive a rate that is higher than the rate in effect on June 30, 2013; and (III) no facility shall receive a rate that is more than four per cent lower than the rate in effect on June 30, 2013, except that any facility that would have been issued a lower rate effective July 1, 2013, than for the rate period ending June 30, 2013, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2013. For the fiscal year ending June 30, 2015, rates in effect for the period ending June 30, 2014, shall remain in effect until June 30, 2015, except any facility that would have been issued a lower rate effective July 1, 2014, than for the rate period ending June 30, 2014, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2014. 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 the commissioner provides, within available appropriations, pro rata fair rent increases, which may, at the discretion of the commissioner, include increases for facilities which have undergone a material change in circumstances related to fair rent additions or moveable equipment placed in service in cost report years ending September 30, 2014, and September 30, 2015, and 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 or agreement with the department, shall be issued such lower rate. For the fiscal year ending June 30, 2018, facilities that received a rate decrease due to the expiration of a 2015 fair rent asset shall receive a rate increase of an equivalent amount effective July 1, 2017. For the fiscal year ending June 30, 2018, the department shall determine facility rates based upon 2016 cost report filings subject to the provisions of this section and applicable regulations, provided no facility shall receive a rate that is higher than the rate in effect on December 31, 2016, and no facility shall receive a rate that is more than two per cent lower than the rate in effect on December 31, 2016. For the fiscal year ending June 30, 2019, no facility shall receive a rate that is higher than the rate in effect on June 30, 2018, except the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2018, if the commissioner provides, within available appropriations, pro rata fair rent increases, which may, at the discretion of the commissioner, include increases for facilities which have undergone a material change in circumstances related to fair rent additions or moveable equipment placed in service in the cost report year ending September 30, 2017, and not otherwise included in rates issued. For the fiscal year ending June 30, 2020, the department shall determine facility rates based upon 2018 cost report filings subject to the provisions of this section, adjusted to reflect any rate increases provided after the cost report year ending September 30, 2018, and applicable regulations, provided no facility shall receive a rate that is higher than the rate in effect on 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 the commissioner provides, within available appropriations, pro rata fair rent increases, which may, at the discretion of the commissioner, include increases for facilities which have undergone a material change in circumstances related to fair rent additions in the cost report year ending September 30, 2018, and are not otherwise included in rates issued. For the fiscal year ending June 30, 2020, no facility shall receive a rate that is more than two per cent lower than the rate in effect on June 30, 2019, unless the facility has an occupancy level of less than seventy per cent, as reported in the 2018 cost report, or an overall rating on Medicare's Nursing Home Compare of one star for the three most recent reporting periods as of July 1, 2019, unless the facility is under an interim rate due to new ownership.]~~ For the fiscal year ending June 30, 2021, no facility shall receive a rate that is higher than the rate in effect on June 30, 2020, except the rate paid to a facility may be higher than the rate paid to the facility for the fiscal year ending June 30, 2020, if the commissioner provides, within available appropriations, pro rata fair rent increases, which may, at the discretion of the commissioner, include increases for facilities which have undergone a material change in circumstances related to fair rent additions in the cost report year ending September 30, 2019, and are not otherwise included in rates issued. [~~The Commissioner of Social Services shall add fair rent increases to any other rate increases established pursuant to this subdivision for a facility which has undergone a material change in circumstances related to fair rent, except for the fiscal years ending June 30, 2010, June 30, 2011, and June 30, 2012, such fair rent increases shall only be provided to facilities with an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. For the fiscal year ending June 30, 2013, the commissioner may, within available appropriations, provide pro rata fair rent increases for facilities which have undergone a material change in circumstances related to fair rent additions placed in service in cost report years ending September 30, 2008, to September 30, 2011, inclusive, and not otherwise included in rates issued. For the fiscal years ending June 30, 2014, and June 30, 2015, the commissioner may, within available appropriations, provide pro rata fair rent increases, which may include moveable equipment at the discretion of the commissioner, for facilities which have undergone a material change in circumstances related to fair rent additions or moveable equipment placed in service in cost report years ending September 30, 2012, and September 30, 2013, and not otherwise included in rates issued. The commissioner shall add fair rent increases associated with an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. Interim rates may take into account reasonable costs incurred by a facility, including wages and benefits. Notwithstanding the provisions of this section, the Commissioner of Social Services may, subject to available appropriations, increase or decrease rates issued to licensed chronic and convalescent nursing homes and licensed rest homes with nursing supervision. Notwithstanding any provision of this section, the Commissioner of Social Services shall, effective July 1, 2015, within available appropriations, adjust facility rates in accordance with the application of standard accounting principles as prescribed by the commissioner, for each facility subject to subsection (a) of this section. Such adjustment shall provide a pro-rata increase based on direct and indirect care employee salaries reported in the 2014 annual cost report, and adjusted to reflect subsequent salary increases, to reflect reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents, or otherwise provided by~~

