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Cost Related Reimbursement System for Long-Term Care Facilities

DESCRIPTION OF ORGANIZATION

Sec. 17-311-1. Description

The commissioner of income maintenance (hereinafter referred to as the commissioner) is empowered and described in 17-311, General Statutes of Connecticut, revised to 1981 (hereinafter referred to as G.S.).

(Effective March 17, 1983)

Sec. 17-311-2. Functions

The commissioner has the duty of establishing annually the cost of services for which payment is to be made to facilities receiving appropriations granted by the General Assembly as set forth in 17-312 G.S. through 17-314 G.S.

(Effective March 17, 1983)

Sec. 17-311-3. Official address

All communications should be addressed to the Commissioner of Income Maintenance, 110 Bartholomew Avenue, Hartford, Connecticut 06115, unless otherwise specified.

(Effective March 17, 1983)

Sec. 17-311-4. Public information

The public may inspect the regulations, decisions, and public records of the commissioner at his office in Hartford. Requests should be submitted in writing to the commissioner at the above-stated official address.

(Effective March 17, 1983)

Sec. 17-311-5. Signature of documents

The duly authorized and official documents of the commissioner including but not limited to the commissioner's orders, notices, and communications, shall be signed by the commissioner or his authorized representative.

(Effective March 17, 1983)

Secs. 17-311-6—17-311-10. Reserved

RULES OF PRACTICE

ARTICLE 1

GENERAL PROVISIONS

Part 1

Scope and Construction of Rules

Sec. 17-311-11. Scope of procedures

These rules govern practice and procedure before the commissioner under the applicable laws of the State of Connecticut except as otherwise provided by statute.

(Effective March 17, 1983)

Sec. 17-311-12. Definitions

The definitions provided by 4-166 and 17-311 G.S. shall govern the interpretation and application of these rules. In addition thereto and except as otherwise required by the context:

(a) “Commissioner” means the commissioner or his designated representative.

(b) “Hearing” means that portion of the commissioner’s proceedings in the disposition of matters delegated to his jurisdiction by law wherein an opportunity for presentation of evidence and argument occurs, which is preceded by due notice and which includes both an opportunity to present to the commissioner such written and oral testimony and argument as the commissioner deems appropriate and an opportunity to examine and cross-examine any witness giving testimony therein. Any such hearing shall be conducted as a public hearing.

(c) “Contested case” means a proceeding in the commissioner’s disposition of matters delegated to his jurisdiction by law in which the legal rights, duties, or privileges of a party are determined by the commissioner after an opportunity for a hearing. The definition stated in 4-166(2) G.S. shall further define this term.

(d) “Party” means each person named or admitted by the commissioner as a party to a contested case, whose legal rights, duties, or privileges will be determined by the commissioner by the final decision therein.

(e) “Intervenor” means each person admitted as a participant in a contested case who is not designated a party.

(f) “Person” means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character to which these rules of practice may apply where appropriate to the context of the regulations herein set forth.

(g) “Petitioner” and “applicant” mean any person who has filed a petition or application requesting action by the commissioner.

(h) “Related parties” means persons or organizations related through marriage, ability to control, ownership, family or business association.

(i) “Levels of care” means chronic and convalescent hospitals, rest homes with nursing supervision, and homes for the aged.

(Effective December 19, 1984)

Sec. 17-311-13. Waiver of rules

Where good cause appears, the commissioner may permit deviation from these rules, except where precluded by statute.

(Effective March 17, 1983)

Sec. 17-311-14. Construction and amendment

These rules shall be so construed by the commissioner as to secure just and expeditious determination of the issues presented hereunder. Amendments and additions to these rules may be adopted by the commissioner by being duly promulgated as regulations in accordance with Chapter 54 of the General Statutes.

(Effective March 17, 1983)

Sec. 17-311-15. Computation of time

Computation of any period of time referred to in these rules begins with the first day following that on which the act which initiates such period of time occurs and ends on the last day of the period so computed. This last day of that period is to be included unless it is a day on which the State offices are closed, in which event the period shall run until the end of the next following business day. When such a period of time, with the intervening Saturdays, Sundays, and legal holidays counted, is five (5) days or less, the said Saturdays, Sundays and legal holidays shall be excluded from the computation; otherwise, such days shall be included in the computation.

