House of Representatives

General Assembly

File No. 463

January Session, 2019

Substitute House Bill No. 7164

House of Representatives, April 8, 2019

The Committee on Human Services reported through REP. ABERCROMBIE of the 83rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

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

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

Section 1. Subsection (b) of section 17b-104 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(b) On July 1, 2007, and annually thereafter, the commissioner shall increase the payment standards over those of the previous fiscal year under the temporary family assistance program and the state-administered general assistance program by the percentage increase, if any, in the most recent calendar year average in the consumer price index for urban consumers over the average for the previous calendar year, provided the annual increase, if any, shall not exceed five per cent, except that the payment standards for the fiscal years ending June 30, 2010, June 30, 2011, June 30, 2012, June 30, 2013, June 30, 2016, June 30, 2017, June 30, 2018, **[**and**]** June 30, 2019, June 30, 2020, and June 30,

2021, shall not be increased.

Sec. 2. Subsection (a) of section 17b-106 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) On July 1, 1989, and annually thereafter, the commissioner shall increase the adult payment standards over those of the previous fiscal year for the state supplement to the federal Supplemental Security Income Program by the percentage increase, if any, in the most recent calendar year average in the consumer price index for urban consumers over the average for the previous calendar year, provided the annual increase, if any, shall not exceed five per cent, except that the adult payment standards for the fiscal years ending June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June 30, 2002, June 30, 2003, June 30, 2004, June 30, 2005, June 30, 2006, June 30, 2007, June 30, 2008, June 30, 2009, June 30, 2010, June 30, 2011, June 30, 2012, June 30, 2013, June 30, 2016, June 30, 2017, June 30, 2018, **[**and**]** June 30, 2019, June 30, 2020, and June 30, 2021, shall not be increased. Effective October 1, 1991, the coverage of excess utility costs for recipients of the state supplement to the federal Supplemental Security Income Program is eliminated. Notwithstanding the provisions of this section, the commissioner may increase the personal needs allowance component of the adult payment standard as necessary to meet federal maintenance of effort requirements.

Sec. 3. Subsection (j) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(j) Notwithstanding the provisions of this section, state rates of payment for the fiscal years ending June 30, 2018, **[**and**]** June 30, 2019, June 30, 2020, and June 30, 2021, for residential care homes, community living arrangements and community companion homes 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 [43 of public act 17-2 of the June special session] 5 of this act.

Sec. 4. Section 17b-244 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) The room and board component of the rates to be paid by the state to private facilities and facilities operated by regional education service centers which are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid program as intermediate care facilities for individuals with intellectual disabilities, shall be determined annually by the Commissioner of Social Services, except that rates effective April 30, 1989, shall remain in effect through October 31, 1989. Any facility with real property other than land placed in service prior to July 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding July 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request by such facility, allow actual debt service, comprised of principal and interest, on the loan or loans in lieu of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, whether actual debt service is higher or lower than such allowed property costs, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. In the case of facilities financed through the Connecticut Housing Finance Authority, the commissioner shall allow actual debt service, comprised of principal, interest and a reasonable repair and replacement reserve on the loan or loans in lieu of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, whether actual debt service is higher or lower than such allowed property costs, provided such debt service terms and amounts are determined by the commissioner at the time the loan is entered into to be reasonable in relation to the useful life

and base value of the property. The commissioner may allow fees associated with mortgage refinancing provided such refinancing will result in state reimbursement savings, after comparing costs over the terms of the existing proposed loans. For the fiscal year ending June 30, 1992, the inflation factor used to determine rates shall be one-half of the gross national product percentage increase for the period between the midpoint of the cost year through the midpoint of the rate year. For fiscal year ending June 30, 1993, the inflation factor used to determine rates shall be two-thirds of the gross national product percentage increase from the midpoint of the cost year to the midpoint of the rate year. For the fiscal years ending June 30, 1996, and June 30, 1997, no inflation factor shall be applied in determining rates. The Commissioner of Social Services shall prescribe uniform forms on which such facilities shall report their costs. Such rates shall be determined on the basis of a reasonable payment for necessary services. Any increase in grants, gifts, fund-raising or endowment income used for the payment of operating costs by a private facility in the fiscal year ending June 30, 1992, shall be excluded by the commissioner from the income of the facility in determining the rates to be paid to the facility for the fiscal year ending June 30, 1993, provided any operating costs funded by such increase shall not obligate the state to increase expenditures in subsequent fiscal years. Nothing contained in this section shall authorize a payment by the state to any such facility in excess of the charges made by the facility for comparable services to the general public. The service component of the rates to be paid by the state to private facilities and facilities operated by regional education service centers which are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid programs as intermediate care facilities for individuals with intellectual disabilities, shall be determined annually by the Commissioner of Developmental Services in accordance with section 17b-244a. For the fiscal year ending June 30, 2008, no facility shall receive a rate that is more than two per cent greater than the rate in effect for the facility on June 30, 2007, except any facility that would have been issued a lower rate effective July 1,

2007, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, no facility shall receive a rate that is more than two per cent greater than the rate in effect for the facility on June 30, 2008, except any facility that would have been issued a lower rate effective July 1, 2008, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2008. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except that (1) the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2009, if a capital improvement required by the Commissioner of Developmental Services for the health or safety of the residents was made to the facility during the fiscal years ending June 30, 2010, or June 30, 2011, and (2) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except that (A) the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2011, if a capital improvement required by the Commissioner of Developmental Services for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2012, and (B) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the department, shall be issued such lower rate. Any facility that has a significant decrease in land and building costs shall receive a reduced rate to reflect such decrease in land and building costs. The rate paid to a facility may be increased if a capital improvement approved by the Department of Developmental Services, in consultation with the Department of Social Services, for the health or safety of the residents was made to the facility during the fiscal year ending June 30, 2014, or June 30, 2015, only to the extent such increases are within available appropriations. For the fiscal years ending June 30, 2016, and June 30,

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

(b) Notwithstanding the provisions of subsection (a) of this section, state rates of payment for the fiscal years ending June 30, 2018, **[**and**]** June 30, 2019, June 30, 2020, and June 30, 2021, for residential care homes, community living arrangements and community companion homes 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 [43 of public act 17-2 of the June special session] 5 of this act.

