



General Assembly

February Session, 2002

**Raised Bill No. 5469**

LCO No. 1378

Referred to Committee on Program Review and Investigations

Introduced by:  
(PRI)

**AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE  
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS  
COMMITTEE RELATIVE TO MEDICAID RATE SETTING FOR NURSING  
HOMES.**

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

1 Section 1. Section 4-65a of the general statutes is repealed and the  
2 following is substituted in lieu thereof (*Effective July 1, 2002*):

3 (a) There shall be an Office of Policy and Management which shall  
4 be responsible for all aspects of state staff planning and analysis in the  
5 areas of budgeting, management, planning, energy policy  
6 determination and evaluation, intergovernmental policy, long-term  
7 care planning, criminal and juvenile justice planning and program  
8 evaluation. The department head shall be the Secretary of the Office of  
9 Policy and Management, who shall be appointed by the Governor in  
10 accordance with the provisions of sections 4-5, 4-6, 4-7 and 4-8, with all  
11 the powers and duties therein prescribed. The Secretary of the Office of  
12 Policy and Management shall be the employer representative (1) in  
13 collective bargaining negotiations concerning changes to the state  
14 employees retirement system and health and welfare benefits, and (2)

15 in all other matters involving collective bargaining, including  
16 negotiation and administration of all collective bargaining agreements  
17 and supplemental understandings between the state and the state  
18 employee unions concerning all executive branch employees except  
19 (A) employees of the Division of Criminal Justice, and (B) faculty and  
20 professional employees of boards of trustees of constituent units of the  
21 state system of higher education. The secretary may designate a  
22 member of the secretary's staff to act as the employer representative in  
23 the secretary's place.

24 (b) There shall be such undersecretaries as may be necessary for the  
25 efficient conduct of the business of the office. Each such undersecretary  
26 shall be appointed by the secretary and shall be qualified and  
27 experienced in the functions to be performed by him. The positions of  
28 each such undersecretary shall be exempt from the classified service.

29 Sec. 2. Section 17b-337 of the general statutes, as amended by section  
30 1 of public act 01-119, is repealed and the following is substituted in  
31 lieu thereof (*Effective July 1, 2002*):

32 [(a) There shall be established a Long-Term Care Planning  
33 Committee for the purpose of exchanging information on long-term  
34 care issues, coordinating policy development and establishing a long-  
35 term care plan for all persons in need of long-term care. Such plan  
36 shall integrate the three components of a long-term care system  
37 including home and community-based services, supportive housing  
38 arrangements and nursing facilities.]

39 (a) The Office of Policy and Management, in consultation with state  
40 agencies responsible for implementing long-term care programs, shall  
41 undertake a comprehensive needs plan for long-term care services. The  
42 plan shall assess the three major components of the long-term care  
43 system, home and community-based services, supportive housing  
44 arrangements and nursing home care to evaluate the need for services  
45 and the cost of providing services. Such plan shall include: (1) A vision  
46 and mission statement for a long-term care system; (2) the current

47 number of persons receiving services; (3) demographic data  
48 concerning such persons by service type; [(4) the current aggregate  
49 cost of such system of services; (5) forecasts of future demand for  
50 services; (6)] (4) the type of services available and the amount of funds  
51 necessary to meet the demand; [(7)] (5) projected costs for programs  
52 associated with such system; [(8)] (6) strategies to promote the  
53 partnership for long-term care program; [(9)] (7) resources necessary to  
54 accomplish goals for the future; [(10) funding sources available; and  
55 (11)] (8) the number and types of providers needed to deliver services;  
56 (9) a nursing home bed need methodology, based on demand and  
57 alternatives available, as well as demographics and the impact of  
58 changes in nursing home bed supply; (10) a comprehensive strategy to  
59 match nursing home bed supply and need by area of the state; (11) an  
60 estimate of the costs of the three component system; and (12)  
61 identification of the funding sources to be utilized to finance the three  
62 component system.

63 (b) The plan shall address how changes in one component of such  
64 long-term care system impact other components of such system. The  
65 plan shall incorporate data measuring the level of care provided to  
66 nursing home residents to gauge whether said population resides in  
67 the most appropriate, least restrictive setting. The plan shall  
68 incorporate data from the federal Centers for Medicare and Medicaid  
69 Services in order to assess and analyze the federal Minimum Data Set.  
70 Said data shall be integrated with facility inspection data derived from  
71 the Department of Public Health and nursing home cost data derived  
72 from the Department of Social Services. Data gathered shall be utilized  
73 to track and evaluate: (1) Resident acuity by facility, (2) the  
74 relationship between facility and costs, (3) acuity and staffing patterns,  
75 (4) changes in acuity over time, and (5) adequacy of the admissions  
76 assessment tool.

77 [(b)] (c) There is established a Long-Term Care Planning Committee  
78 to exchange information on long-term care issues, coordinate policy  
79 development and provide advice to the Office of Policy and

80 Management on the development of the long-term care plan pursuant  
81 to subsection (a) of this section. The Long-Term Care Planning  
82 Committee shall, within available appropriations, study issues relative  
83 to long-term care including, but not limited to, the case-mix system of  
84 Medicaid reimbursement, community-based service options, access to  
85 long-term care and geriatric psychiatric services. Such committee shall  
86 evaluate issues relative to long-term care in light of the United States  
87 Supreme Court decision, *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999),  
88 requiring states to place persons with disabilities in community  
89 settings rather than in institutions when such placement is  
90 appropriate, the transfer to a less restrictive setting is not opposed by  
91 such persons and such placement can be reasonably accommodated.

92 [(c)] (d) The Long-Term Care Planning Committee shall consist of:  
93 (1) The chairpersons and ranking members of the joint standing and  
94 select committees of the General Assembly having cognizance of  
95 matters relating to human services, public health, elderly services and  
96 long-term care; (2) the Commissioner of Social Services, or the  
97 commissioner's designee; (3) one member of the Office of Policy and  
98 Management appointed by the Secretary of the Office of Policy and  
99 Management; (4) one member from the Department of Social Services  
100 appointed by the Commissioner of Social Services; (5) one member  
101 from the Department of Public Health appointed by the Commissioner  
102 of Public Health; (6) one member from the Department of Economic  
103 and Community Development appointed by the Commissioner of  
104 Economic and Community Development; (7) one member from the  
105 Office of Health Care Access appointed by the Commissioner of  
106 Health Care Access; (8) one member from the Department of Mental  
107 Retardation appointed by the Commissioner of Mental Retardation; (9)  
108 one member from the Department of Mental Health and Addiction  
109 Services appointed by the Commissioner of Mental Health and  
110 Addiction Services; (10) one member from the Department of  
111 Transportation appointed by the Commissioner of Transportation; (11)  
112 one member from the Department of Children and Families appointed  
113 by the Commissioner of Children and Families; and (12) the executive

114 director of the Office of Protection and Advocacy for Persons with  
115 Disabilities or the executive director's designee. The committee shall  
116 convene no later than ninety days after June 4, 1998. Any vacancy shall  
117 be filled by the appointing authority. The chairperson shall be elected  
118 from among the members of the committee. The committee shall seek  
119 the advice and participation of any person, organization or state or  
120 federal agency it deems necessary to carry out the provisions of this  
121 section.