(Effective March 17, 1983)

Sec. 17-311-16. Extensions of time

At the discretion of the commissioner for good cause shown, any time limit prescribed or allowed by these rules may be extended. All requests for extensions shall be made before the expiration of the period originally prescribed or as previously extended.

(Effective March 17, 1983)

Sec. 17-311-17. Effect of filing, public records

(a) The filing with the commissioner of any application, request for advisory ruling, petition, or request of any nature whatsoever shall not relieve any person of the obligation to comply with any statute or with any regulation or order of the commissioner.

(b) Any request, petition, or application filed for the purpose of securing from the commissioner any final decision or other action authorized by law shall be part of the public records of the commissioner as defined by statute.

(Effective March 17, 1983)

Sec. 17-311-18. Consolidation of proceedings

Proceedings involving related questions of law or fact may be consolidated by the commissioner.

(Effective March 17, 1983)

Sec. 17-311-19. Rules of conduct

Where applicable, the canons of professional ethics and the canons of judicial ethics adopted and approved by the judges of the Superior Court govern the conduct of the Commissioner; the state employees serving the commissioner, and all attorneys, agents, representatives, and any other persons who shall appear before the commissioner in any hearing, meeting, contested case or other proceeding.

(Effective March 17, 1983)

Sec. 17-311-20. Ex parte communication

Unless required for the disposition of matters ex parte authorized by law, the commissioner shall not communicate directly or indirectly with any party or intervenor concerning any issue of fact or law involved in any contested case that has been commenced under these rules, except upon notice and opportunity for all parties to participate. The commissioner may communicate with and may have the aid and advice of such persons as are assigned to assist him in any contested case. In a contested case, this rule shall not be construed to preclude such routine communications as are necessary to permit the commissioner and/or such persons as are assigned to assist him to investigate facts and to conduct the informal conferences allowed by these rules of practice at any time before, during, and after the hearing thereof.

(Effective March 17, 1983)

Part 2**Formal Requirements****Sec. 17-311-21. Principal office**

The principal office of the commissioner is located at 110 Bartholomew Avenue, Hartford, Connecticut. The office of the commissioner is open from 8:30 a.m. to 4:30 p.m. each weekday except Saturdays, Sundays and legal holidays.

(Effective March 17, 1983)

Sec. 17-311-22. Date of filing

All orders, decisions, findings of fact, requests, correspondence, motions, petitions and any other documents governed by these rules shall be deemed to have been issued or received on the date on which they are issued or received by the commissioner at his principal office, except as may hereinafter be provided.

(Effective March 17, 1983)

Sec. 17-311-23. Signatures

Every request, application, notice, motion, petition, brief, and memorandum addressed to the commissioner shall be signed in behalf of the person filing.

(Effective March 17, 1983)

Sec. 17-311-24. Identification of communications to the commissioner

Communications should embrace only one matter and should contain the name and address of the sender and an appropriate file reference to the subject of the communication. When the subject matter pertains to a proceeding pending before the commissioner, the title of the proceeding and the docket number should be given. Failure to observe this rule may result in rejection and return of the communication to the sender by the commissioner.

(Effective March 17, 1983)

Sec. 17-311-25. Formal requirements as to copies of documents and other papers filed in proceedings

In addition to the original, there shall also be filed three (3) copies for the use of the commissioner, unless the filing of a greater or lesser number of such copies is directed by the commissioner.

(Effective March 17, 1983)

Sec. 17-311-26. Service

(a) **General rule.** Service of all documents and other papers filed in all proceedings, including but not limited to motions, petitions, applications, notices, briefs, and exhibits shall be by personal delivery or by first class mail, except as hereinafter provided.

(b) **On whom served.** All documents and other papers shall be served by the person filing the same on every party in the proceeding and all such additional persons as the commissioner shall direct.

(c) **Service by the commissioner.** A copy of any document or other paper served by the commissioner, showing the addresses to which the document or other paper was mailed, shall be placed in the commissioner's files and shall thereafter be prima facie evidence of the fact and date of such service.

(d) **Service of written notice.** Written notice of all orders, decisions or authorizations issued by the commissioner shall be given to the party affected thereby or to such other person as the commissioner may deem appropriate by personal service upon such person or by first class mail.