(c) The Commissioner of Social Services and the Commissioner of Developmental Services shall adopt regulations in accordance with the provisions of chapter 54 to implement the provisions of this section.

Sec. 5. (*Effective July 1, 2019*) Notwithstanding subsection (a) of section 17b-244 of the general statutes, as amended by this act, and subsections (a) to (i), inclusive, of section 17b-340 of the general statutes, or any other provision of the general statutes, or regulation adopted thereunder, the state rates of payments in effect for the fiscal year ending June 30, 2016, for residential care homes, community living arrangements and community companion homes that receive the flat rate for residential services under section 17-311-54 of the regulations of Connecticut state agencies shall remain in effect until June 30, 2021.

Sec. 6. Subdivision (1) of subsection (h) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(h) (1) For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate in excess of one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate that is less than one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to sixty-five per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred thirty per cent of the median of operating cost components in effect January 1, 1992. Beginning with the fiscal year ending June 30, 1993, for the purpose of determining allowable fair rent, a residential care home with allowable

fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Beginning with the fiscal year ending June 30, 1997, a residential care home with allowable fair rent less than three dollars and ten cents per day shall be reimbursed as having allowable fair rent equal to three dollars and ten cents per day. Property additions placed in service during the cost year ending September 30, 1996, or any succeeding cost year shall receive a fair rent allowance for such additions as an addition to three dollars and ten cents per day if the fair rent for the facility for property placed in service prior to September 30, 1995, is less than or equal to three dollars and ten cents per day. Beginning with the fiscal year ending June 30, 2016, a residential care home shall be reimbursed the greater of the allowable accumulated fair rent reimbursement associated with real property additions and land as calculated on a per day basis or three dollars and ten cents per day if the allowable reimbursement associated with real property additions and land is less than three dollars and ten cents per day. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (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) 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, as amended by this act, 17b-353, as amended by this act, 17b-354 or 17b-355. For the fiscal years ending June 30, 2014, and June 30, 2015, for those facilities that have a calculated rate greater than the rate in effect for the fiscal year ending June 30, 2013, the commissioner may increase facility rates based upon available appropriations up to a stop gain as determined by the commissioner. No facility shall be issued a rate that is lower than the rate in effect on June 30, 2013, except that any facility that would have been issued a lower rate for the fiscal year ending June 30, 2014, or the fiscal year ending June 30, 2015, due to interim rate status or agreement with the commissioner, shall be issued such lower rate. For the fiscal year ending June 30, 2014, and each fiscal year thereafter, a residential care home shall receive a rate increase for any capital improvement made during the fiscal year for the health and safety of residents and approved by the Department of Social Services, provided such rate increase is within available appropriations. For the fiscal year ending June 30, 2015, and each succeeding fiscal year thereafter, costs of less than ten thousand dollars that are incurred by a facility and are associated with any land, building or nonmovable equipment repair or improvement that are reported in the cost year used to establish the facility's rate shall not be capitalized for a period of more than five years for rate-setting purposes. For the fiscal year ending June 30, 2015, subject to available appropriations, the commissioner may, at the commissioner's discretion: Increase the inflation cost limitation under subsection (c) of section 17-311-52 of the regulations of Connecticut state agencies, provided such inflation

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

Sec. 7. Subsection (g) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(g) 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, **[**and**]** 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, as amended by this act, 17b-353, as amended by this act, 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.

Sec. 8. Subdivision (4) of subsection (f) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(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 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 Internet web site of one star on June 1, 2019. 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, as amended by this act, 17b-353, as amended by this act, 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, as amended by this act, 17b-353, as amended by this act, 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.

Sec. 9. Section 19a-545 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) A receiver appointed pursuant to the provisions of sections 19a-541 to 19a-549, inclusive, in operating a nursing home facility or residential care home, shall have the same powers as a receiver of a corporation under section 52-507, except as provided in subsection (c) of this section and shall exercise such powers to remedy the conditions that constituted grounds for the imposition of receivership, assure adequate health care for the residents and preserve the assets and property of the owner. If such facility or home is placed in receivership it shall be the duty of the receiver to notify each resident and each resident's guardian or conservator, if any, or legally liable relative or other responsible party, if known. Such receiver may correct or eliminate any deficiency in the structure or furnishings of such facility or home that endangers the safety or health of the residents while they remain in such facility or home, provided the total cost of correction does not exceed **[**three**]** ten thousand dollars. The court may order expenditures for this purpose in excess of three thousand dollars on application from such receiver. If any resident is transferred or discharged such receiver shall provide for: (1) Transportation of the resident and such resident's belongings and medical records to the place where such resident is being transferred or discharged; (2) aid in locating an alternative placement and discharge planning in accordance with section 19a-535; (3) preparation for transfer to

mitigate transfer trauma, including but not limited to, participation by the resident or the resident's guardian in the selection of the resident's alternative placement, explanation of alternative placements and orientation concerning the placement chosen by the resident or the resident's guardian; and (4) custodial care of all property or assets of residents that are in the possession of an owner of such facility or home. The receiver shall preserve all property, assets and records of residents that the receiver has custody of and shall provide for the prompt transfer of the property, assets and records to the alternative placement of any transferred resident. In no event may the receiver transfer all residents and close such facility or home without a court order and without complying with the notice and discharge plan requirements for each resident in accordance with section 19a-535.

