
OLR Bill Analysis

sHB 7164

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES.

SUMMARY

This bill makes several unrelated changes to statutes affecting various human services programs in the Department of Social Services (DSS). Among other things, the bill freezes certain cash assistance benefit rates; caps rates paid to various institutional and residential facilities; and prohibits certain employer non-compete agreements. It also streamlines the process by which certain non-viable nursing homes may seek closure, institutes performance-based payment methodologies for nursing homes and hospitals, and limits or eliminates certain rate appeals under Medicaid.

The bill also makes minor and conforming changes.

EFFECTIVE DATE: July 1, 2019, except for provisions on homemaker-companion non-compete covenants and rate appeals, which are effective upon passage.

§ 1 — TEMPORARY FAMILY ASSISTANCE (TFA) AND STATE ADMINISTERED GENERAL ASSISTANCE (SAGA) RATES

Freezes TFA and SAGA rates

The bill extends through FY 21 a freeze on payment standards (i.e., benefits) for DSS's TFA and SAGA cash assistance programs at FY 15 rates.

TFA provides temporary cash assistance to families that meet certain income and asset limits. In general, SAGA provides cash assistance to single or married individuals who have low incomes; do not qualify for any other cash assistance program; and who are temporarily unable to work due to medical reasons or qualify as unemployable.

§ 2 — STATE SUPPLEMENT PROGRAM (SSP) RATES

Freezes SSP rates

Generally, low-income people who are aged, blind, or have a disability can receive federal Supplemental Security Income (SSI) benefits if they meet certain financial eligibility requirements. The state supplements SSI benefits with SSP benefits for those who are eligible. To calculate the benefit, DSS subtracts from the beneficiary's income any applicable disregards and compares the difference to the program's payment standard. If the net income figure is less than the benefit, the person qualifies, and the benefit equals the difference between them.

The law generally requires the DSS commissioner to annually increase SSP payment standards based on the consumer price index within certain parameters. The bill extends the current freeze on these payment standards at FY 15 rates for the next two fiscal years (FYs 20 and 21).

§§ 3-5 — RESIDENTIAL CARE HOMES, COMMUNITY LIVING ARRANGEMENTS, AND COMMUNITY COMPANION HOMES

Freezes rates for certain facilities through FY 21

Under the bill, regardless of rate-setting laws or regulations to the contrary, the rates the state pays to residential care homes, community living arrangements, and community companion homes that receive the flat rate for residential services in FY 16 remain in effect through FY 21. State regulations permit these facilities to have their rates determined on a flat rate basis rather than on the basis of submitted cost reports (Conn. Agencies Regs. § 17-311-54).

§ 6 — RESIDENTIAL CARE HOMES

Authorizes certain fair rent increases for residential care homes in FYs 20 and 21

For both FY 20 and 21, the bill caps rates for residential care homes at FY 19 levels, with an exception for homes that receive certain proportional fair rent increases. The bill allows the DSS commissioner to provide such increases within available appropriations to homes with documented fair rent additions placed in service in cost report years ending on September 30 in 2018 and 2019.

§§ 4 & 7 — INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) AND BOARDING HOMES

Freezes, with exceptions, rates for certain boarding homes and ICFs/IIDs

For FY 20 and FY 21, the bill generally freezes rates paid by DSS at FY 19 levels for (1) ICFs/IID and (2) room and board at private residential facilities and similar facilities operated by regional educational service centers that are licensed to provide residential care for individuals with certain disabilities (i.e., non-ICFs/IIDs boarding homes). Within available appropriations, the bill allows these rates to exceed the FY 19 level if capital improvements were (1) made in FY 20 or FY 21 for the health and safety of residents and (2) approved by the Department of Developmental Services (DDS) in consultation with DSS.

The bill also extends through FY 21 a provision allowing DSS to provide fair rent increases to any ICFs/IIDs with an approved certificate of need that undergo a material change in circumstances related to fair rent.

§ 8 — NURSING HOME RATES

Caps nursing home rates at FY 19 levels with certain exceptions

For FY 20, the bill requires DSS to determine Medicaid nursing facility rates based on 2018 cost reports, but it caps FY 20 and 21 rates at FY 19 levels with an exception for those facilities that receive DSS proportional fair rent increases. The bill allows the DSS commissioner to provide such increases within available appropriations, including to facilities that have undergone a material change in circumstance related to fair rent additions in the cost report years ending on September 30 in 2018 and 2019 and not otherwise included in issued rates.

For FY 20, the bill provides a stop-loss for facilities maintaining high occupancy levels and quality standards. Under the bill, no facility can receive a rate that is more than 2% less than its FY 19 rate if it has (1) an occupancy level of 70% or greater, as reported in its 2018 cost report; and (2) an overall rating on Medicare's Nursing Home Compare

Internet website of more than one star on June 1, 2019 (see BACKGROUND).