(Effective March 17, 1983)

ARTICLE 2

CONTESTED CASES

Part 1

Parties, Intervention and Participation

Sec. 17-311-27. Designation of parties

(a) In issuing the notice of hearing, the commissioner will designate as parties any persons known to the commissioner whose legal rights, duties, or privileges

are being determined in the contested case and any person whose participation as a party is then deemed by the commissioner to be necessary to the proper disposition of such proceeding subject to such person complying with 4-177a G.S.

(b) Subsequent to the issuance of the notice of hearing, no other person before the commissioner other than the petitioner and, in self-pay rate hearings, the self-pay patients affected by the self-pay rate determination at issue shall have standing as a party within the definition of 4-166 (8) G.S. except upon the express order of the commissioner.

(c) The commissioner will designate all self-pay patients or, in the case of incompetent self-pay patients, their guardians or conservators as parties of record, because self-pay rate hearings involve what rates self-pay patients pay to their nursing homes.

(d) At the commencement of a self-pay rate hearing, the nursing home shall submit for the record a written list of the names and addresses of all of its present and past self-pay patients and their guardians or conservators who are affected by the self-pay rate years which are the subject of such hearing. Failure of the nursing home to submit such written list shall constitute cause for a default of the facility at the self-pay rate hearing. The commissioner or his designated hearing officer or presiding officer shall have the discretion not to default a facility which inadvertently made a minor or technical error in its list and is willing to correct such minor or technical error if possible.

(Effective March 28, 1990)

Sec. 17-311-28. Participation by persons other than parties

(a) **Permission to participate.** At any time prior to the commencement of oral testimony in any hearing on a contested case, any person may request that the commissioner permit that person to participate in the hearing. Any person not a party that is so permitted to participate in the hearing will be identified as an intervenor for the purposes of these regulations and will participate in those portions of the contested case that the commissioner shall expressly authorize.

(b) **Status of a non-party that has been admitted to participate.** No grant or leave to participate in the hearing as an intervenor or in any other manner shall be deemed to be an admission by the commissioner that the person he has permitted to participate is a party in interest that may be aggrieved by any final decision, order, or ruling of the commissioner unless such grant of leave to participate expressly so states. An intervenor is a party of record for the limited purposes described in 4-183 G.S.

(Effective March 17, 1983)

Sec. 17-311-29. Representation of parties and intervenors

Each person authorized to participate in a contested case as a party or as an intervenor shall file a written notice of appearance with the commissioner. Such appearance may be filed in behalf of parties and intervenors by an attorney, an agent, or other duly authorized representative subject to the rules hereinabove stated. The filing of a written appearance may be excused in behalf of the commissioner.

(Effective March 17, 1983)

Part 2

Hearings

Sec. 17-311-30. Commencement of contested case

When a hearing is required by law as to any person, the contested case shall be deemed to commence on the date of issuance of the agency determination which

is the subject of the filing of the request, application, or petition for purposes of 4-174 to 4-183 G.S.

(Effective March 28, 1990)

Sec. 17-311-31. Place of hearings

All hearings of the commissioner shall be held at Hartford at the office of the commissioner, unless a different place is designated by statute or by direction of the commissioner.

(Effective March 17, 1983)

Sec. 17-311-32. Notice of hearings

(a) **Persons notified.** Except when the commissioner shall otherwise direct, the commissioner shall give written notice of a hearing in any pending matter to all persons designated as parties, to all persons who have been permitted to participate as intervenors, to all persons otherwise required by statute to be notified, and to such other persons as have filed with the commissioner their written request for notice of hearing in the particular matter. Written notice shall be given to such additional persons as the commissioner shall direct. The commissioner may give such public notice of the hearing as the commissioner shall deem appropriate.

(b) **Contents of notice.** Notice of a hearing shall include but shall not be limited to the following: (1) a statement of the time, place, and nature of the hearing; (2) a statement of the legal authority under which the hearing is to be held and the identification of statutes and/or regulations that are involved; (3) a short and plain statement of fact describing the purpose of the hearing.

(Effective March 28, 1990)

Sec. 17-311-33. General provisions

(a) **Purpose of hearing.** The purpose of any hearing the commissioner conducts under Chapter 54 G.S. shall be to provide to all parties an opportunity to present evidence and argument on all issues to be considered by the commissioner.