(b) Not later than ninety days after the date of appointment as a receiver, such receiver shall take all necessary steps to stabilize the operation of the facility in order to ensure the health, safety and welfare of the residents of such facility. The receiver shall immediately commence the closure of the facility if the overall occupancy of the facility is below seventy per cent and the closing of the facility is consistent with the strategic rebalancing plan developed in accordance with section 17b-369. In addition, within a reasonable time period after the date of appointment, not to exceed **[**six months**]** forty-five days, the receiver shall **[**: (1) Determine**]** determine whether the facility can continue to operate and provide adequate care to residents in substantial compliance with applicable federal and state law within the facility's state payments as established by the Commissioner of Social Services pursuant to subsection (f) of section 17b-340, as amended by this act, together with income from self-pay residents, Medicare payments and other current income and shall report such determination to the court. **[**; and (2) seek facility purchase proposals.**]** Within a reasonable time period after the date of appointment, not to exceed six months, the receiver shall seek facility purchase proposals if the receiver's determination under this section finds that continued operation of the facility is viable. If the receiver determines that the facility will be unable to continue to operate in compliance with said

requirements, the receiver shall promptly request an order of the court to close the facility and make arrangements for the orderly transfer of residents pursuant to subsection (a) of this section unless the receiver determines that a transfer of the facility to a qualified purchaser is expected during the six-month period commencing on the date of the receiver's appointment. If a transfer is not completed within such period and all purchase and sale proposal efforts have been exhausted, the receiver shall request an immediate order of the court to close the facility and make arrangements for the orderly transfer of residents pursuant to subsection (a) of this section.

(c) The court may limit the powers of a receiver appointed pursuant to the provisions of sections 19a-541 to 19a-549, inclusive, to those necessary to solve a specific problem.

Sec. 10. Section 17b-352 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) For the purposes of this section and section 17b-353, as amended by this act, "facility" means a residential facility for persons with intellectual disability licensed pursuant to section 17a-277 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities, a nursing home, rest home or residential care home, as defined in section 19a-490. "Facility" does not include a nursing home that does not participate in the Medicaid program and is associated with a continuing care facility as described in section 17b-520.

(b) Any facility which intends to (1) transfer all or part of its ownership or control prior to being initially licensed; (2) introduce any additional function or service into its program of care or expand an existing function or service; (3) terminate a service or decrease substantially its total bed capacity; or (4) relocate all or a portion of such facility's licensed beds, to a new facility or replacement facility, shall submit a complete request for permission to implement such transfer, addition, expansion, increase, termination, decrease or relocation of facility beds [with such information as the department

requires**]** to the Department of Social Services with such information as the department requires, provided no permission or request for permission to close a facility is required when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545, as amended by this act. The Office of the Long-Term Care Ombudsman pursuant to section 17a-405 shall be notified by the facility of any proposed actions pursuant to this subsection at the same time the request for permission is submitted to the department and when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545, as amended by this act.

(c) A facility may submit a petition for closure to the Department of Social Services. The Department of Social Services may authorize the closure of a facility if the facility's management demonstrates to the satisfaction of the Commissioner of Social Services in the petition for closure that the facility (1) is not viable based on actual and projected operating losses; (2) has an occupancy rate of less than seventy per cent of the facility's licensed bed capacity; (3) closure is consistent with the strategic rebalancing plan developed in accordance with section 17b-369; (4) is in compliance with the requirements of Sections 1128I(h) and 1819(h)(4) of the Social Security Act and 42 CFR 483.75; and (5) is not providing special services that would go unmet if the facility closes. The department shall review a petition for closure to the extent it deems necessary and the facility shall submit information the department requests or deems necessary to substantiate that the facility closure is consistent with the provisions of this subsection. The Office of the Long-Term Care Ombudsman shall be notified by the facility at the same time as a petition for closure is submitted to the department. Any facility acting pursuant to this subsection shall provide written notice, on the same date that the facility submits its petition for closure, to all patients, guardians or conservators, if any, or legally liable relatives or other responsible parties, if known, and shall post such notice in a conspicuous location at the facility. The facility's written notice shall be accompanied by an informational letter issued jointly from the Office of the Long-Term Care Ombudsman and the Department of Rehabilitation Services on patients' rights and services

available as they relate to the petition for closure. The informational letter shall also state the date and time that the Office of the Long-Term Care Ombudsman and the Department of Public Health will hold an informational session at the facility for patients, guardians or conservators, if any, and legally liable relatives or other responsible parties, if known, about their rights and the process concerning a petition for closure. The notice shall state: (A) The date the facility submitted the petition for closure, (B) that only the Department of Social Services has the authority to either grant or deny the petition for closure, (C) that the Department of Social Services has up to thirty days to grant or deny the petition for closure, (D) a brief description of the reason or reasons for submitting the petition for closure, (E) that no patient shall be involuntarily transferred or discharged within or from a facility pursuant to state and federal law because of the filing of a petition for closure, (F) that all patients have a right to appeal any proposed transfer or discharge, and (G) the name, mailing address and telephone number of the Office of the Long-Term Care Ombudsman and local legal aid office. The commissioner shall grant or deny a petition for closure within thirty days of receiving such request.