§ 9 — NURSING HOME RECEIVERSHIP

Modifies requirements on nursing home receivers

The bill allows a nursing home receiver to spend up to \$10,000 (an increase of \$7,000 over current law) to correct a structural or furnishings deficiency that endangers the safety or health of its residents, but it retains existing law's authorization for courts to approve such expenses above \$3,000. (Presumably, a receiver would only apply for court approval of expenses over \$10,000.)

By law, a court may appoint a receiver for a nursing home facility (i.e., nursing home, residential care home, or rest home with 24-hour nursing supervision per CGS § 19a-490) if the home, among other things, is substantially unsafe or experiencing serious financial loss (CGS § 19a-543).

Under the bill, a receiver must determine whether the facility can continue to operate with existing income sources and provide adequate resident care in substantial compliance with applicable federal and state laws. The receiver must report to the court within his or her first 45 days of receivership, instead of six months under current law.

Additionally, current law requires a receiver to seek purchase proposals within the first six month of receivership. The bill requires a receiver to do so only for facilities found to be viable. The bill also requires receivers to immediately commence the closure process for facilities with less than 70% occupancy when the closure is consistent with the state's strategic rebalancing plan for long-term services and supports (LTSS).

§§ 10 & 11 — VOLUNTARY FACILITY CLOSURES

Exempts certain nonviable facilities that are seeking to close from a public hearing requirement

Closure Petitions

The bill establishes a process for a financially distressed facility (i.e.,

ICF/IID, nursing home, rest home, or residential care home) that meets certain criteria to voluntarily petition DSS to authorize its closure. Under the bill, the department may authorize closure if the facility management's petition demonstrates to the commissioner's satisfaction that closing the facility is consistent with DSS' LTSS strategic rebalancing plan, which includes a review of regional nursing home bed capacity, and that the facility:

1. is not viable given actual and projected operating losses;
2. has an occupancy rate of less than 70% of its licensed bed capacity;
3. is in compliance with federal Medicaid and Medicare rules about quality assurance and program improvement, termination of facilities that immediately jeopardize health and safety, and closure notification; and
4. is not providing special services that would go unmet if closed.

The bill requires (1) DSS to review a closure petition to the extent it deems necessary and (2) the facility to submit any information the department requests to substantiate that the closure is consistent with the bill's provisions. DSS must grant or deny the petition within 30 days. The bill exempts facilities seeking to close under these provisions from a DPH public hearing requirement that existing law imposes on facilities that close or substantially reduce capacity.

Closure Notifications

The bill requires the facility to also do the following, at the same time as its closure petition submission to DSS: (1) notify the office of the long-term care (LTC) ombudsman; (2) provide written notice to all patients, guardians, conservators, legally liable relatives, or other responsible parties; and (3) post such notice in a conspicuous facility location.

The facility's written notice must be accompanied by an informational letter, issued jointly by the office of the LTC ombudsman

and the Department of Rehabilitation Services (DORS), on available patients' rights and services related to the facility's closure petition. The letter must also state the date and time that the LTC ombudsman and DPH will hold an informational session at the facility about patient rights and the closure petition process. (Presumably, this letter would be based upon a prewritten template; otherwise it is not clear that the ombudsman would have time to issue it.)

The notice must state:

1. the date the facility submitted the closure petition;
2. that DSS has the sole authority to grant or deny the petition and has up to 30 days to do so;
3. a brief description of the reason or reasons for submitting the petition;
4. that no patient shall be involuntarily transferred or discharged within, or from, a facility pursuant to state and federal law because of the petition filing and all patients have a right to appeal any proposed transfer or discharge; and
5. the name, mailing address, and telephone number of the offices of the LTC ombudsman and local legal aid.

§ 12 — HOME CARE SERVICES NONCOMPETE AGREEMENTS

Prohibits noncompete agreements for employees of home care service agencies

The bill prohibits a homemaker, companion, or home health services agency from enforcing a covenant not to compete (i.e., noncompete agreements) in its employment agreements with caregiver staff members. The bill defines a "covenant not to compete" as any contract or agreement that restricts the right of an individual to provide these services (1) in any geographic area of the state for any period of time or (2) to a specific individual. Under the bill, these contract provisions are void and unenforceable (see BACKGROUND).

§ 13 — MEDICARE SAVINGS PROGRAM ASSET TEST

Implements an eligibility asset test for the Medicare savings program

The bill reduces eligibility for the Medicare Savings Program (MSP) as of July 1, 2020, by requiring the DSS commissioner to apply an asset test in accordance with federal Medicaid regulations. (Federal law sets certain requirements for states' programs that choose to determine program eligibility based, in part, on an individual's assets.) MSP program participants get help from the state's Medicaid program with their Medicare cost sharing, including with premiums and deductibles.

