Senate

General Assembly **_File No. 371_**

January Session, 2025 Senate Bill No. 805

Senate, April 1, 2025

The Committee on Human Services reported through SEN. LESSER of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT REQUIRING NURSING HOMES TO SPEND NOT LESS THAN EIGHTY PER CENT OF REVENUES ON DIRECT PATIENT CARE.

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

Section 1. Subsection (a) of section 17b-340d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2025*):

(a) The Commissioner of Social Services shall implement an acuity-based methodology for Medicaid reimbursement of nursing home services effective July 1, 2022. Notwithstanding section 17b-340, for the fiscal year ending June 30, 2023, and annually thereafter, the Commissioner of Social Services shall establish Medicaid rates paid to nursing home facilities based on cost years ending on September thirtieth in accordance with the following:

(1) Case-mix adjustments to the direct care component, which will be based on Minimum Data Set resident assessment data as well as cost data reported for the cost year ending September 30, 2019, shall be made effective beginning July 1, 2022, and updated every quarter thereafter. After modeling such case-mix adjustments, the Commissioner of Social

Services shall evaluate impact on a facility by facility basis and, not later than October 1, 2021, (A) make recommendations to the Secretary of the Office of Policy and Management, and (B) submit a report on the recommendations, in accordance with the provisions of section 11-4a, 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 on any adjustments needed to facilitate the transition to the new methodology on July 1, 2022. This evaluation may include a review of inflationary allowances, case mix and budget adjustment factors and stop loss and stop gain corridors and the ability to make such adjustments within available appropriations.

(2) Beginning July 1, 2022, facilities [will be required to] <u>shall</u> comply with collection and reporting of quality metrics as specified by the Department of Social Services, after consultation with the nursing home industry, consumers, employees and the Department of Public Health. Rate adjustments based on performance on quality metrics [will] <u>shall</u> be phased in, beginning July 1, 2022, with a period of reporting only. Effective July 1, 2023, the Department of Social Services shall issue individualized reports annually to each nursing home facility showing the impact to the Medicaid rate for such home based on the quality metrics program. A nursing home facility receiving an individualized quality metrics report may use such report to evaluate the impact of the quality metrics program on said facility's Medicaid reimbursement. Not later than June 30, 2025, the department shall submit a report, in accordance with the provisions of section 11-4a, 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 on the quality metrics program. Such report shall include information regarding individualized reports and the anticipated impact on nursing homes if the state were to implement a rate withhold on nursing homes that fail to meet certain quality metrics.

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

(4) Allowable costs shall be divided into the following five cost components: (A) Direct costs, which shall include salaries for nursing personnel, related fringe benefits and costs for nursing personnel supplied by a temporary nursing services agency; (B) indirect costs, which shall include professional fees, dietary expenses, housekeeping expenses, laundry expenses, supplies related to patient care, salaries for indirect care personnel and related fringe benefits; (C) fair rent, which shall be defined in regulations adopted in accordance with subsection (b) of this section; (D) capital-related costs, which shall include property taxes, insurance expenses, equipment leases and equipment depreciation; and (E) administrative and general costs, which shall include maintenance and operation of plant expenses, salaries for administrative and maintenance personnel and related fringe benefits. For (i) direct costs, the maximum cost shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; (ii) indirect costs, the maximum cost shall be equal to one hundred fifteen per cent of the state-wide median allowable cost; (iii) fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 17b-353; (iv) capital-related costs, there shall be no maximum; and (v) administrative and general costs, the maximum shall be equal to the state-wide median allowable cost. For purposes of this subdivision, "temporary nursing services agency" and "nursing personnel" have the same meaning as provided in section 19a-118.

(5) Costs in excess of the maximum amounts established under this subsection shall not be recognized as allowable costs, except that the commissioner may establish rates whereby allowable costs may exceed such maximum amounts for beds which are restricted to use by patients with acquired immune deficiency syndrome, traumatic brain injury or other specialized services.

(6) On or after June 30, 2022, 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 most recently filed cost report that are not otherwise included in the rates issued. The commissioner may

provide, 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 most recently filed cost report. The commissioner may allow minimum fair rent as the basis upon which reimbursement associated with improvements to real property is added.

(7) For the purpose of determining allowable fair rent, a facility with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Any facility with a rate of return on real property other than land in excess of eleven per cent shall have such allowance revised to eleven per cent. Any facility or its related realty affiliate which finances or refinances debt through bonds issued by the Connecticut Health and Education Facilities Authority shall report the terms and conditions of such financing or refinancing to the Commissioner of Social Services not later than thirty days after completing such financing or refinancing. The commissioner may revise the facility's fair rent component of its rate to reflect any financial benefit the facility or its related realty affiliate received as a result of such financing or refinancing. The commissioner shall determine allowable fair rent for real property other than land based on the rate of return for the cost year in which such bonds were issued. The financial benefit resulting from a facility financing or refinancing debt through such bonds shall be shared between the state and the facility to an extent determined by the commissioner on a case-by-case basis and shall be reflected in an adjustment to the facility's allowable fair rent.

(8) A facility shall receive cost efficiency adjustments for indirect costs and for administrative and general costs if such costs are below the state-wide median costs. The cost efficiency adjustments shall equal twenty-five per cent of the difference between allowable reported costs and the applicable median allowable cost established pursuant to subdivision (4) of this subsection.