[(c)**]** (d) An applicant, prior to submitting a certificate of need application, shall request, in writing, application forms and instructions from the department. The request shall include: (1) The name of the applicant or applicants; (2) a statement indicating whether the application is for (A) a new, additional, expanded or replacement facility, service or function or relocation of facility beds, (B) a termination or reduction in a presently authorized service or bed capacity, or (C) any new, additional or terminated beds and their type; (3) the estimated capital cost; (4) the town where the project is or will be located; and (5) a brief description of the proposed project. Such request shall be deemed a letter of intent. No certificate of need application shall be considered submitted to the department unless a current letter of intent, specific to the proposal and in accordance with the provisions of this subsection, has been on file with the department for not less than ten business days. For purposes of this subsection, "a current letter of intent" means a letter of intent on file with the

department for not more than one hundred eighty days. A certificate of need application shall be deemed withdrawn by the department, if a department completeness letter is not responded to within one hundred eighty days. The Office of the Long-Term Care Ombudsman shall be notified by the facility at the same time as the letter of intent is submitted to the department.

[(d)**]** (e) Any facility acting pursuant to subdivision (3) of subsection (b) of this section shall provide written notice, at the same time it submits its letter of intent, to all patients, guardians or conservators, if any, or legally liable relatives or other responsible parties, if known, and shall post such notice in a conspicuous location at the facility. The facility's written notice shall be accompanied by an informational letter issued jointly from the Office of the Long-Term Care Ombudsman and the Department of Rehabilitation Services on patients' rights and services available as they relate to the letter of intent. The notice shall state the following: (1) The projected date the facility will be submitting its certificate of need application, (2) that only the Department of Social Services has the authority to either grant, modify or deny the application, (3) that the Department of Social Services has up to ninety days to grant, modify or deny the certificate of need application, (4) a brief description of the reason or reasons for submitting a request for permission, (5) that no patient shall be involuntarily transferred or discharged within or from a facility pursuant to state and federal law because of the filing of the certificate of need application, (6) that all patients have a right to appeal any proposed transfer or discharge, and (7) the name, mailing address and telephone number of the Office of the Long-Term Care Ombudsman and local legal aid office.

[(e)**]** (f) The department shall review a request made pursuant to subsection (b) of this section to the extent it deems necessary, including, but not limited to, in the case of a proposed transfer of ownership or control prior to initial licensure, the financial responsibility and business interests of the transferee and the ability of the facility to continue to provide needed services, or in the case of the

addition or expansion of a function or service, ascertaining the availability of the function or service at other facilities within the area to be served, the need for the service or function within the area and any other factors the department deems relevant to a determination of whether the facility is justified in adding or expanding the function or service. The commissioner shall grant, modify or deny the request within ninety days of receipt thereof, except as otherwise provided in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the department has requested additional information subsequent to the commencement of the commissioner's review period. The director of the office of certificate of need and rate setting may extend the review period for a maximum of thirty days if the applicant has not filed in a timely manner information deemed necessary by the department. The applicant may request and shall receive a hearing in accordance with section 4-177 if aggrieved by a decision of the commissioner.

[(f)**]** (g) The Commissioner of Social Services shall not approve any requests for beds in residential facilities for persons with intellectual disability which are licensed pursuant to section 17a-227 and are certified to participate in the Title XIX Medicaid Program as intermediate care facilities for individuals with intellectual disabilities, except those beds necessary to implement the residential placement goals of the Department of Developmental Services which are within available appropriations.

[(g)**]** (h) The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this section.

Sec. 11. Subsection (d) of section 17b-353 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(d) Except as provided in this subsection, no facility shall be allowed to close or decrease substantially its total bed capacity until such time as a public hearing has been held in accordance with the provisions of

this subsection and the Commissioner of Social Services has approved the facility's request unless such decrease is associated with a census reduction. The commissioner may impose a civil penalty of not more than five thousand dollars on any facility that fails to comply with the provisions of this subsection. Penalty payments received by the commissioner pursuant to this subsection shall be deposited in the special fund established by the department pursuant to subsection (c) of section 17b-357 and used for the purposes specified in said subsection (c). The commissioner or the commissioner's designee shall hold a public hearing upon the earliest occurrence of: (1) Receipt of any letter of intent submitted by a facility to the department, or (2) receipt of any certificate of need application. Such hearing shall be held at the facility for which the letter of intent or certificate of need application was submitted not later than thirty days after the date on which such letter or application was received by the commissioner. The commissioner or the commissioner's designee shall provide both the facility and the public with notice of the date of the hearing not less than fourteen days in advance of such date. Notice to the facility shall be by certified mail and notice to the public shall be by publication in a newspaper having a substantial circulation in the area served by the facility. The provisions of this subsection shall not apply to any certificate of need approval requested for the relocation of a facility, or a portion of a facility's licensed beds, to a new or replacement facility nor to a facility that is closing pursuant to subsection (c) of section 17b-352, as amended by this act.

Sec. 12. (NEW) (*Effective from passage*) For purposes of this section "covenant not to compete" means any contract or agreement that restricts the right of an individual to provide homemaker, companion or home health services (1) in any geographic area of the state for any period of time, or (2) to a specific individual. Any covenant not to compete is against public policy and shall be void and unenforceable.