122 [(d) Not later than January 1, 1999, and every three years thereafter,  
123 the Long-Term Care Planning Committee]

124 (e) Not later than July 1, 2003, and biennially thereafter, the Office of  
125 Policy and Management shall submit a long-term care plan pursuant  
126 to subsection (a) of this section to the joint standing and select  
127 committees of the General Assembly having cognizance of matters  
128 relating to human services, public health, elderly services and long-  
129 term care, in accordance with the provisions of section 11-4a, and such  
130 plan shall serve as a guide for the actions of state agencies in  
131 developing and modifying programs that serve persons in need of  
132 long-term care.

133 [(e)] (f) Any state agency, when developing or modifying any  
134 program that, in whole or in part, provides assistance or support to  
135 persons with long-term care needs, shall, to the maximum extent  
136 feasible, include provisions that support care-giving provided by  
137 family members and other informal caregivers and promote consumer-  
138 directed care.

139 Sec. 3. (NEW) (Effective July 1, 2002) As used in chapter 319y of the  
140 general statutes, "case-mix" means a numerical value established for  
141 each nursing facility, calculated by (1) applying case-mix weights  
142 established by the federal Centers for Medicare and Medicaid Services  
143 Thirty-Four Group Resource Utilization Group, Version III to each  
144 Medicaid resident's Resource Utilization Group by facility using the  
145 cost report period for which rates will be rebased, provided that when

146 a Medicaid resident has more than one Resource Utilization Group for  
147 the cost report period, the case-mix weight applied to each Resource  
148 Utilization Group is weighted by the number of Medicaid days the  
149 Medicaid resident was in the group, and (2) aggregating the case-mix  
150 weights by facility and computing a mean for each facility.

151 Sec. 4. Section 17b-340 of the general statutes, as amended by  
152 sections 38, 52 and 62 of public act 01-2 of the June special session and  
153 sections 95 and 129 of public act 01-9 of the June special session, is  
154 repealed and the following is substituted in lieu thereof (*Effective July*  
155 *1, 2002*):

156 (a) The rates to be paid by or for persons aided or cared for by the  
157 state or any town in this state to licensed chronic and convalescent  
158 nursing homes, chronic disease hospitals associated with chronic and  
159 convalescent nursing homes, rest homes with nursing supervision and  
160 to licensed residential care homes, as defined by section 19a-490, as  
161 amended, and to residential facilities for the mentally retarded which  
162 are licensed pursuant to section 17a-227 and certified to participate in  
163 the Title XIX Medicaid program as intermediate care facilities for the  
164 mentally retarded, for room, board and services specified in licensing  
165 regulations issued by the licensing agency shall be determined  
166 annually, except as otherwise provided in this subsection, after a  
167 public hearing, by the Commissioner of Social Services, to be effective  
168 July first of each year except as otherwise provided in this subsection.  
169 Such rates shall be determined on a basis of a reasonable payment for  
170 such necessary services, which basis shall take into account as a factor  
171 the costs of such services and the Medicaid resident case-mix of  
172 chronic and convalescent nursing homes and rest homes with nursing  
173 supervision. Rates shall be case-mix adjusted using a resident  
174 classification system known as Resource Utilization Groups, Version  
175 III based on assessments conducted using the federal Minimum Data  
176 Set. Cost of such services shall include (1) reasonable costs mandated  
177 by collective bargaining agreements with certified collective  
178 bargaining agents or other agreements between the employer and

179 employees, provided "employees" shall not include persons employed  
180 as managers or chief administrators or required to be licensed as  
181 nursing home administrators, and (2) compensation for services  
182 rendered by proprietors at prevailing wage rates, as determined by  
183 application of principles of accounting as prescribed by said  
184 commissioner. Cost of such services shall not include amounts paid by  
185 the facilities to employees as salary, or to attorneys or consultants as  
186 fees, where the responsibility of the employees, attorneys, or  
187 consultants is to persuade or seek to persuade the other employees of  
188 the facility to support or oppose unionization. Nothing in this  
189 subsection shall prohibit inclusion of amounts paid for legal counsel  
190 related to the negotiation of collective bargaining agreements, the  
191 settlement of grievances or normal administration of labor relations.  
192 The commissioner may, in his discretion, allow the inclusion of  
193 extraordinary and unanticipated costs of providing services which  
194 were incurred to avoid an immediate negative impact on the health  
195 and safety of patients. [The commissioner may, in his discretion, based  
196 upon review of a facility's costs, direct care staff to patient ratio and  
197 any other related information, revise a facility's rate for any increases  
198 or decreases to total licensed capacity of more than ten beds or changes  
199 to its number of licensed rest home with nursing supervision beds and  
200 chronic and convalescent nursing home beds. The commissioner may  
201 so revise a facility's rate established for the fiscal year ending June 30,  
202 1993, and thereafter for any bed increases, decreases or changes in  
203 licensure effective after October 1, 1989.] Effective July 1, 1991, in  
204 facilities which have both a chronic and convalescent nursing home  
205 and a rest home with nursing supervision, the rate for the rest home  
206 with nursing supervision shall not exceed such facility's rate for its  
207 chronic and convalescent nursing home. All such facilities for which  
208 rates are determined under this subsection shall report on a fiscal year  
209 basis ending on the thirtieth day of September. Such report shall be  
210 submitted to the commissioner by the thirty-first day of December. The  
211 commissioner may reduce the rate in effect for a facility which fails to  
212 report on or before such date by an amount not to exceed ten per cent

213 of such rate. The commissioner shall annually, on or before the  
214 fifteenth day of February, report the data contained in the reports of  
215 such facilities to the joint standing committee of the General Assembly  
216 having cognizance of matters relating to appropriations. For the cost  
217 reporting year commencing October 1, 1985, and for subsequent cost  
218 reporting years, facilities shall report the cost of using the services of  
219 any nursing pool employee by separating said cost into two categories,  
220 the portion of the cost equal to the salary of the employee for whom  
221 the nursing pool employee is substituting shall be considered a  
222 nursing cost and any cost in excess of such salary shall be further  
223 divided so that seventy-five per cent of the excess cost shall be  
224 considered an administrative or general cost and twenty-five per cent  
225 of the excess cost shall be considered a nursing cost, provided if the  
226 total nursing pool costs of a facility for any cost year are equal to or  
227 exceed fifteen per cent of the total nursing expenditures of the facility  
228 for such cost year, no portion of nursing pool costs in excess of fifteen  
229 per cent shall be classified as administrative or general costs. The  
230 commissioner, in determining such rates, shall also take into account  
231 the classification of patients or boarders according to special care  
232 requirements or classification of the facility according to such factors  
233 as facilities and services and such other factors as he deems reasonable,  
234 including anticipated fluctuations in the cost of providing such  
235 services. The commissioner may establish a separate rate for a facility  
236 or a portion of a facility for traumatic brain injury patients who require  
237 extensive care but not acute general hospital care. Such separate rate  
238 shall reflect the special care requirements of such patients. If changes  
239 in federal or state laws, regulations or standards adopted subsequent  
240 to June 30, 1985, result in increased costs or expenditures in an amount  
241 exceeding one-half of one per cent of allowable costs for the most  
242 recent cost reporting year, the commissioner shall adjust rates and  
243 provide payment for any such increased reasonable costs or  
244 expenditures within a reasonable period of time retroactive to the date  
245 of enforcement. Nothing in this section shall be construed to require  
246 the Department of Social Services to adjust rates and provide payment