~~a facility to its employees. For purposes of this subsection, "employee" shall not include a person employed as a facility's manager, chief administrator, a person required to be licensed as a nursing home administrator or any individual who receives compensation for services pursuant to a contractual arrangement and who is not directly employed by the facility. The commissioner may establish an upper limit for reasonable costs associated with salary adjustments beyond which the adjustment shall not apply. Nothing in this section shall require the commissioner to distribute such adjustments in a way that jeopardizes anticipated federal reimbursement. Facilities that receive such adjustment but do not provide increases in employee salaries as described in this subsection on or before July 31, 2015, may be subject to a rate decrease in the same amount as the adjustment by the commissioner. Of the amount appropriated for this purpose, no more than nine million dollars shall go to increases based on reasonable costs mandated by collective bargaining agreements.~~] Notwithstanding the provisions of this subsection, effective July 1, 2019, October 1, 2020, and January 1, 2021, the commissioner shall, within available appropriations, increase rates for the purpose of wage and benefit enhancements for facility employees. The commissioner shall adjust the rate paid to the facility in the form of a rate adjustment to reflect any rate increases paid after the cost report year ending September 30, 2018. Facilities that receive a rate adjustment for the purpose of wage and benefit enhancements but do not provide increases in employee salaries as described in this subsection on or before September 30, 2019, October 31, 2020, and January 31, 2021, respectively, may be subject to a rate decrease in the same amount as the adjustment by the commissioner.

(5) For the purpose of determining allowable fair rent, a facility with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent[,]. [~~provided for the fiscal years ending June 30, 1996, and June 30, 1997, the reimbursement may not exceed the twenty-fifth percentile of the state-wide allowable fair rent for the fiscal year ending June 30, 1995. On and after July 1, 1998, the Commissioner of Social Services may allow minimum fair rent as the basis upon which reimbursement associated with improvements to real property is added. Beginning with the fiscal year ending June 30, 1996, any facility with a rate of return on real property other than land in excess of eleven per cent shall have such allowance revised to eleven per cent. Any facility or its related realty affiliate which finances or refinances debt through bonds issued by the State of Connecticut Health and Education Facilities Authority shall report the terms and conditions of such financing or refinancing to the Commissioner of Social Services within thirty days of completing such financing or refinancing. The Commissioner of Social Services may revise the facility's fair rent component of its rate to reflect any financial benefit the facility or its related realty affiliate received as a result of such financing or refinancing, including but not limited to, reductions in the amount of debt service payments or period of debt repayment. The commissioner shall allow actual debt service costs for bonds issued by the State of Connecticut Health and Educational Facilities Authority if such costs do not exceed property costs allowed pursuant to subsection (f) of section 17-311-52 of the~~

regulations of Connecticut state agencies, provided the commissioner may allow higher debt service costs for such bonds for good cause. For facilities which first open on or after October 1, 1992, the commissioner shall determine allowable fair rent for real property other than land based on the rate of return for the cost year in which such bonds were issued. The financial benefit resulting from a facility financing or refinancing debt through such bonds shall be shared between the state and the facility to an extent determined by the commissioner on a case-by-case basis and shall be reflected in an adjustment to the facility's allowable fair rent.]

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

[(7) For the fiscal year ending June 30, 1992, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban) All Items minus one and one-half per cent. For the fiscal year ending June 30, 1993, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban) All Items minus one and three quarters per cent. For the fiscal years ending June 30, 1994, and June 30, 1995, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban) All Items minus two per cent. For the fiscal year ending June 30, 1996, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban) All Items minus two and one-half per cent. For the fiscal year ending June 30, 1997, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban) All Items minus three and one-half per cent. For the fiscal year ending June 30, 1992, and any succeeding fiscal year, allowable fair rent shall be those reported in the annual report of long-term care facilities for the cost year ending the immediately preceding September thirtieth. The inflation index to be used pursuant to this subsection shall be computed to reflect inflation between the midpoint of the cost year through the midpoint of the rate year. The Department of Social Services shall study methods of reimbursement for fair rent and shall report its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to human services on or before January 15, 1993.