Sec. 13. Section 17b-256f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

The Commissioner of Social Services shall increase income disregards used to determine eligibility by the Department of Social Services for the federal Qualified Medicare Beneficiary, the Specified Low-Income Medicare Beneficiary and the Qualifying Individual programs, administered in accordance with the provisions of 42 USC 1396d(p), by such amounts that shall result in persons with income that is (1) less than two hundred eleven per cent of the federal poverty level qualifying for the Qualified Medicare Beneficiary program, (2) at or above two hundred eleven per cent of the federal poverty level but less than two hundred thirty-one per cent of the federal poverty level qualifying for the Specified Low-Income Medicare Beneficiary program, and (3) at or above two hundred thirty-one per cent of the federal poverty level but less than two hundred forty-six per cent of the federal poverty level qualifying for the Qualifying Individual program. The commissioner shall **[**not**]** apply an asset test for eligibility under the Medicare Savings Program. Such asset test shall be set in accordance with the provisions of 42 USC 1396d(p)(1)(C). The commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran. The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the commissioner prints notice of the intent to adopt the regulations on the department's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Such policies and procedures shall be valid until the time final regulations are adopted.

Sec. 14. Subsections (a) and (b) of section 17b-238 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) **[**The Commissioner of Social Services shall establish annually the cost of services for which payment is to be made under the provisions of section 17b-239.**]** All hospitals receiving state aid shall submit their

cost data under oath on forms approved by the [commissioner] Commissioner of Social Services. The commissioner may adopt, in accordance with the provisions of chapter 54, regulations concerning the submission of data by [institutions and agencies] providers to which payments are to be made under sections 17b-239, as amended by this act, 17b-243, 17b-244, as amended by this act, 17b-340, as amended by this act, 17b-341 and section 17b-343, and the defining of policies utilized by the commissioner in establishing rates under said sections, which data and policies are necessary for the efficient administration of said sections. The commissioner shall provide, upon request, a statement of interpretation of the Medicaid cost-related reimbursement system regulations for long-term care facilities reimbursed under section 17b-340, as amended by this act, concerning allowable and unallowable costs or expenditures. Such statement of interpretation shall not be construed to constitute a regulation violative of chapter 54. Failure of such statement of interpretation to address a specific unallowable cost or expenditure fact pattern shall in no way prevent the commissioner from enforcing all applicable laws and regulations.

(b) Any [institution or agency] provider to which payments are to be made under [sections 17b-239 to 17b-246, inclusive, and sections 17b-340 and 17b-343 which] section 17b-239, as amended by this act, 17b-244, as amended by this act, 17b-244a or 17b-340, as amended by this act, that is aggrieved by any decision of [said] the commissioner in setting or revising a provider-specific rate that applies to such provider or in taking an action regarding such provider for which an appeal is required pursuant to 42 CFR 431, Subpart D, may, within ten days after written notice thereof from the commissioner, obtain, by written request to the commissioner, a rehearing on all items of aggrievement [. On and after July 1, 1996, a] involving a provider-specific rate or an action for which an appeal is required pursuant to 42 CFR 431, Subpart D. A rehearing shall be held by the commissioner or his designee, provided a detailed written description of all such items is filed within ninety days of written notice of the commissioner's decision. The rehearing shall be held within thirty days of the filing of the detailed

written description of each specific item of aggrievement. The commissioner shall issue a final decision within sixty days of the close of evidence or the date on which final briefs are filed, whichever occurs later. Any designee of the commissioner who presides over such rehearing shall be impartial and shall not be employed within the Department of Social Services office of certificate of need and rate setting. Any such items not resolved at such rehearing to the satisfaction of **[**either such institution or agency**]** such provider or said commissioner shall be submitted to binding arbitration to an arbitration board consisting of one member appointed by the **[**institution or agency**]** provider, one member appointed by the commissioner and one member appointed by the Chief Court Administrator from among the retired judges of the Superior Court, which retired judge shall be compensated for his services on such board in the same manner as a state referee is compensated for his services under section 52-434. The proceedings of the arbitration board and any decisions rendered by such board shall be conducted in accordance with the provisions of the Social Security Act, 49 Stat. 620 (1935), 42 USC 1396, as amended from time to time, and chapter 54. For purposes of this subsection, "provider-specific rate" means a rate or other payment methodology that applies only to one provider and was set or revised by the department based on cost or other information specific to such provider. "Provider-specific rate" does not include any rate or payment methodology that applies to more than one provider or that applies state-wide to any category of providers.

Sec. 15. Section 17b-242 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Department of Social Services shall determine the rates to be paid to home health care agencies and homemaker-home health aide agencies by the state or any town in the state for persons aided or cared for by the state or any such town. **[**For the period from February 1, 1991, to January 31, 1992, inclusive, payment for each service to the state shall be based upon the rate for such service as determined by the Office of Health Care Access, except that for those providers whose