(b) **Order of presentation.** In hearings on requests, applications, and petitions, the party that shall open and close the presentation of any part of the matter shall be the person making the request, the applicant, or the petitioner.

(c) **Limiting number of witnesses.** To avoid unnecessary cumulative evidence, the commissioner may limit the number of witnesses or the time for testimony upon a particular issue in the course of any hearing.

(d) **The commissioner may permit any party to offer testimony in written form.** Such written testimony shall be received in evidence with the same force and effect as though it were stated orally by the witness who has given evidence, provided that each such witness shall be present at the hearing at which testimony is offered, shall adopt the written testimony under oath, and shall be made available for cross-examination as directed by the commissioner. Prior to its admission, such written testimony shall be subject to objections by parties.

(Effective March 17, 1983)

Sec. 17-311-34. Witnesses and testimony

The commissioner, his designated hearing officer and/or his designated presiding officer may administer oaths, take testimony under oath relative to the case, subpoena witnesses and require the production of records, physical evidence, papers and documents to any hearings held in the case pursuant to 4-177b G.S.

(Effective March 28, 1990)

Sec. 17-311-35. Rules of evidence

The following rules of evidence shall be followed in the admission of testimony and exhibits in all hearings held under Chapter 54 G.S.

(a) **General.** Any oral or documentary evidence may be received; but the commissioner shall, as a matter of policy, exclude irrelevant, immaterial, or unduly repetitious evidence. The commissioner shall give effect to the rules of privilege recognized by law in Connecticut where appropriate to the conduct of the hearing. Subject to these requirements any testimony may be received in written form as herein provided.

(b) **Documentary evidence, copies.** Documentary evidence should be submitted in original form, but may be received in the form of copies or excerpts at the discretion of the commissioner. Upon request by any party an opportunity shall be granted to compare the copy with the original if available, which shall be produced for this purpose by the person offering such copy as evidence.

(c) **Cross-examination.** Cross-examination may be conducted as the commissioner shall find to be required for a full and true disclosure of the facts.

(d) **Facts noticed, committee records.** The commissioner may take administrative notice of judicially cognizable facts, including the records and the prior decisions and orders of the commissioner and the former committee on state payments. Any exhibit admitted as evidence by the commissioner in a prior hearing may be offered as evidence in a subsequent hearing and admitted as an exhibit therein; but the commissioner shall not deem such exhibit to be cognizable in whole or in part for this purpose and shall not consider any facts set forth therein unless such exhibit is duly admitted as evidence in the matter then being heard.

(e) **Facts noticed, scope and procedure.** The commissioner may take administrative notice of generally recognized technical or scientific facts within the commissioner's specialized knowledge. Parties shall be afforded an opportunity to contest the material so noticed by being notified before or during the hearing, or by an appropriate reference in preliminary reports or otherwise of the material noticed. The commissioner shall nevertheless employ the commissioner's experience, technical competence, and specialized knowledge in evaluating the evidence presented at the hearing for the purpose of making his finding of facts and arriving at a final decision.

(Effective March 17, 1983)

Sec. 17-311-36. Filing of added exhibits and testimony

Upon order of the commissioner before, during, or after the hearing any party shall prepare and file added exhibits and written testimony. Such added exhibits and testimony shall be deemed to be an offer of evidence and shall be subject to such comment, reply, and contest as due process shall require.

(Effective March 17, 1983)

Sec. 17-311-37. Uncontested disposition of request, application or petition

Unless precluded by law, any request, application, or petition may be resolved by stipulation, agreed settlement, consent-order or default, subject to the order of the commissioner. Upon such disposition a copy of the order of the commissioner shall be served on each party.

(Effective March 17, 1983)

Sec. 17-311-38. Delegations of powers to hearing officers or presiding officers

(a) As provided in 17-2 G.S., the commissioner may delegate the power and authority to any deputy, assistant, investigator or supervisor to serve as hearing

officer or presiding officer at a contested case hearing and to render final decision in said contested case.

(b) The commissioner may delegate the power and authority to any person to serve as hearing officer or presiding officer at a contested case hearing and to recommend a proposed decision to the commissioner with compliance with 4-179 G.S. when required by said statute.