247 for any increases in costs resulting from an inspection of a facility by  
248 the Department of Public Health. Such assistance as the commissioner  
249 requires from other state agencies or departments in determining rates  
250 shall be made available to him at his request. Payment of the rates  
251 established hereunder shall be conditioned on the establishment by  
252 such facilities of admissions procedures which conform with this  
253 section, section 19a-533 and all other applicable provisions of the law  
254 and the provision of equality of treatment to all persons in such  
255 facilities. The established rates shall be the maximum amount  
256 chargeable by such facilities for care of such beneficiaries, and the  
257 acceptance by or on behalf of any such facility of any additional  
258 compensation for care of any such beneficiary from any other person  
259 or source shall constitute the offense of aiding a beneficiary to obtain  
260 aid to which he is not entitled and shall be punishable in the same  
261 manner as is provided in subsection (b) of section 17b-97. For the fiscal  
262 year ending June 30, 1992, rates for licensed residential care homes and  
263 intermediate care facilities for the mentally retarded may receive an  
264 increase not to exceed the most recent annual increase in the Regional  
265 Data Resources Incorporated McGraw-Hill Health Care Costs:  
266 Consumer Price Index (all urban)-All Items. Rates for newly certified  
267 intermediate care facilities for the mentally retarded shall not exceed  
268 one hundred fifty per cent of the median rate of rates in effect on  
269 January 31, 1991, for intermediate care facilities for the mentally  
270 retarded certified prior to February 1, 1991.

271 (b) The Commissioner of Social Services shall adopt, and from time  
272 to time amend, regulations in accordance with the provisions of  
273 chapter 54 to establish rates of payments for nursing homes and other  
274 residential facilities and to specify other allowable services. For  
275 purposes of this section, other allowable services means those services  
276 required by any medical assistance beneficiary residing in such home  
277 or hospital which are not already covered in the rate set by the  
278 commissioner in accordance with the provisions of subsection (a) of  
279 this section.

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

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

300 (e) Except as provided in this subsection, the provisions of  
301 subsections (c) and (d) of this section shall not apply to any facility  
302 subject to the requirements of this section, which on October 1, 1981,  
303 (1) was accepting payments from the commissioner in accordance with  
304 the provisions of subsection (a) of this section, (2) was accepting  
305 medical assistance payments from another state for at least twenty per  
306 cent of its patients, and (3) had not notified the commissioner of any  
307 intent to terminate its provider agreement, in accordance with section  
308 17b-271, provided no patient residing in any such facility on May 22,  
309 1984, shall be removed from such facility for purposes of meeting the  
310 requirements of this subsection. If the commissioner finds that the  
311 number of beds available to medical assistance patients from this state  
312 in any such facility is less than fifteen per cent the provisions of

313 subsections (c) and (d) of this section shall apply to that number of  
314 beds which is less than said percentage.

315 (f) For the fiscal year ending June 30, 1992, the rates paid by or for  
316 persons aided or cared for by the state or any town in this state to  
317 facilities for room, board and services specified in licensing regulations  
318 issued by the licensing agency, except intermediate care facilities for  
319 the mentally retarded and residential care homes, shall be based on the  
320 cost year ending September 30, 1989. For the fiscal years ending June  
321 30, 1993, and June 30, 1994, such rates shall be based on the cost year  
322 ending September 30, 1990. Notwithstanding the provisions of section  
323 17b-344, such rates shall be determined by the Commissioner of Social  
324 Services in accordance with this section and the regulations of  
325 Connecticut state agencies promulgated by the commissioner and in  
326 effect on April 1, 1991, except that:

327 (1) Allowable costs shall be divided into the following five cost  
328 components: Direct costs, which shall include salaries for nursing  
329 personnel, related fringe benefits and nursing pool costs; indirect costs,  
330 which shall include professional fees, dietary expenses, housekeeping  
331 expenses, laundry expenses, supplies related to patient care, salaries  
332 for indirect care personnel and related fringe benefits; fair rent, which  
333 shall be defined in accordance with subsection (f) of section 17-311-52  
334 of the regulations of Connecticut state agencies; capital-related costs,  
335 which shall include property taxes, insurance expenses, equipment  
336 leases and equipment depreciation; and administrative and general  
337 costs, which shall include maintenance and operation of plant  
338 expenses, salaries for administrative and maintenance personnel and  
339 related fringe benefits. The commissioner may provide a rate  
340 adjustment for nonemergency transportation services required by  
341 nursing facility residents. Such adjustment shall be a fixed amount  
342 determined annually by the commissioner based upon a review of  
343 costs and other associated information. Allowable costs shall not  
344 include costs for ancillary services payable under Part B of the  
345 Medicare program.

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

352 (B) Chronic and convalescent nursing homes and rest homes with  
353 nursing supervision grouped pursuant to subparagraph (A) of this  
354 subdivision shall be further grouped into case-mix peer groups for  
355 purposes of determining allowable direct care costs. Said facilities  
356 case-mix indices shall be arrayed and the case-mix peer groups shall be  
357 as follows (i) a low case-mix peer group shall be comprised of facilities  
358 with case-mixed indices in the lower third of the total index range; (ii)  
359 a mid case-mix peer group shall be comprised of facilities with case-  
360 mix indices in the middle third of the total index range, and (iii) a high  
361 case-mix peer group shall be comprised of three facilities with case-  
362 mix indices in the top third of the total index range.

363 (3) For the fiscal year ending June 30, 1992, per diem maximum  
364 allowable costs for each cost component shall be as follows: For direct  
365 costs, the maximum shall be equal to one hundred forty per cent of the  
366 median allowable cost of that peer grouping; for indirect costs, the  
367 maximum shall be equal to one hundred thirty per cent of the state-  
368 wide median allowable cost; for fair rent, the amount shall be  
369 calculated utilizing the amount approved by the Office of Health Care  
370 Access pursuant to section 19a-638; for capital-related costs, there shall  
371 be no maximum; and for administrative and general costs, the  
372 maximum shall be equal to one hundred twenty-five per cent of the  
373 state-wide median allowable cost. For the fiscal year ending June 30,  
374 1993, per diem maximum allowable costs for each cost component  
375 shall be as follows: For direct costs, the maximum shall be equal to one  
376 hundred forty per cent of the median allowable cost of that peer  
377 grouping; for indirect costs, the maximum shall be equal to one  
378 hundred twenty-five per cent of the state-wide median allowable cost;