Medicaid rates for the year ending January 31, 1991, exceed the median rate, no increase shall be allowed. For those providers whose rates for the year ending January 31, 1991, are below the median rate, increases shall not exceed the lower of the prior rate increased by the most recent annual increase in the consumer price index for urban consumers or the median rate. In no case shall any such rate exceed the eightieth percentile of rates in effect January 31, 1991, nor shall any rate exceed the charge to the general public for similar services. Rates effective February 1, 1992, shall be based upon rates as determined by the Office of Health Care Access, except that increases shall not exceed the prior year's rate increased by the most recent annual increase in the consumer price index for urban consumers and rates effective February 1, 1992, shall remain in effect through June 30, 1993. Rates effective July 1, 1993, shall be based upon rates as determined by the Office of Health Care Access except if the Medicaid rates for any service for the period ending June 30, 1993, exceed the median rate for such service, the increase effective July 1, 1993, shall not exceed one per cent. If the Medicaid rate for any service for the period ending June 30, 1993, is below the median rate, the increase effective July 1, 1993, shall not exceed the lower of the prior rate increased by one and one-half times the most recent annual increase in the consumer price index for urban consumers or the median rate plus one per cent. The Commissioner of Social Services shall establish a fee schedule for home health services to be effective on and after July 1, 1994. The commissioner may annually modify such fee schedule if such modification is needed to ensure that the conversion to an administrative services organization is cost neutral to home health care agencies and homemaker-home health aide agencies in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality. The commissioner shall increase the fee schedule for home health services provided under the Connecticut home-care program for the elderly established under section 17b-342, effective July 1, 2000, by two per cent over the fee schedule for home health services for the previous year.**]** The commissioner may increase any fee payable to a home health care agency or homemaker-home health aide

agency upon the application of such an agency evidencing extraordinary costs related to (1) serving persons with AIDS; (2) high-risk maternal and child health care; (3) escort services; or (4) extended hour services. In no case shall any rate or fee exceed the charge to the general public for similar services. **[**A home health care agency or homemaker-home health aide agency which, due to any material change in circumstances, is aggrieved by a rate determined pursuant to this subsection may, within ten days of receipt of written notice of such rate from the Commissioner of Social Services, request in writing a hearing on all items of aggrievement. The commissioner shall, upon the receipt of all documentation necessary to evaluate the request, determine whether there has been such a change in circumstances and shall conduct a hearing if appropriate.**]** The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. The commissioner may implement policies and procedures to carry out the provisions of this subsection while in the process of adopting regulations, provided notice of intent to adopt the regulations is published **[**in the Connecticut Law Journal**]** on the department's Internet web site and the eRegulations System not later than twenty days after the date of implementing the policies and procedures. **[**Such policies and procedures shall be valid for not longer than nine months.**]**

(b) The Department of Social Services shall monitor the rates charged by home health care agencies and homemaker-home health aide agencies. Such agencies shall file annual cost reports and service charge information with the department.

(c) The home health services fee schedule shall include a fee for the administration of medication, which shall apply when the purpose of a nurse's visit is limited to the administration of medication. Administration of medication may include, but is not limited to, blood pressure checks, glucometer readings, pulse rate checks and similar indicators of health status. The fee for medication administration shall include administration of medications while the nurse is present, the pre-pouring of additional doses that the client will self-administer at a

later time and the teaching of self-administration. The department shall not pay for medication administration in addition to any other nursing service at the same visit. The department may establish prior authorization requirements for this service. Before implementing such change, the Commissioner of Social Services shall consult with the chairpersons of the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services. The commissioner shall monitor Medicaid home health care savings achieved through the implementation of nurse delegation of medication administration pursuant to section 19a-492e. If, by January 1, 2016, the commissioner determines that the rate of savings is not adequate to meet the annualized savings assumed in the budget for the biennium ending June 30, 2017, the department may reduce rates for medication administration as necessary to achieve the savings assumed in the budget. Prior to any rate reduction, the department shall report to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services provider specific cost and utilization trend data for those patients receiving medication administration. Should the department determine it necessary to reduce medication administration rates under this section, it shall examine the possibility of establishing a separate Medicaid supplemental rate or a pay-for-performance program for those providers, as determined by the commissioner, who have established successful nurse delegation programs.

(d) The home health services fee schedule established pursuant to subsection (c) of this section shall include rates for psychiatric nurse visits.

(e) The Department of Social Services, when processing or auditing claims for reimbursement submitted by home health care agencies and homemaker-home health aide agencies shall, in accordance with the provisions of chapter 15, accept electronic records and records bearing the electronic signature of a licensed physician or licensed practitioner of a healthcare profession that has been submitted to the home health

care agency or homemaker home-health aide agency.

(f) If the electronic record or signature that has been transmitted to a home health care agency or homemaker-home health aide agency is illegible or the department is unable to determine the validity of such electronic record or signature, the department shall review additional evidence of the accuracy or validity of the record or signature, including, but not limited to, (1) the original of the record or signature, or (2) a written statement, made under penalty of false statement, from (A) the licensed physician or licensed practitioner of a health care profession who signed such record, or (B) if such licensed physician or licensed practitioner of a health care profession is unavailable, the medical director of the agency verifying the accuracy or validity of such record or signature, and the department shall make a determination whether the electronic record or signature is valid.

(g) The Department of Social Services, when auditing claims submitted by home health care agencies and homemaker-home health aide agencies, shall consider any signature from a licensed physician or licensed practitioner of a health care profession that may be required on a plan of care for home health services, to have been provided in timely fashion if (1) the document bearing such signature was signed prior to the time when such agency seeks reimbursement from the department for services provided, and (2) verbal or telephone orders from the licensed physician or licensed practitioner of a health care profession were received prior to the commencement of services covered by the plan of care and such orders were subsequently documented. Nothing in this subsection shall be construed as limiting the powers of the Commissioner of Public Health to enforce the provisions of sections 19-13-D73 and 19-13-D74 of the regulations of Connecticut state agencies and 42 CFR 484.18(c).

(h) For purposes of this section, "licensed practitioner of a healthcare profession" has the same meaning as "licensed practitioner" in section 21a-244a.