(8) On and after July 1, 1994, costs shall be rebased no more frequently than every two years and no

~~less frequently than every four years, as determined by the commissioner. The commissioner shall determine whether and to what extent a change in ownership of a facility shall occasion the rebasing of the facility's costs.~~

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

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

~~[(11) Notwithstanding the provisions of this subsection, interim rates issued for facilities on and after July 1, 1991, shall be subject to applicable fiscal year cost component limitations established pursuant to subdivision (3) of this subsection.~~

~~(12) A chronic and convalescent nursing home having an ownership affiliation with and operated at the same location as a chronic disease hospital may request that the commissioner approve an exception to applicable rate-setting provisions for chronic and convalescent nursing homes and establish a rate for the fiscal years ending June 30, 1992, and June 30, 1993, in accordance with regulations in effect June 30, 1991. Any such rate shall not exceed one hundred sixty-five per cent of the median rate established for chronic and convalescent nursing homes established under this section for the applicable fiscal year.]~~

~~[(13) For the fiscal year ending June 30, 2014, and any succeeding fiscal year,~~] (8) [~~f~~]For purposes of computing minimum allowable patient days, utilization of a facility's certified beds shall be determined at a minimum of ninety per cent of capacity, except for new facilities and facilities which are certified for additional beds which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure.

~~[(14) The Commissioner of Social Services shall adjust facility rates from April 1, 1999, to June 30, 1999, inclusive, by a per diem amount representing each facility's allocation of funds appropriated for the purpose of wage, benefit and staffing enhancement. A facility's per diem allocation of such funding shall be computed as follows: (A) The facility's direct and indirect component salary, wage,~~

nursing pool and allocated fringe benefit costs as filed for the 1998 cost report period deemed allowable in accordance with this section and applicable regulations without application of cost component maximums specified in subdivision (3) of this subsection shall be totalled; (B) such total shall be multiplied by the facility's Medicaid utilization based on the 1998 cost report; (C) the resulting amount for the facility shall be divided by the sum of the calculations specified in subparagraphs (A) and (B) of this subdivision for all facilities to determine the facility's percentage share of appropriated wage, benefit and staffing enhancement funding; (D) the facility's percentage share shall be multiplied by the amount of appropriated wage, benefit and staffing enhancement funding to determine the facility's allocated amount; and (E) such allocated amount shall be divided by the number of days of care paid for by Medicaid on an annual basis including days for reserved beds specified in the 1998 cost report to determine the per diem wage and benefit rate adjustment amount. The commissioner may adjust a facility's reported 1998 cost and utilization data for the purposes of determining a facility's share of wage, benefit and staffing enhancement funding when reported 1998 information is not substantially representative of estimated cost and utilization data for the fiscal year ending June 30, 2000, due to special circumstances during the 1998 cost report period including change of ownership with a part year cost filing or reductions in facility capacity due to facility renovation projects. Upon completion of the calculation of the allocation of wage, benefit and staffing enhancement funding, the commissioner shall not adjust the allocations due to revisions submitted to previously filed 1998 annual cost reports. In the event that a facility's rate for the fiscal year ending June 30, 1999, is an interim rate or the rate includes an increase adjustment due to a rate request to the commissioner or other reasons, the commissioner may reduce or withhold the per diem wage, benefit and staffing enhancement allocation computed for the facility. Any enhancement allocations not applied to facility rates shall not be reallocated to other facilities and such unallocated amounts shall be available for the costs associated with interim rates and other Medicaid expenditures. The wage, benefit and staffing enhancement per diem adjustment for the period from April 1, 1999, to June 30, 1999, inclusive, shall also be applied to rates for the fiscal years ending June 30, 2000, and June 30, 2001, except that the commissioner may increase or decrease the adjustment to account for changes in facility capacity or operations. Any facility accepting a rate adjustment for wage, benefit and staffing enhancements shall apply payments made as a result of such rate adjustment for increased allowable employee wage rates and benefits and additional direct and indirect component staffing. Adjustment funding shall not be applied to wage and salary increases provided to the administrator, assistant administrator, owners or related party employees. Enhancement payments may be applied to increases in costs associated with staffing purchased from staffing agencies provided such costs are deemed necessary and reasonable by the commissioner. The commissioner shall compare expenditures for wages, benefits and staffing for the 1998 cost report period to such expenditures in the 1999, 2000 and 2001 cost report periods to verify whether a facility has applied additional payments to specified enhancements. In the event that the commissioner determines that a facility did not apply additional payments to specified enhancements, the commissioner shall recover such amounts from the facility through rate adjustments or other means. The commissioner may require facilities to file cost reporting forms, in addition to the annual cost report, as may be necessary, to verify the appropriate application of

~~wage, benefit and staffing enhancement rate adjustment payments. For the purposes of this subdivision, "Medicaid utilization" means the number of days of care paid for by Medicaid on an annual basis including days for reserved beds as a percentage of total resident days~~.]