(9) On and after July 1, 2025, costs shall be rebased no more frequently than every two years and no less frequently than every four years, as determined by the commissioner. There shall be no inflation adjustment during a year in which a facility's rates are rebased. The commissioner shall determine whether and to what extent a change in ownership of a facility shall occasion the rebasing of the facility's costs.

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

(11) There shall be no increase to rates based on inflation or any inflationary factor for the fiscal years ending June 30, 2022, and June 30, 2023, unless otherwise authorized under subdivision (1) of this subsection. Notwithstanding section 17-311-52 of the regulations of Connecticut state agencies, for the fiscal years ending June 30, 2024, and June 30, 2025, there shall be no inflationary increases to rates beyond those already factored into the model for the transition to an acuity-based reimbursement system. Notwithstanding any other provisions of this chapter, any subsequent increase to allowable operating costs, excluding fair rent, shall be inflated by the gross domestic product deflator when funding is specifically appropriated for such purposes in the enacted budget. The rate of inflation shall be computed by comparing the most recent rate year to the average of the gross domestic product deflator for the previous four fiscal quarters ending March thirty-first. Any increase to rates based on inflation shall be applied prior to the application of any other budget adjustment factors that may impact such rates.

<u>(12) For the fiscal year beginning July 1, 2025, and each fiscal year thereafter, the commissioner shall require a nursing home facility to spend not less than eighty per cent of funding received from Medicaid, Medicare and all other payment sources on direct care of residents, provided the commissioner may adjust the percentage spent on direct care for a nursing home facility with a capital improvement project or a fair rent increase approved by the commissioner. For the fiscal year</u>

beginning July 1, 2027, and each fiscal year thereafter, the commissioner may decrease rates of Medicaid reimbursement for any nursing home that does not comply with the provisions of this subdivision. For purposes of this subdivision, (A) "direct care" means hands-on care provided to a facility resident by nursing personnel, including, but not limited to, assistance with feeding, bathing, toileting, dressing, lifting or moving residents, medication administration and salary, fringe benefits and supplies related to direct care; and (B) "nursing personnel" means an advanced practice registered nurse, licensed pursuant to chapter 378, a registered nurse or practical nurse, licensed pursuant to chapter 378, or a nurse's aide, registered pursuant to chapter 378a.

[(12)**]** (13) For purposes of computing minimum allowable patient days, utilization of a facility's certified beds shall be determined at a minimum of ninety per cent of capacity, except for facilities that have undergone a change in ownership, new facilities, and facilities which are certified for additional beds which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure.

[(13)**]** (14) Rates determined under this section shall comply with federal laws and regulations.

[(14)**]** (15) The Commissioner of Social Services may authorize an interim rate for a facility demonstrating circumstances particular to that individual facility impacting facility finances or costs not reflected in the underlying rates.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2025*	17b-340d(a)

HS *Joint Favorable*

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 26 $	FY 27 $	FY 28 $
Social Services, Dept.	GF - Cost	at least $90,300	at least $90,300	at least $90,300
State Comptroller - Fringe Benefits[1]	GF - Cost	36,800	36,800	36,800
Social Services, Dept.	GF - Potential Savings	None	None	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in a cost to the Department of Social Services (DSS) associated with requiring nursing homes to spend at least 80% of payment sources, including Medicaid and Medicare, on direct care. DSS will incur costs to reflect an additional associate accounts examiner (annual salary of $90,300 with associated fringe of approximately $36,800) to meet the requirements of the bill. To the extent DSS requires system modifications, the agency could experience additional costs.

Beginning in FY 28, DSS may incur savings related to lower Medicaid rates paid to any nursing homes not meeting the provisions of the bill. For context, the state share of Medicaid payments to nursing homes is approximately $700 million annually.

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 40.71% of payroll in FY 26.

The Out Years

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

OLR Bill Analysis

SB 805

AN ACT REQUIRING NURSING HOMES TO SPEND NOT LESS THAN EIGHTY PER CENT OF REVENUES ON DIRECT PATIENT CARE.

SUMMARY

This bill requires the Department of Social Services (DSS) commissioner, beginning with fiscal year 2026, to require nursing homes to spend at least 80% of their funding from Medicaid, Medicare, and all other payment sources on residents' direct care. However, it allows the commissioner to adjust this percentage for nursing homes with a capital improvement project or fair rent increase DSS approved. Beginning with fiscal year 2028, the commissioner may decrease Medicaid reimbursement for any nursing home that does not comply.

Under the bill, "direct care" means hands-on care nursing personnel provide to facility residents (e.g., help with feeding, bathing, toileting, dressing, lifting or moving residents, or administering medication). It also includes nursing personnel's salary and fringe benefits and the cost of supplies to provide hands-on care. Nursing personnel include advanced practice registered nurses, registered or practical nurses, and nurse's aides.

EFFECTIVE DATE: July 1, 2025

BACKGROUND

Related Bill

sSB 11, § 7, favorably reported by the Human Services Committee, also requires nursing homes to spend at least 80% of their funding on residents' direct care.

COMMITTEE ACTION

Human Services Committee

Joint Favorable

Yea 17 Nay 5 (03/13/2025)