Sec. 16. Section 17b-239 of the general statutes is amended by

adding subsections (k) and (l) as follows (*Effective July 1, 2019*):

(NEW) (k) (1) The Commissioner of Social Services shall implement one or more value-based payment methodologies in accordance with this subsection in order to improve health outcomes and reduce unnecessary costs, as determined by the commissioner. Such value-based payment methodologies may be phased in over time to the extent determined necessary by the commissioner and may include, but need not be limited to, methods that are designed to: (A) Reduce inpatient hospital readmissions; (B) reduce unnecessary caesarian section deliveries, take appropriate actions to reduce preterm deliveries and improve obstetrical care outcomes; (C) address outpatient infusions involving high-cost medications by implementing performance-based payments; and (D) implement such other policies as determined by the commissioner.

(2) In addition to any value-based payment methodology implemented in accordance with subdivision (1) of this subsection, the Commissioner of Social Services shall reduce the total applicable rate payments by fifteen per cent for each readmission, as defined in this subdivision. For purposes of this subdivision, "readmission" means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual for observation services provided to the individual for the same or similar diagnosis or diagnoses not later than thirty days from the date of such discharge. Nothing in this subdivision shall preclude the commissioner from establishing additional value-based payment methodologies regarding readmissions.

(3) Notwithstanding any other provision of the general statutes, each applicable hospital rate and supplemental payment methodology designated by the commissioner shall incorporate each value-based payment methodology established pursuant to this section, including structuring applicable payment based on each hospital's performance on the applicable measures for each value-based payment methodology.

(NEW) (l) Medicaid payments to hospitals shall be made only in compliance with federal law. If any Medicaid payments to hospitals are not eligible for federal financial participation, the Department of Social Services shall adjust payments to hospitals to the extent necessary to ensure that no Medicaid payments are made to hospitals that are not eligible for federal financial participation for all applicable payments and for all applicable time periods. No provision of this section or section 17b-239e, as amended by this act, shall be construed as requiring the Department of Social Services to make any Medicaid payments to hospitals that are not eligible for federal financial participation.

Sec. 17. Section 17b-239e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) On or before January 1, 2012, the Commissioner of Social Services, in consultation with the Commissioners of Public Health and Mental Health and Addiction Services and the Secretary of the Office of Policy and Management, shall submit to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies a plan concerning the implementation of a cost neutral acuity-based method for establishing rates to be paid to hospitals that is phased in over a period of time.

(b) (1) Subject to federal approval, the Department of Social Services shall establish supplemental pools for certain hospitals, as determined by the department in consultation with the Connecticut Hospital Association, including, but not limited to, such pools as a supplemental inpatient pool, a supplemental outpatient pool, a supplemental small hospital pool, and a supplemental mid-size hospital pool. **[**The Department of Social Services shall publish the required public notice for all Medicaid state plan amendments necessary to establish the pools not later than fifteen days after passage of this section or December 1, 2017, whichever is sooner.

(2) (A) For the fiscal year ending June 30, 2018, the amount of funds

in the supplemental pools shall total in the aggregate five hundred ninety-eight million four hundred forty thousand one hundred thirty-eight dollars.

(B) For the fiscal year ending June 30, 2019, the amount of funds in the supplemental pools shall total in the aggregate four hundred ninety-six million three hundred forty thousand one hundred thirty-eight dollars.

(C) For the fiscal year ending June 30, 2020, the amount of funds in the supplemental pools shall total in the aggregate one hundred sixty-six million five hundred thousand dollars.**]**

[(3)**]** (2) The department shall distribute supplemental payments to applicable hospitals based on criteria determined by the department in consultation with the Connecticut Hospital Association, including, but not limited to, utilization and proportion of total Medicaid expenditures. Such consultation shall include, at a minimum, that the department shall send proposed distribution criteria in writing to the Connecticut Hospital Association not less than thirty days before making any payments based on such criteria and shall provide an opportunity to discuss such criteria prior to making any payments based on such criteria. **[**, except that, for the first twenty-five per cent of supplemental payments for the fiscal year ending June 30, 2018, such consultation shall include sending the distribution criteria not less than seven days before making any payments based on such criteria.

(4) Subject to subdivision (1) of this subsection, for the fiscal years ending June 30, 2018, and June 30, 2019, the Department of Social Services shall make supplemental payments to applicable hospitals in accordance with the following schedule:

(A) The first twenty-five per cent of supplemental payments for the fiscal year ending June 30, 2018, shall be made: (i) On or before November 30, 2017, for the supplemental inpatient pool and supplemental small hospital pool; (ii) thirty days after the effective date of this section, but not later than January 1, 2018, for the

supplemental mid-size hospital pool; (iii) thirty days after the effective date of this section, but not later than January 1, 2018, for the supplemental outpatient pool; and (iv) not later than thirty days after submission of the Medicaid state plan amendments for such payments for any pool not set forth herein required to be established to comply with federal law. The department shall make each payment by the dates set forth in this subparagraph even if each applicable Medicaid state plan amendment approval has not yet been received from the Centers for Medicare and Medicaid Services, provided each payment remains subject to federal approval and may later be recovered if federal approval is not obtained.

(B) The second twenty-five per cent of such supplemental payments shall be made on or before December 31, 2017, except that the department may delay such payments until fourteen days after receiving approval from the Centers for Medicare and Medicaid Services for the Medicaid state plan amendment or amendments necessary for the state to receive federal Medicaid funds for such supplemental payments.