379 for fair rent, the amount shall be calculated utilizing the amount  
380 approved by the Office of Health Care Access pursuant to section 19a-  
381 638; for capital-related costs, there shall be no maximum; and for  
382 administrative and general costs the maximum shall be equal to one  
383 hundred fifteen per cent of the state-wide median allowable cost. For  
384 the fiscal year ending June 30, 1994, per diem maximum allowable  
385 costs for each cost component shall be as follows: For direct costs, the  
386 maximum shall be equal to one hundred thirty-five per cent of the  
387 median allowable cost of that peer grouping; for indirect costs, the  
388 maximum shall be equal to one hundred twenty per cent of the state-  
389 wide median allowable cost; for fair rent, the amount shall be  
390 calculated utilizing the amount approved by the Office of Health Care  
391 Access pursuant to section 19a-638; for capital-related costs, there shall  
392 be no maximum; and for administrative and general costs the  
393 maximum shall be equal to one hundred ten per cent of the state-wide  
394 median allowable cost. For the fiscal year ending June 30, 1995, per  
395 diem maximum allowable costs for each cost component shall be as  
396 follows: For direct costs, the maximum shall be equal to one hundred  
397 thirty-five per cent of the median allowable cost of that peer grouping;  
398 for indirect costs, the maximum shall be equal to one hundred twenty  
399 per cent of the state-wide median allowable cost; for fair rent, the  
400 amount shall be calculated utilizing the amount approved by the  
401 Office of Health Care Access pursuant to section 19a-638; for capital-  
402 related costs, there shall be no maximum; and for administrative and  
403 general costs the maximum shall be equal to one hundred five per cent  
404 of the state-wide median allowable cost. For the fiscal year ending June  
405 30, 1996, and any succeeding fiscal year, except for the fiscal years  
406 ending June 30, 2000, and June 30, 2001, for facilities with an interim  
407 rate in one or both periods, per diem maximum allowable costs for  
408 each cost component shall be as follows: For direct costs, the maximum  
409 shall be equal to one hundred thirty-five per cent of the median  
410 allowable cost of that peer grouping; for indirect costs, the maximum  
411 shall be equal to one hundred fifteen per cent of the state-wide median  
412 allowable cost; for fair rent, the amount shall be calculated utilizing the

413 amount approved pursuant to section 19a-638; for capital-related costs,  
414 there shall be no maximum; and for administrative and general costs  
415 the maximum shall be equal to the state-wide median allowable cost.  
416 For the fiscal years ending June 30, 2000, and June 30, 2001, for  
417 facilities with an interim rate in one or both periods, per diem  
418 maximum allowable costs for each cost component shall be as follows:  
419 For direct costs, the maximum shall be equal to one hundred forty-five  
420 per cent of the median allowable cost of that peer grouping; for  
421 indirect costs, the maximum shall be equal to one hundred twenty-five  
422 per cent of the state-wide median allowable cost; for fair rent, the  
423 amount shall be calculated utilizing the amount approved pursuant to  
424 section 19a-638; for capital-related costs, there shall be no maximum;  
425 and for administrative and general costs, the maximum shall be equal  
426 to the state-wide median allowable cost and such medians shall be  
427 based upon the same cost year used to set rates for facilities with  
428 prospective rates. For the fiscal year ending June 30, 2004, and each  
429 fiscal year thereafter, direct care costs shall be arrayed for each case-  
430 mix peer group, per diem maximum allowable direct care costs for  
431 each group shall be equal to one hundred fifteen per cent of median  
432 costs for the low case-mix peer group, one hundred twenty per cent of  
433 median costs for the middle case-mix peer group and one hundred  
434 twenty-five per cent of median costs for the high case-mix peer group.  
435 Costs in excess of the maximum amounts established under this  
436 subsection shall not be recognized as allowable costs, except that the  
437 Commissioner of Social Services (A) may allow costs in excess of  
438 maximum amounts for any facility with patient days covered by  
439 Medicare, including days requiring coinsurance, in excess of twelve  
440 per cent of annual patient days which also has patient days covered by  
441 Medicaid in excess of fifty per cent of annual patient days; (B) may  
442 establish a pilot program whereby costs in excess of maximum  
443 amounts shall be allowed for beds in a nursing home which has a  
444 managed care program and is affiliated with a hospital licensed under  
445 chapter 368v; and (C) may establish rates whereby allowable costs may  
446 exceed such maximum amounts for beds approved on or after July 1,

447 1991, which are restricted to use by patients with acquired immune  
448 deficiency syndrome or traumatic brain injury.

449 [(4) For the fiscal year ending June 30, 1992, (A) no facility shall  
450 receive a rate that is less than the rate it received for the rate year  
451 ending June 30, 1991; (B) no facility whose rate, if determined pursuant  
452 to this subsection, would exceed one hundred twenty per cent of the  
453 state-wide median rate, as determined pursuant to this subsection,  
454 shall receive a rate which is five and one-half per cent more than the  
455 rate it received for the rate year ending June 30, 1991; and (C) no  
456 facility whose rate, if determined pursuant to this subsection, would be  
457 less than one hundred twenty per cent of the state-wide median rate,  
458 as determined pursuant to this subsection, shall receive a rate which is  
459 six and one-half per cent more than the rate it received for the rate year  
460 ending June 30, 1991. For the fiscal year ending June 30, 1993, no  
461 facility shall receive a rate that is less than the rate it received for the  
462 rate year ending June 30, 1992, or six per cent more than the rate it  
463 received for the rate year ending June 30, 1992. For the fiscal year  
464 ending June 30, 1994, no facility shall receive a rate that is less than the  
465 rate it received for the rate year ending June 30, 1993, or six per cent  
466 more than the rate it received for the rate year ending June 30, 1993.  
467 For the fiscal year ending June 30, 1995, no facility shall receive a rate  
468 that is more than five per cent less than the rate it received for the rate  
469 year ending June 30, 1994, or six per cent more than the rate it received  
470 for the rate year ending June 30, 1994. For the fiscal years ending June  
471 30, 1996, and June 30, 1997, no facility shall receive a rate that is more  
472 than three per cent more than the rate it received for the prior rate  
473 year. For the fiscal year ending June 30, 1998, a facility shall receive a  
474 rate increase that is not more than two per cent more than the rate that  
475 the facility received in the prior year. For the fiscal year ending June  
476 30, 1999, a facility shall receive a rate increase that is not more than  
477 three per cent more than the rate that the facility received in the prior  
478 year and that is not less than one per cent more than the rate that the  
479 facility received in the prior year, exclusive of rate increases associated  
480 with a wage, benefit and staffing enhancement rate adjustment added