(Effective March 28, 1990)

Sec. 17-311-39. Record in a contested case

The record in a contested case shall include: (1) written notice related to the case; (2) all petitions, pleadings, motions and intermediate rulings; (3) evidence received or considered; (4) questions and offers of proof, objections and rulings thereon; (5) the official transcript, if any, of proceedings relating to the case, or, if not transcribed, any recording or stenographic record of the proceedings; (6) proposed final decisions and exceptions thereto, where the hearing officer or presiding officer has not been delegated the authority to render final decision directly, and (7) the final decision.

(Effective March 28, 1990)

Sec. 17-311-40. Final decision in a contested case

All decisions and orders of the commissioner concluding a contested case shall be in writing. The commissioner will serve a copy of his final decision on each party in the manner required by these rules of practice and by Chapter 54 G.S.

(Effective March 17, 1983)

ARTICLE 3

MISCELLANEOUS PROCEEDINGS

Part 1

Petitions Concerning Adoption of Regulations

Sec. 17-311-41. General rule

These rules set forth the procedure to be followed by the commissioner in the disposition of a petition concerning the promulgation, amendment, or repeal of regulations.

(Effective March 17, 1983)

Sec. 17-311-42. Form of petition

Any person may at any time petition the commissioner to promulgate, amend, or repeal any regulation. The petition shall conform to the rules hereinabove stated, where applicable, and shall set forth clearly and concisely the text of the proposed regulation, amendment, or repeal. Such petition shall also state the facts and arguments that favor the action it proposes by including such data, facts, and arguments in the petition or in a brief annexed thereto. The petition shall be addressed to the commissioner and sent by mail or delivered in person during normal business hours. The petition shall be signed by the petitioner and shall furnish the address of the petitioner and the name and address of the petitioner's attorney, if applicable.

(Effective March 17, 1983)

Sec. 17-311-43. Procedure after petition filed

(a) **Decision on petition.** Upon receipt of the petition, the commissioner shall within thirty (30) days determine whether to deny the petition or to initiate regulation-making proceedings in accordance with law.

(b) **Procedure on denial.** If the commissioner denies the petition, the commissioner shall give the petitioner notice in writing, stating the reasons for the denial. (Effective March 17, 1983)

Part 2

Requests for Declaratory Rulings

Sec. 17-311-44. General

These rules set forth the procedure to be followed by the commissioner in the disposition of a request for declaratory rulings as to the validity of any regulation, or the applicability to specified circumstances of a provision of the General Statutes, a regulation, or a final decision on a matter within the jurisdiction of the commissioner.

Such a ruling of the commissioner disposing of a petition for a declaratory ruling shall have the same status as any decision or order of the commissioner in a contested case.

(Effective March 28, 1990)

Sec. 17-311-45. Form of petition for declaratory ruling

(a) Any person may petition the commissioner, or the commissioner may on his own motion initiate a proceeding, for a declaratory ruling as to the validity of any regulation, or the applicability to specified circumstances of a provision of the General Statutes, a regulation, or a final decision on a matter within the agency, provided that a petition to contest any regulation on the ground of non-compliance with the procedural requirements of Chapter 54 G.S. may only be filed within two years from the effective date of the regulation. Such petition shall be addressed to the commissioner and be sent by mail or delivered in person during normal business hours. Petitioner must file with the commissioner an original and five (5) copies of the petition.

(b) If the commissioner determines that a declaratory ruling will not be rendered, the commissioner shall within sixty (60) days thereafter notify the person so inquiring that the petition has been denied and furnish a statement of the reasons on which the commissioner relied in so deciding.

(c) A petition for declaratory ruling shall contain the following sections in the order indicated here:

(1) A statement of the questions being presented for a ruling, expressed in the terms and circumstances of the specific request but without unnecessary detail. This statement shall identify the statute, regulation or final decision which is the basis for the petition and shall identify the particular aspects thereof and special circumstances to which the question of validity or applicability is directed.

(2) A statement of the facts material to the consideration of the questions presented.

(3) A statement of the position of the practitioner with respect to the questions being presented.

(4) An argument amplifying the reasons relied upon for the petitioner's position, including any appropriate legal citations, must be included with the petition or be in an attached brief.

(5) A signature by the petitioner or legal representative, his address, telephone number and facsimile machine telephone number, if any, of the petitioner and legal representative, if applicable.