(C) The third twenty-five per cent of supplemental payments shall be made on or before March 31, 2018, even if each applicable Medicaid state plan amendment approval has not yet been received from the Centers for Medicare and Medicaid Services, provided each payment remains subject to federal approval and may later be recovered if federal approval is not obtained.

(D) Supplemental payments for each subsequent twenty-five per cent of the supplemental payment for each of the fiscal years ending June 30, 2018, and June 30, 2019, shall be made in corresponding installments on or before the last day of March, June, September and December during each said fiscal year, except that the department may delay such payments until fourteen days after receiving approval from the Centers for Medicare and Medicaid Services for the Medicaid state plan amendment or amendments necessary for the state to receive federal Medicaid funds for such supplemental payments.**]**

(c) Out of the aggregate amount of the supplemental pools described in subsection (b) of this section, within available appropriations, the following amounts shall be allocated based on each hospital's performance on quality measures determined by the Department of Social Services: Fifteen million dollars in the fiscal year ending June 30, 2020, and forty-five million dollars for the fiscal year ending June 30, 2021. Such allocations shall be made proportionally from each of the supplemental pools established pursuant to subsection (b) of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2019*	17b-104(b)
Sec. 2	*July 1, 2019*	17b-106(a)
Sec. 3	*July 1, 2019*	17b-340(j)
Sec. 4	*July 1, 2019*	17b-244
Sec. 5	*July 1, 2019*	New section
Sec. 6	*July 1, 2019*	17b-340(h)(1)
Sec. 7	*July 1, 2019*	17b-340(g)
Sec. 8	*July 1, 2019*	17b-340(f)(4)
Sec. 9	*July 1, 2019*	19a-545
Sec. 10	*July 1, 2019*	17b-352
Sec. 11	*July 1, 2019*	17b-353(d)
Sec. 12	*from passage*	New section
Sec. 13	*July 1, 2020*	17b-256f
Sec. 14	*from passage*	17b-238(a) and (b)
Sec. 15	*from passage*	17b-242
Sec. 16	*July 1, 2019*	17b-239
Sec. 17	*July 1, 2019*	17b-239e

Statement of Legislative Commissioners:
In Section 8, "are" was added before "not otherwise" and in Section 10(c) "this petition" was changed to "the petition" for clarity; and in Section 16(k)(1) and (2), the phrase "effective on or after July 1, 2019," was deleted for internal consistency with the effective date and clarity.

HS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 20 $	FY 21 $
Social Services, Dept.	GF - Savings	21.2 million	54.8 million

Note: GF=General Fund

Municipal Impact: None

Explanation

Sections 1 and **2** freeze rate increases for the Temporary Family Assistance (TFA), State Administered General Assistance (SAGA), and supplemental assistance programs, resulting in savings to the Department of Social Services (DSS) of $2.6 million in FY 20 and $4.8 million in FY 21.

Sections 3-6 limit increases in rates paid to certain facilities, which is anticipated to result in savings of approximately $1.7 million in FY 20 and $3.7 million in FY 21.

Section 7 limits increases in rates paid to intermediate care facilities for individuals with intellectual disabilities (ICF-IDs) with certain exceptions, which is anticipated to result in savings of approximately $790,000 in FY 20 and $1.7 million in FY 21.

Section 8 limits increases in nursing home rates with certain exceptions, which is anticipated to result in savings of approximately $14.4 million in FY 20 and $30.6 million in FY 21.

Section 8 also rebases nursing home rates in FY 20 and eliminates the stop loss provision for nursing homes with low occupancy rates or low federal quality measure scores. This is anticipated to result in state

savings of $2.4 million in FY 20 and $2.9 million in FY 21. After factoring in the federal share, the total Medicaid savings is $4.9 million in FY 20 and $5.8 million in FY 21.

Sections 9-11 make changes to nursing home receivership and closure requirements. To the extent these changes result in a facility closing sooner than it otherwise would have, the state could experience a savings.

Section 12 prohibits covenants not to compete, which is not anticipated to result in a fiscal impact to the state.

Section 13 establishes an asset test at the federal minimum level under the Medicare Savings Program (MSP). This results in a net state cost of $2.8 million in FY 20 and savings of $8.7 million in FY 21.

In FY 20, funding supports nine positions to assist with ongoing asset verification requirements and IT upgrades for an asset verification system under ImpaCT. In FY 21, personnel and IT costs are offset by savings due to implementing an asset test ($7,650 for individuals and $11,340 for couples), effective July 1, 2020. The savings reflects the current cost of deductibles, coinsurance and copayments for those with income up to 211% FPL. In addition, less federal grants revenue will need to be diverted to cover the costs of premiums, resulting in additional revenue of $16 million in FY 21. After considering the administrative costs, Medicaid savings, and federal grants revenue impact, the annualized net savings to the state is $25.6 million.

Sections 14 and **15** make changes to the appeals process for certain rates by limiting a rehearing for items of aggrievement to those involving a provider-specific rate or as required by federal law. This will limit potential future state costs associated with rates that otherwise could have been aggrieved and revised under current law.

Section 16 establishes a reduction to the rates paid for hospital readmissions within 30 days for the same or similar diagnosis. This is

anticipated to result in state savings of approximately $2 million in FY 20 and $2.4 million in FY 21. After factoring in the federal share, this results in Medicaid program savings of $6.1 million in FY 20 and $7.3 million in FY 21.

Section 17 requires that $15 million in FY 20 and $45 million in FY 21 of supplemental payments to hospitals be proportionally distributed based on each hospital's performance on quality measures, as determined by DSS.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

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)