481 for the period from April 1, 1999, to June 30, 1999, inclusive. For the  
482 fiscal year ending June 30, 2000, each facility, except a facility with an  
483 interim rate or replaced interim rate for the fiscal year ending June 30,  
484 1999, and a facility having a certificate of need or other agreement  
485 specifying rate adjustments for the fiscal year ending June 30, 2000,  
486 shall receive a rate increase equal to one per cent applied to the rate the  
487 facility received for the fiscal year ending June 30, 1999, exclusive of  
488 the facility's wage, benefit and staffing enhancement rate adjustment.  
489 For the fiscal year ending June 30, 2000, no facility with an interim rate,  
490 replaced interim rate or scheduled rate adjustment specified in a  
491 certificate of need or other agreement for the fiscal year ending June  
492 30, 2000, shall receive a rate increase that is more than one per cent  
493 more than the rate the facility received in the fiscal year ending June  
494 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a  
495 facility with an interim rate or replaced interim rate for the fiscal year  
496 ending June 30, 2000, and a facility having a certificate of need or other  
497 agreement specifying rate adjustments for the fiscal year ending June  
498 30, 2001, shall receive a rate increase equal to two per cent applied to  
499 the rate the facility received for the fiscal year ending June 30, 2000,  
500 subject to verification of wage enhancement adjustments pursuant to  
501 subdivision (15) of this subsection. For the fiscal year ending June 30,  
502 2001, no facility with an interim rate, replaced interim rate or  
503 scheduled rate adjustment specified in a certificate of need or other  
504 agreement for the fiscal year ending June 30, 2001, shall receive a rate  
505 increase that is more than two per cent more than the rate the facility  
506 received for the fiscal year ending June 30, 2000. For the fiscal year  
507 ending June 30, 2002, each facility shall receive a rate that is two and  
508 one-half per cent more than the rate the facility received in the prior  
509 fiscal year. For the fiscal year ending June 30, 2003, each facility shall  
510 receive a rate that is two per cent more than the rate the facility  
511 received in the prior fiscal year.] (4) The Commissioner of Social  
512 Services shall add fair rent increases to any other rate increases  
513 established pursuant to [this] subdivision (7) of this subsection for a  
514 facility which has undergone a material change in circumstances

515 related to fair rent.

516 (5) For the purpose of determining allowable fair rent, a facility with  
517 allowable fair rent less than the twenty-fifth percentile of the state-  
518 wide allowable fair rent shall be reimbursed as having allowable fair  
519 rent equal to the twenty-fifth percentile of the state-wide allowable fair  
520 rent, provided for the fiscal years ending June 30, 1996, and June 30,  
521 1997, the reimbursement may not exceed the twenty-fifth percentile of  
522 the state-wide allowable fair rent for the fiscal year ending June 30,  
523 1995. On and after July 1, 1998, the Commissioner of Social Services  
524 may allow minimum fair rent as the basis upon which reimbursement  
525 associated with improvements to real property is added. Beginning  
526 with the fiscal year ending June 30, 1996, any facility with a rate of  
527 return on real property other than land in excess of eleven per cent  
528 shall have such allowance revised to eleven per cent. Any facility or its  
529 related realty affiliate which finances or refinances debt through bonds  
530 issued by the State of Connecticut Health and Education Facilities  
531 Authority shall report the terms and conditions of such financing or  
532 refinancing to the Commissioner of Social Services within thirty days  
533 of completing such financing or refinancing. The Commissioner of  
534 Social Services may revise the facility's fair rent component of its rate  
535 to reflect any financial benefit the facility or its related realty affiliate  
536 received as a result of such financing or refinancing, including but not  
537 limited to, reductions in the amount of debt service payments or  
538 period of debt repayment. The commissioner shall allow actual debt  
539 service costs for bonds issued by the State of Connecticut Health and  
540 Educational Facilities Authority if such costs do not exceed property  
541 costs allowed pursuant to subsection (f) of section 17-311-52 of the  
542 regulations of Connecticut state agencies, provided the commissioner  
543 may allow higher debt service costs for such bonds for good cause. For  
544 facilities which first open on or after October 1, 1992, the commissioner  
545 shall determine allowable fair rent for real property other than land  
546 based on the rate of return for the cost year in which such bonds were  
547 issued. The financial benefit resulting from a facility financing or  
548 refinancing debt through such bonds shall be shared between the state

549 and the facility to an extent determined by the commissioner on a case-  
550 by-case basis and shall be reflected in an adjustment to the facility's  
551 allowable fair rent.

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

558 (7) (A) For the fiscal year ending June 30, [1992] 2004, allowable  
559 operating costs, excluding fair rent, shall be inflated using the  
560 [Regional Data Resources Incorporated McGraw-Hill Health Care  
561 Costs: Consumer Price Index (all urban)-All Items minus one and one-  
562 half per cent. For the fiscal year ending June 30, 1993, allowable  
563 operating costs, excluding fair rent, shall be inflated using the Regional  
564 Data Resources Incorporated McGraw-Hill Health Care Costs:  
565 Consumer Price Index (all urban)-All Items minus one and three-  
566 quarters per cent. For the fiscal years ending June 30, 1994, and June  
567 30, 1995, allowable operating costs, excluding fair rent, shall be inflated  
568 using the Regional Data Resources Incorporated McGraw-Hill Health  
569 Care Costs: Consumer Price Index (all urban)-All Items minus two per  
570 cent. For the fiscal year ending June 30, 1996, allowable operating  
571 costs, excluding fair rent, shall be inflated using the Regional Data  
572 Resources Incorporated McGraw-Hill Health Care Costs: Consumer  
573 Price Index (all urban)-All Items minus two and one-half per cent. For  
574 the fiscal year ending June 30, 1997, allowable operating costs,  
575 excluding fair rent, shall be inflated using the Regional Data Resources  
576 Incorporated McGraw-Hill Health Care Costs: Consumer Price Index  
577 (all urban)-All Items minus three and one-half per cent] skilled nursing  
578 facility market basket inflation index. For the fiscal year ending June  
579 30, 2004, and each fiscal year thereafter in which costs are rebased, the  
580 skilled nursing facility market basket inflation index projected by Data  
581 Resources Incorporated-Wharton Econometric Forecasting Association

582 shall be used to inflate costs from the midpoint of the cost year to the  
583 midpoint of the rate year. For the fiscal year ending June 30, 1992, and  
584 any succeeding fiscal year, allowable fair rent shall be those reported  
585 in the annual report of long-term care facilities for the cost year ending  
586 the immediately preceding September thirtieth. [The inflation index to  
587 be used pursuant to this subsection shall be computed to reflect  
588 inflation between the midpoint of the cost year through the midpoint  
589 of the rate year. The Department of Social Services shall study methods  
590 of reimbursement for fair rent and shall report its findings and  
591 recommendations to the joint standing committee of the General  
592 Assembly having cognizance of matters relating to human services on  
593 or before January 15, 1993.]

594 (B) For the fiscal year ending June 30, 2005, and each fiscal year  
595 thereafter in which costs are not rebased, rates shall be inflated using  
596 the skilled nursing facility market basket inflation index annual  
597 increase.

598 (8) On and after July 1, [1994] 2003, costs shall be rebased [no more  
599 frequently than every two years and no less frequently than every four  
600 years, as determined by the commissioner. The commissioner shall  
601 determine whether and to what extent a change in ownership of a  
602 facility shall occasion the rebasing of the facility's costs] every three  
603 years.