[(15)] (9) The interim rate established to become effective upon sale of any licensed chronic and convalescent home or rest home with nursing supervision for which a receivership has been imposed pursuant to sections 19a-541 to 19a-549, inclusive, shall not exceed the rate in effect for the facility at the time of the imposition of the receivership, subject to any annual increases permitted by this section; provided the Commissioner of Social Services may, in the commissioner's discretion, and after consultation with the receiver, establish an increased rate for the facility if the commissioner with approval of the Secretary of the Office of Policy and Management determines that such higher rate is needed to keep the facility open and to ensure the health, safety and welfare of the residents at such facility.

[(g)] (f) [~~For the fiscal year ending June 30, 1993, any intermediate care facility for individuals with intellectual disabilities with an operating cost component of its rate in excess of one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any intermediate care facility for individuals with intellectual disabilities with an operating cost component of its rate that is less than one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to thirty per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred forty per cent of the median of operating cost components in effect January 1, 1992. Any facility with real property other than land placed in service prior to October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding October 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request, allow actual debt service, comprised of principal and interest, in excess of property costs allowed pursuant to section 17-311-52 of the regulations of Connecticut state agencies, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. For the fiscal year ending June 30, 1995, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any~~

succeeding fiscal year, no rate shall exceed three hundred seventy-five dollars per day unless the commissioner, in consultation with the Commissioner of Developmental Services, determines after a review of program and management costs, that a rate in excess of this amount is necessary for care and treatment of facility residents. For the fiscal year ending June 30, 2002, rate period, the Commissioner of Social Services shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2000 costs to include a three and one-half per cent inflation factor. For the fiscal year ending June 30, 2003, rate period, the commissioner shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2001 costs to include a one and one-half per cent inflation factor, except that such increase shall be effective November 1, 2002, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until October 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate updated effective November 1, 2002, in accordance with applicable statutes and regulations. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until September 30, 2004. Effective October 1, 2004, each facility shall receive a rate that is five per cent greater than the rate in effect September 30, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is four per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (1) The federal financial participation matching funds associated with the rate increase are no longer available; or (2) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than three per cent greater than the rate in effect for the facility on September 30, 2006, except any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal year ending June 30, 2008, each facility shall receive a rate that is two and nine tenths per cent greater than the rate in effect for the period ending June 30, 2007, except any facility that would have been issued a

~~lower rate effective July 1, 2007, than for the rate period ending June 30, 2007, due to interim rate status, or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2009, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2014, and June 30, 2015, rates shall not exceed those in effect for the period ending June 30, 2013, except the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2013, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2014, or June 30, 2015, to the extent such rate increases are within available appropriations. Any facility that would have been issued a lower rate for the fiscal year ending June 30, 2014, or the fiscal year ending June 30, 2015, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2016, and June 30, 2017, rates shall not exceed those in effect for the period ending June 30, 2015, except the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2015, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2016, or June 30, 2017, to the extent such rate increases are within available appropriations. For the fiscal years ending June 30, 2016, and June 30, 2017, and each succeeding fiscal year, any facility that would have been issued a lower rate, due to interim rate status, a change in allowable fair rent or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2018, and June 30, 2019, rates shall not exceed those in effect for the period ending June 30, 2017, except the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2017, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2018, or June 30, 2019, only to the extent such rate increases are within available appropriations.~~]For the fiscal years ending June 30, 2020, and June 30, 2021, rates shall not exceed those in effect for the fiscal year ending June 30, 2019, except the rate paid to a facility may be higher than the rate paid to the facility for the fiscal year ending June 30, 2019, if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2020, or June 30, 2021, only to the extent such rate increases are within available

appropriations. Any facility that has a significant decrease in land and building costs shall receive a reduced rate to reflect such decrease in land and building costs. For the fiscal years ending June 30, 2012, June 30, 2013, June 30, 2014, June 30, 2015, June 30, 2016, June 30, 2017, June 30, 2018, June 30, 2019, June 30, 2020, and June 30, 2021, the Commissioner of Social Services may provide fair rent increases to any facility that has undergone a material change in circumstances related to fair rent and has an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. Notwithstanding the provisions of this section, the Commissioner of Social Services may, within available appropriations, increase or decrease rates issued to intermediate care facilities for individuals with intellectual disabilities to reflect a reduction in available appropriations as provided in subsection (a) of this section. [~~For the fiscal years ending June 30, 2014, and June 30, 2015, the commissioner shall not consider rebasing in determining rates.~~]