§§ 14 & 15 — MEDICAID RATE ESTABLISHMENT AND APPEALS

Eliminates annual hospital rate establishment; limits right to appeal to certain Medicaid rates

The bill eliminates the requirement that the DSS commissioner annually establish Medicaid rates for hospitals. Additionally, it limits the right to appeal established Medicaid rates and certain actions.

By law, health care facilities can appeal the Medicaid rates DSS sets for them, and DSS must hold "rehearings." Currently, if the issue is not resolved at a rehearing, either DSS or the facility can request binding arbitration (CGS § 17b-238(b)). The bill removes this right to appeal Medicaid rates for aggrieved institutions and agencies (e.g., hospitals, home health care agencies, homemaker home health agencies, and federally qualified health centers).

Conversely, the bill authorizes certain aggrieved Medicaid providers to appeal (1) a provider-specific rate established by DSS and (2) an action taken by DSS for which an appeal is required under federal regulations (i.e., nursing facility or ICFs/IIDs appeals). It provides the same deadlines for the appeals process as under current law for appeals by institutions and agencies (i.e., a hearing within 30 days and a decision within 60 days). Under the bill, a provider-specific rate does not include any rate or payment methodology that applies to more than one provider or statewide to any provider category.

Under current law, DSS may implement policies and procedures about Medicaid rates and reimbursements to home health care and homemaker-health aide providers while in the process of adopting

regulations, as long as it publishes notice of its intent to adopt the regulations in the Connecticut Law Journal no later than 20 days after implementing the policies and procedures. Such policies and procedures are invalid after nine months. The bill (1) requires DSS to instead post the notice on its website and the state's eRegulations system and (2) removes the nine-month sunset provision on policies and procedures.

§§ 16 & 17 — HOSPITAL PERFORMANCE-BASED PAYMENTS

Requires hospital rates and supplemental payments to incorporate value-based methodologies

The bill requires the DSS commissioner to implement one or more value-based payment methodologies in order to improve health outcomes and reduce unnecessary costs and allows him, if necessary, to phase them in over time. It requires each applicable hospital rate and supplemental payment methodology designated by the commissioner to incorporate each value-based payment methodology established under the bill, including structuring applicable payments based on each hospital's performance on the applicable measures.

Under the bill, such payment methodologies may include methods designed to:

1. reduce inpatient hospital readmissions;
2. reduce unnecessary caesarian section deliveries, take appropriate actions to reduce preterm deliveries, and improve obstetrical care outcomes;
3. address outpatient infusions involving high-cost medications by implementing performance-based payments; and
4. implement other such policies as determined by the commissioner.

The bill also requires the commissioner to reduce the total applicable rate payments by 15% for each readmission of an individual who was discharged from an applicable hospital for the same or

similar diagnosis or diagnoses within 30 days from the date of such discharge.

The bill requires Medicaid payments to hospitals to be in compliance with federal law. It requires DSS to adjust hospital Medicaid payments to ensure that no payments are made to hospitals that are not eligible for federal matching funds for all applicable payments and time periods (e.g., payments that exceed the federal upper payment limit (UPL) would be ineligible for federal matching funds).

Within available appropriations, the bill allocates \$15 million in FY 20, and \$45 million for FY 21 in budgeted supplemental payments to be distributed proportionally based on each hospital's performance on DSS-established quality measures. The bill eliminates the requirement under current law that the supplemental pools contain \$166.5 million for FY 20.

It also deletes obsolete FY 18 and 19 payment amounts and a notice requirement.

BACKGROUND

Nursing Home Compare Website (§ 8)

Recently, the Centers for Medicare and Medicaid Services (CMS) have publicly reported the rates at which nursing home patients are readmitted to the hospital within one month. These hospital readmission rates are now available on CMS's Nursing Home Compare website, which evaluates nursing home quality of care based on a five-star rating system. Starting in October 2018, nursing homes with high re-hospitalization rates will lose 2% of their Medicare reimbursements, and higher-performing nursing homes will receive additional funds.

Noncompete Agreements in Connecticut (§ 12)

Connecticut law currently prohibits certain noncompete agreements between an employer and (1) an employee working as a security guard (CGS § 31-50a) and (2) a broadcast employee (CGS § 31-50b).

In determining the validity of noncompete agreements, Connecticut courts generally consider the following five factors: (1) length of time of the restriction, (2) geographic scope of the restriction, (3) fairness of the protection provided to the employer, (4) extent to which the noncompete restricts the employee from pursuing his or her occupation, and (5) public interest (*Branson Ultrasonics Corp. v. Stratman*, 921 F. Supp. 909 (D. Conn. 1996)).

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute

Yea 11 Nay 7 (03/21/2019)