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

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

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

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

617 (13) A chronic and convalescent nursing home having an ownership  
618 affiliation with and operated at the same location as a chronic disease  
619 hospital may request that the commissioner approve an exception to  
620 applicable rate-setting provisions for chronic and convalescent nursing  
621 homes and establish a rate for the fiscal years ending June 30, 1992,  
622 and June 30, 1993, in accordance with regulations in effect June 30,  
623 1991. Any such rate shall not exceed one hundred sixty-five per cent of  
624 the median rate established for chronic and convalescent nursing  
625 homes established under this section for the applicable fiscal year.

626 (14) For the fiscal year ending June 30, 1994, and any succeeding  
627 fiscal year, for purposes of computing minimum allowable patient  
628 days, utilization of a facility's certified beds shall be determined at a  
629 minimum of ninety-five per cent of capacity, except for new facilities  
630 and facilities which are certified for additional beds which may be  
631 permitted a lower occupancy rate for the first three months of  
632 operation after the effective date of licensure.

633 (15) The Commissioner of Social Services shall adjust facility rates  
634 from April 1, 1999, to June 30, 1999, inclusive, by a per diem amount  
635 representing each facility's allocation of funds appropriated for the  
636 purpose of wage, benefit and staffing enhancement. A facility's per  
637 diem allocation of such funding shall be computed as follows: (A) The  
638 facility's direct and indirect component salary, wage, nursing pool and  
639 allocated fringe benefit costs as filed for the 1998 cost report period  
640 deemed allowable in accordance with this section and applicable  
641 regulations without application of cost component maximums  
642 specified in subdivision (3) of this subsection shall be totalled; (B) such  
643 total shall be multiplied by the facility's Medicaid utilization based on  
644 the 1998 cost report; (C) the resulting amount for the facility shall be

645 divided by the sum of the calculations specified in subparagraphs (A)  
646 and (B) of this subdivision for all facilities to determine the facility's  
647 percentage share of appropriated wage, benefit and staffing  
648 enhancement funding; (D) the facility's percentage share shall be  
649 multiplied by the amount of appropriated wage, benefit and staffing  
650 enhancement funding to determine the facility's allocated amount; and  
651 (E) such allocated amount shall be divided by the number of days of  
652 care paid for by Medicaid on an annual basis including days for  
653 reserved beds specified in the 1998 cost report to determine the per  
654 diem wage and benefit rate adjustment amount. The commissioner  
655 may adjust a facility's reported 1998 cost and utilization data for the  
656 purposes of determining a facility's share of wage, benefit and staffing  
657 enhancement funding when reported 1998 information is not  
658 substantially representative of estimated cost and utilization data for  
659 the fiscal year ending June 30, 2000, due to special circumstances  
660 during the 1998 cost report period including change of ownership with  
661 a part year cost filing or reductions in facility capacity due to facility  
662 renovation projects. Upon completion of the calculation of the  
663 allocation of wage, benefit and staffing enhancement funding, the  
664 commissioner shall not adjust the allocations due to revisions  
665 submitted to previously filed 1998 annual cost reports. In the event  
666 that a facility's rate for the fiscal year ending June 30, 1999, is an  
667 interim rate or the rate includes an increase adjustment due to a rate  
668 request to the commissioner or other reasons, the commissioner may  
669 reduce or withhold the per diem wage, benefit and staffing  
670 enhancement allocation computed for the facility. Any enhancement  
671 allocations not applied to facility rates shall not be reallocated to other  
672 facilities and such unallocated amounts shall be available for the costs  
673 associated with interim rates and other Medicaid expenditures. The  
674 wage, benefit and staffing enhancement per diem adjustment for the  
675 period from April 1, 1999, to June 30, 1999, inclusive, shall also be  
676 applied to rates for the fiscal years ending June 30, 2000, and June 30,  
677 2001, except that the commissioner may increase or decrease the  
678 adjustment to account for changes in facility capacity or operations.

679 Any facility accepting a rate adjustment for wage, benefit and staffing  
680 enhancements shall apply payments made as a result of such rate  
681 adjustment for increased allowable employee wage rates and benefits  
682 and additional direct and indirect component staffing. Adjustment  
683 funding shall not be applied to wage and salary increases provided to  
684 the administrator, assistant administrator, owners or related party  
685 employees. Enhancement payments may be applied to increases in  
686 costs associated with staffing purchased from staffing agencies  
687 provided such costs are deemed necessary and reasonable by the  
688 commissioner. The commissioner shall compare expenditures for  
689 wages, benefits and staffing for the 1998 cost report period to such  
690 expenditures in the 1999, 2000 and 2001 cost report periods to verify  
691 whether a facility has applied additional payments to specified  
692 enhancements. In the event that the commissioner determines that a  
693 facility did not apply additional payments to specified enhancements,  
694 the commissioner shall recover such amounts from the facility through  
695 rate adjustments or other means. The commissioner may require  
696 facilities to file cost reporting forms, in addition to the annual cost  
697 report, as may be necessary, to verify the appropriate application of  
698 wage, benefit and staffing enhancement rate adjustment payments. For  
699 the purposes of this subdivision, "Medicaid utilization" means the  
700 number of days of care paid for by Medicaid on an annual basis  
701 including days for reserved beds as a percentage of total resident days.

702 (16) On and after July 1, 2002, there shall be a unit within the  
703 Department of Social Services for matters relating to certificate of need,  
704 rate setting, and financial stability of nursing facilities. Said unit shall  
705 have a staff of thirteen persons responsible for (A) establishing rates in  
706 accordance with this section, to include maintaining, analyzing, and  
707 calculating case-mix indices for each nursing facility to adjust rates in  
708 accordance with this section, (B) overseeing audits in accordance with  
709 this section, and (C) developing information needed for the interim  
710 rate panel established pursuant to this section. The director of such  
711 unit shall develop a plan to oversee and improve the financial stability  
712 of nursing homes. Such plan shall be developed by July 1, 2003, and

713 submitted to the joint standing committees of the General Assembly  
714 having cognizance of matters relating to human services and public  
715 health and to the select committee of the General Assembly having  
716 cognizance of matters relating to aging, in accordance with the  
717 provisions of section 11-4a.

718 (17) (A) There is established a rate review panel comprised of five  
719 members, one from the Office of Policy and Management, one each  
720 from the Department of Social Services and the Department of Public  
721 Health, a health care economist or similar health care expert appointed  
722 by the Governor, and a financial management expert appointed by the  
723 Governor. (B) The panel shall meet quarterly to consider requests from  
724 nursing facilities for interim rates or special adjustments. Such requests  
725 from facilities shall be acted upon within six months' time of the date  
726 on which the request was filed with the panel. (C) The panel shall  
727 establish its criteria in writing, including standards for requests.  
728 Criteria shall be based solely on financial hardship; change of  
729 ownership alone shall not be a criterion. Facilities shall provide  
730 supporting documentation of financial hardship, including the results  
731 of any independent audit. (D) The panel shall establish criteria to limit  
732 the number of interim rates or special adjustments granted to one  
733 facility. Decisions shall be made on the established criteria, based on  
734 the comprehensive plan for long-term care including the need for beds  
735 in nursing facilities. The panel, in granting an interim rate on special  
736 adjustment, may impose conditions of the facility's operation.