(d) The date of filing of any petition shall be the date the petition is received by the commissioner in the form prescribed by this regulation. Only complete petitions filed in conformance with this section will be considered by the commissioner.

(Effective March 28, 1990)

Sec. 17-311-46. Procedure after petition for declaratory ruling filed

(a) Within thirty days after receipt of a petition for a declaratory ruling, the commissioner shall give notice of the petition to all persons to whom notice is required by any provision of law and to all persons who have requested notice of declaratory ruling petitions on the subject matter of the petition.

(b) If the commissioner deems a hearing necessary or helpful in determining any issue concerning the request for declaratory ruling, the commissioner may schedule such hearing and give such notice thereof as shall be appropriate.

(c) Within forty-five calendar days of the submission of the complete petition for a declaratory ruling, persons wishing to be admitted to the proceeding as parties or intervenors shall file a petition with the commissioner. Such persons, in submitting their position and evidence in the declaratory ruling proceeding, shall comply with the other provisions of these regulations concerning the form, content and filing procedures for a petition. If the commissioner conducts a hearing, the commissioner or his designated hearing officer or presiding officer has the discretion to limit the participation of intervenors in such hearing, including the rights to inspect and copy records, to introduce evidence and to cross-examine, so as to promote the orderly conduct of the proceedings.

(d) Within sixty days after receipt of a petition for a declaratory ruling, the commissioner in writing shall: (1) issue a ruling declaring the validity of a regulation or the applicability of the provision of the General Statutes, the regulation, or the final decision in question to the specified circumstances, (2) order the matter set for specified proceedings, (3) agree to issue a declaratory ruling by a specified date, (4) decide not to issue a declaratory ruling and initiate regulation-making proceedings, under Section 4-168, on the subject, or (5) decide not to issue a declaratory ruling, stating the reasons for his action.

(e) A copy of all rulings issued and any actions taken under this section shall be promptly delivered to the petitioner and other parties personally or by United States mail, certified or registered, postage prepaid, return receipt requested.

(f) If the agency conducts a hearing in a proceeding for declaratory ruling, the provisions of subsection (b) of 4-177c, G.S., 4-178 G.S. and 4-179 G.S. shall apply to the hearing, except that if the commissioner delegates to the presiding officer or hearing officer the power to render final decision directly, he or she may do so.

(g) If the commissioner renders a declaratory ruling, a copy of the ruling shall be sent personally or by United States mail, certified or registered, postage prepaid, return receipt requested to the person requesting it and to that person's attorney, if applicable, and to any other person who has filed a written request for a copy with the commissioner.

(h) If the commissioner does not issue a declaratory ruling within one hundred eighty days after the filing of a petition therefor, the commissioner shall be deemed to have decided not to issue such ruling.

(i) Any time requirement in this section may be extended with the agreement of the petitioner.

(j) The commissioner shall keep a record of the proceeding as provided in 4-177 G.S.

(Effective March 28, 1990)

Part 3

Miscellaneous Provisions

Sec. 17-311-47. Commissioner investigations

The commissioner may at any time institute investigations for such purpose as may be authorized by law, including but not limited to investigations of the submission of any false or misleading fiscal information or data which may lead to suspension of payments pursuant to 17-311(c) G.S.

(Effective March 17, 1983)

Sec. 17-311-48. Procedures

The rules of notice, practice, and procedure set forth in Article 2 govern any hearing held in the course of such an investigation.

(Effective March 17, 1983)

Sec. 17-311-49. Reserved

ARTICLE 4

COST RELATED REIMBURSEMENT SYSTEM

Sec. 17-311-50. Annual report used for submission of cost data

Pursuant to sec. 17-311 of the General Statutes, the committee on state payments, (hereinafter referred to as "committee") approved, effective August 17, 1976, a cost report form designated the "Annual Report of Long-term Care Facilities" (hereinafter referred to as "annual report"). Such report shall be used to provide the commissioner with detailed cost information concerning the services provided by each certified and licensed long-term care facility for persons aided or cared for by the state.

The required completed annual report must be received by the commissioner no later than December 31 of each year for the cost year ending September 30 of that year, if a facility wishes to receive payment for persons aided or cared for by the state. Such report shall include the original and one clear copy. All documents must bear the original signatures of the administrator, owner and independent public accountant.