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

311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. Beginning with the fiscal year ending June 30, 1997, minimum allowable patient days for rate computation purposes for a residential care home with twenty-five beds or less shall be eighty-five per cent of licensed capacity. Beginning with the fiscal year ending June 30, 2002, for the purposes of determining the allowable salary of an administrator of a residential care home with sixty beds or less the department shall revise the allowable base salary to thirty seven thousand dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies. The rates for the fiscal year ending June 30, 2002, shall be based upon the increased allowable salary of an administrator, regardless of whether such amount was expended in the 2000 cost report period upon which the rates are based. Beginning with the fiscal year ending June 30, 2000, and until the fiscal year ending June 30, 2009, inclusive, the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall be increased by two per cent, and beginning with the fiscal year ending June 30, 2002, the inflation adjustment for rates made in accordance with subsection (c) of said section shall be increased by one per cent. Beginning with the fiscal year ending June 30, 1999, for the purpose of determining the allowable salary of a related party, the department shall revise the maximum salary to twenty-seven thousand eight hundred fifty-six dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies and beginning with the fiscal year ending June 30, 2001, such allowable salary shall be computed on an hourly basis and the maximum number of hours allowed for a related party other than the proprietor shall be increased from forty hours to forty-eight hours per work week. For the fiscal year ending June 30, 2005, each facility shall receive a rate that is two and one quarter per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is determined in accordance with applicable law and subject to appropriations, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (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 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except that (I) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (II) [~~t]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~~] Beginning with the fiscal year ending June 30, 2015, subject to available appropriations, the commissioner may, at the commissioner's discretion[~~:~~ ~~Increase the inflation cost limitation under subsection (c) of section 17-311-52 of the regulations of Connecticut state agencies, provided such inflation allowance factor does not exceed a maximum of five per cent;~~ establish a minimum rate of return applied to real property of five per cent inclusive of

assets placed in service during cost year 2013; waive the standard rate of return under subsection (f) of section 17-311-52 of the regulations of Connecticut state agencies for ownership changes or health and safety improvements that exceed one hundred thousand dollars and that are required under a consent order from the Department of Public Health.[~~; and waive the rate of return adjustment under subsection (f) of section 17-311-52 of the regulations of Connecticut state agencies to avoid financial hardship. For the fiscal years ending June 30, 2016, and June 30, 2017, rates shall not exceed those in effect for the period ending June 30, 2015, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in cost report years ending September 30, 2014, and September 30, 2015, that are not otherwise included in rates issued. For the fiscal years ending June 30, 2016, and June 30, 2017, and each succeeding fiscal year, any facility that would have been issued a lower rate, due to interim rate status, a change in allowable fair rent or agreement with the department, shall be issued such lower rate. For the fiscal year ending June 30, 2018, rates shall not exceed those in effect for the period ending June 30, 2017, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2016, that are not otherwise included in rates issued. For the fiscal year ending June 30, 2019, rates shall not exceed those in effect for the period ending June 30, 2018, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2017, that are not otherwise included in rates issued. For the fiscal year ending June 30, 2020, rates shall not exceed those in effect for the fiscal year ending June 30, 2019, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2018, that are not otherwise included in rates issued~~.] For the fiscal year ending June 30, 2021, rates shall not exceed those in effect for the fiscal year ending June 30, 2020, except the commissioner may, in the commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2019, that are not otherwise included in rates issued.

[(~~2) 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.~~]

[~~(i) Notwithstanding the provisions of this section, the Commissioner of Social Services shall establish~~

~~a fee schedule for payments to be made to chronic disease hospitals associated with chronic and convalescent nursing homes to be effective on and after July 1, 1995. The fee schedule may be adjusted annually beginning July 1, 1997, to reflect necessary increases in the cost of services.~~]

[(j)] (h) Notwithstanding the provisions 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.