737 (18) The Commissioner of Social Services, or a designated  
738 representative, shall conduct desk and field audits of facility cost  
739 reports submitted to the commissioner pursuant to subsection (a) of  
740 this section in order to establish a facility's Medicaid rate. The  
741 commissioner, or a designated representative, shall conduct a desk  
742 audit of each annual facility cost report submitted. The commissioner  
743 shall conduct random field audits of the cost reports of any facility.  
744 Such field audits shall occur at the commissioner's discretion and shall  
745 not be limited to cost year reports on which a facility's costs are

746 rebased but may include any or all years from the facility's last full  
747 field audit. Such field audits shall verify reasonable costs used to  
748 establish the facility's Medicaid rate, detect any early signs of financial  
749 distress and substantiate the facility's case-mix peer grouping when  
750 such grouping has changed and impacted the facility's rate. Such audit  
751 may include a nurse consultation to review the facility's change in  
752 case-mix peer grouping.

753 (g) For the fiscal year ending June 30, 1993, any intermediate care  
754 facility for the mentally retarded with an operating cost component of  
755 its rate in excess of one hundred forty per cent of the median of  
756 operating cost components of rates in effect January 1, 1992, shall not  
757 receive an operating cost component increase. For the fiscal year  
758 ending June 30, 1993, any intermediate care facility for the mentally  
759 retarded with an operating cost component of its rate that is less than  
760 one hundred forty per cent of the median of operating cost  
761 components of rates in effect January 1, 1992, shall have an allowance  
762 for real wage growth equal to thirty per cent of the increase  
763 determined in accordance with subsection (q) of section 17-311-52 of  
764 the regulations of Connecticut state agencies, provided such operating  
765 cost component shall not exceed one hundred forty per cent of the  
766 median of operating cost components in effect January 1, 1992. Any  
767 facility with real property other than land placed in service prior to  
768 October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a  
769 rate of return on real property equal to the average of the rates of  
770 return applied to real property other than land placed in service for the  
771 five years preceding October 1, 1993. For the fiscal year ending June 30,  
772 1996, and any succeeding fiscal year, the rate of return on real property  
773 for property items shall be revised every five years. The commissioner  
774 shall, upon submission of a request, allow actual debt service,  
775 comprised of principal and interest, in excess of property costs allowed  
776 pursuant to section 17-311-52 of the regulations of Connecticut state  
777 agencies, provided such debt service terms and amounts are  
778 reasonable in relation to the useful life and the base value of the  
779 property. For the fiscal year ending June 30, 1995, and any succeeding

780 fiscal year, the inflation adjustment made in accordance with  
781 subsection (p) of section 17-311-52 of the regulations of Connecticut  
782 state agencies, shall not be applied to real property costs. For the fiscal  
783 year ending June 30, 1996, and any succeeding fiscal year, the  
784 allowance for real wage growth as determined in accordance with  
785 subsection (q) of section 17-311-52 of the regulations of Connecticut  
786 state agencies, shall not be applied. For the fiscal year ending June 30,  
787 1996, and any succeeding fiscal year, no rate shall exceed three  
788 hundred seventy-five dollars per day unless the commissioner, in  
789 consultation with the Commissioner of Mental Retardation,  
790 determines after a review of program and management costs, that a  
791 rate in excess of this amount is necessary for care and treatment of  
792 facility residents. For the fiscal year ending June 30, 2002, rate period,  
793 the Commissioner of Social Services shall increase the inflation  
794 adjustment for rates made in accordance with subsection (p) of section  
795 17-311-52 of the Regulations of State Agencies to update allowable  
796 fiscal year 2000 costs to include a three and one-half per cent inflation  
797 factor. For the fiscal year ending June 30, 2003, rate period, the  
798 commissioner shall increase the inflation adjustment for rates made in  
799 accordance with subsection (p) of section 17-311-52 of the Regulations  
800 of State Agencies to update allowable fiscal year 2001 costs to include a  
801 one and one-half per cent inflation factor.

802 (h) For the fiscal year ending June 30, 1993, any residential care  
803 home with an operating cost component of its rate in excess of one  
804 hundred thirty per cent of the median of operating cost components of  
805 rates in effect January 1, 1992, shall not receive an operating cost  
806 component increase. For the fiscal year ending June 30, 1993, any  
807 residential care home with an operating cost component of its rate that  
808 is less than one hundred thirty per cent of the median of operating cost  
809 components of rates in effect January 1, 1992, shall have an allowance  
810 for real wage growth equal to sixty-five per cent of the increase  
811 determined in accordance with subsection (q) of section 17-311-52 of  
812 the regulations of Connecticut state agencies, provided such operating  
813 cost component shall not exceed one hundred thirty per cent of the

814 median of operating cost components in effect January 1, 1992.  
815 Beginning with the fiscal year ending June 30, 1993, for the purpose of  
816 determining allowable fair rent, a residential care home with allowable  
817 fair rent less than the twenty-fifth percentile of the state-wide  
818 allowable fair rent shall be reimbursed as having allowable fair rent  
819 equal to the twenty-fifth percentile of the state-wide allowable fair  
820 rent. Beginning with the fiscal year ending June 30, 1997, a residential  
821 care home with allowable fair rent less than three dollars and ten cents  
822 per day shall be reimbursed as having allowable fair rent equal to  
823 three dollars and ten cents per day. Property additions placed in  
824 service during the cost year ending September 30, 1996, or any  
825 succeeding cost year shall receive a fair rent allowance for such  
826 additions as an addition to three dollars and ten cents per day if the  
827 fair rent for the facility for property placed in service prior to  
828 September 30, 1995, is less than or equal to three dollars and ten cents  
829 per day. For the fiscal year ending June 30, 1996, and any succeeding  
830 fiscal year, the allowance for real wage growth, as determined in  
831 accordance with subsection (q) of section 17-311-52 of the regulations  
832 of Connecticut state agencies shall not be applied. For the fiscal year  
833 ending June 30, 1996, and any succeeding fiscal year, the inflation  
834 adjustment made in accordance with subsection (p) of section  
835 17-311-52 of the regulations of Connecticut state agencies shall not be  
836 applied to real property costs. Beginning with the fiscal year ending  
837 June 30, 1997, minimum allowable patient days for rate computation  
838 purposes for a residential care home with twenty-five beds or less shall  
839 be eighty-five per cent of licensed capacity. Beginning with the fiscal  
840 year ending June 30, 2002, for the purposes of determining the  
841 allowable salary of an administrator of a residential care home with  
842 sixty beds or less the department shall revise the allowable base salary  
843 to thirty-seven thousand dollars to be annually inflated thereafter in  
844 accordance with section 17-311-52 of the regulations of Connecticut  
845 state agencies. The rates for the fiscal year ending June 30, 2002, shall  
846 be based upon the increased allowable salary of an administrator,  
847 regardless of whether such amount was expended in the 2000 cost

848 report period upon which the rates are based. Beginning with the fiscal  
849 year ending June 30, 2000, the inflation adjustment for rates made in  
850 accordance with subsection (p) of section 17-311-52 of the regulations  
851 of state agencies shall be increased by two per cent, and beginning  
852 with the fiscal year ending June 30, 2002, the inflation adjustment for  
853 rates made in accordance with subsection (c) of said section shall be  
854 increased by one per cent. Beginning with the fiscal year ending June  
855 30, 1999, for the purpose of determining the allowable salary of a  
856 related party, the department shall revise the maximum salary to  
857 twenty-seven thousand eight hundred fifty-six dollars to be annually  
858 inflated thereafter in accordance with section 17-311-52 of the  
859 regulations of Connecticut state agencies and beginning with the fiscal  
860 year ending June 30, 2001, such allowable salary shall be computed on  
861 an hourly basis and the maximum number of hours allowed for a  
862 related party other than the proprietor shall be increased from forty  
863 hours to forty-eight hours per work week.

864 (i) Notwithstanding the provisions of this section, the  
865 Commissioner of Social Services shall establish a fee schedule for  
866 payments to be made to chronic disease hospitals associated with  
867 chronic and convalescent nursing homes to be effective on and after  
868 July 1, 1995. The fee schedule may be adjusted annually beginning July  
869 1, 1997, to reflect necessary increases in the cost of services.

870 Sec. 5. Subsection (b) of section 17b-352 of the general statutes is  
871 repealed and the following is substituted in lieu thereof (*Effective July*  
872 *1, 2002*):

873 (b) Any facility which intends to (1) transfer all or part of its  
874 ownership or control; [prior to being initially licensed;] (2) introduce  
875 any additional function or service into its program of care or expand  
876 an existing function or service; or (3) terminate a service or decrease  
877 substantially its total bed capacity, shall submit a complete request for  
878 permission to implement such transfer, addition, expansion, increase,  
879 termination or decrease with such information as the department

880 requires to the Department of Social Services.

881       Sec. 6. Section 17b-355 of the general statutes, as amended by section  
882 63 of public act 01-2 of the June special session and section 129 of  
883 public act 01-9 of the June special session, is repealed and the following  
884 is substituted in lieu thereof (*Effective July 1, 2003*):

885       In determining whether a request submitted pursuant to sections  
886 17b-352 to 17b-354, inclusive, will be granted, modified or denied, the  
887 Commissioner of Social Services shall consider the following: The  
888 relationship of the request to the [state health plan] long-term care plan  
889 established pursuant to section 17b-337, as amended by this act, the  
890 financial feasibility of the request and its impact on the applicant's  
891 rates and financial condition, the contribution of the request to the  
892 quality, accessibility and cost-effectiveness of health care delivery in  
893 the region, whether there is clear public need for the request, the  
894 relationship of any proposed change to the applicant's current  
895 utilization statistics, the business interests of all owners, partners,  
896 associates, incorporators, directors, sponsors, stockholders and  
897 operators and the personal background of such persons, and any other  
898 factor which the department deems relevant. Whenever the granting,  
899 modification or denial of a request is inconsistent with the [state  
900 health] long-term care plan, a written explanation of the reasons for  
901 the inconsistency shall be included in the decision. In considering  
902 whether there is clear public need for any request for additional  
903 nursing home beds associated with a continuing care facility submitted  
904 pursuant to section 17b-354, as amended, the commissioner shall only  
905 consider the need for beds for current and prospective residents of the  
906 continuing care facility. In considering whether there is clear public  
907 need for any request for the relocation of beds, the commissioner shall  
908 consider whether there is a demonstrated bed need in the towns  
909 within a fifteen-mile radius of the town in which the beds are  
910 proposed to be located. Bed need shall be based on the long-term care  
911 plan, the recent occupancy percentage of area nursing facilities, and  
912 the projected bed need for no more than five years into the future at

913 ninety-seven and one-half per cent occupancy using the latest official  
914 population projections by town and age as published by the Office of  
915 Policy and Management and the latest available state-wide nursing  
916 facility utilization statistics by age cohort from the Department of  
917 Public Health. The commissioner may also consider area specific  
918 utilization and reductions in utilization rates to account for the  
919 increased use of less institutional alternatives.

920 Sec. 7. Section 19a-1c of the general statutes is repealed and the  
921 following is substituted in lieu thereof (*Effective July 1, 2002*):

922 (a) Whenever the words "Commissioner of Public Health and  
923 Addiction Services" are used or referred to in the following sections of  
924 the general statutes, the words "Commissioner of Public Health" shall  
925 be substituted in lieu thereof and whenever the words "Department of  
926 Public Health and Addiction Services" are used or referred to in the  
927 following sections of the general statutes, the words "Department of  
928 Public Health" shall be substituted in lieu thereof: 1-21b, 2-20a, 3-129,  
929 4-5, 4-38c, 4-60i, 4-67e, 4a-12, 4a-16, 4a-51, 5-169, 7-22a, 7-42, 7-44, 7-45,  
930 7-48, 7-49, 7-51, 7-52, 7-53, 7-54, 7-55, 7-59, 7-60, 7-62a, 7-62b, 7-62c, 7-  
931 65, 7-70, 7-72, 7-73, 7-74, 7-127e, 7-504, 7-536, 8-159a, 8-206d, 8-210, 10-  
932 19, 10-71, 10-76d, 10-203, 10-204a, 10-207, 10-212, 10-212a, 10-214, 10-  
933 215d, 10-253, 10-282, 10-284, 10-292, 10a-132, 10a-155, 10a-162a, 12-62f,  
934 12-263a, 12-407, 12-634, 13a-175b, 13a-175ee, 13b-38n, 14-227a, 14-227c,  
935 15-121, 15-140r, 15-140u, 16-19z, 16-32e, 16-43, 16-50c, 16-50d, 16-50j,  
936 16-261a, 16-262l, 16-262m, 16-262n, 16-262o, 16-262q, 16a-36, 16a-36a,  
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1012 (b) If the term "Department of Public Health and Addiction  
1013 Services" is used or referred to in any public or special act of 1995 or

1014 1996, or in any section of the general statutes which is amended in 1995  
1015 or 1996, it shall be deemed to mean or refer to the Department of  
1016 Public Health.

1017 (c) If the term "Commissioner of Public Health and Addiction  
1018 Services" is used or referred to in any public or special act of 1995 or  
1019 1996, or in any section of the general statutes which is amended in 1995  
1020 or 1996, it shall be deemed to mean or refer to the Commissioner of  
1021 Public Health.

1022 Sec. 8. (*Effective July 1, 2002*) Section 19a-538 of the general statutes is  
1023 repealed.

This act shall take effect as follows:	
Section 1	<i>July 1, 2002</i>
Sec. 2	<i>July 1, 2002</i>
Sec. 3	<i>July 1, 2002</i>
Sec. 4	<i>July 1, 2002</i>
Sec. 5	<i>July 1, 2002</i>
Sec. 6	<i>July 1, 2003</i>
Sec. 7	<i>July 1, 2002</i>
Sec. 8	<i>July 1, 2002</i>

**Statement of Purpose:**

To implement the recommendations of the legislative program review and investigations committee relative to Medicaid rate setting for nursing homes.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*