Failure to submit the annual report in a complete and timely manner shall result in the commissioner not promulgating an individual cost-related rate for such facility for the next rate year beginning July 1. Instead, for such delinquent facilities, the commissioner may authorize a rate comparable to the lowest rate paid to a facility for the same level of care.

(Effective March 17, 1983)

Sec. 17-311-51. Type of system used in promulgating rates; prospective rates; cost year; rate year; retroactive rate adjustment

Effective July 1, 1976, the system for determining per diem rates of payment to long-term care facilities in the state of Connecticut shall be an individual cost-related prospective rate system derived from cost information provided by each facility in the annual report, required by the commissioner, for each cost year ending September 30 which precedes the rate year beginning July 1 of the succeeding year. The first cost reporting period for which this cost-related system shall be effective shall be October 1, 1974 through September 30, 1975, with the rate determined

pursuant to this system to be effective for the period July 1, 1976 through June 30, 1977:

(a) In the event that the rate determined on the basis of the cost period October 1, 1974 through September 30, 1975 is less than the amount paid to a provider pursuant to the interim rate adopted by the committee on November 5, 1975 and re-enacted on August 17, 1976, no retroactive adjustment shall be made in favor of the state so as to require a repayment by a provider for the period prior to April 1, 1977.

(b) In the event that the rate determined on the basis of the cost period October 1, 1974 through September 30, 1975 exceeds the amount paid to a provider pursuant to the interim rate adopted by the committee on November 5, 1975 and re-enacted on August 17, 1976, the commissioner shall make a retroactive adjustment in favor of the provider and shall make payments to the provider from July 1, 1976 to the date of the determination of the new rate pursuant to this system.

(Effective March 17, 1983)

Sec. 17-311-52. Computation of per diem reimbursement rates

Per diem reimbursement rates shall be calculated for each level of care, e.g., chronic and convalescent hospital, rest home with nursing supervision and home for the aged, based upon:

(a) Allowable routine costs related to the provision of patient care as set forth in subchapter 18, part A of title 42 of the U.S. Code, section 1393 et seq. and the regulations promulgated thereunder (hereinafter referred to as medicare statutes and regulations) except as modified by these regulations and the Connecticut state plan approved by the United States department of health and human services.

(b) The allowable salary limits pursuant to the following schedule:

(1) For 1986

Administrators'

| <i>Number of Beds Within Level of Care</i> | <i>Base</i> | <i>Add per Bed Increment</i> | <i>Maximum</i> |
|--|-------------|----------------------------------|----------------|
|--|-------------|----------------------------------|----------------|

Homes for the Aged and

Other Community Group Homes

| | | | |
|----------|----------|-----|----------|
| 1-60 | \$20,000 | 92 | \$25,530 |
| 61-120 | 25,530 | 101 | 31,590 |
| 121-over | 31,590 | 80 | 36,465 |

Rest Home With Nursing Supervision

| | | | |
|----------|----------|-----|----------|
| 1-30 | \$20,000 | 108 | \$23,253 |
| 31-60 | 23,253 | 236 | 30,333 |
| 61-120 | 30,333 | 110 | 36,933 |
| 112-180 | 36,933 | 112 | 43,653 |
| 181-over | 43,653 | 110 | 50,254 |

**Chronic and Convalescent Hospital
and Multi-level Facilities**

| | | | |
|----------|----------|-------|----------|
| 1-60 | \$21,537 | \$238 | \$35,817 |
| 61-120 | 35,817 | 176 | 46,379 |
| 121-180 | 46,379 | 133 | 54,359 |
| 181-over | 54,359 | 112 | 61,078 |

Assistant Administrators

For facilities of over 99 certified beds, one assistant administrator (in addition to the administrator) may be allowed for each 100 beds at a salary of up to a maximum of 70% of the allowable salary paid to the administrator.

Director of Nurses

| <i>Number of Beds</i> | <i>Base</i> | <i>Add per Bed</i> | |
|-----------------------|-------------|--------------------|----------------|
| | | <i>Increment</i> | <i>Maximum</i> |
| 1-60 | \$15,042 | \$166 | \$25,002 |
| 61-120 | 25,002 | 125 | 32,502 |
| 121-180 | 32,502 | 93 | 38,082 |
| 181-over | 38,082 | 77 | 42,733 |

Dietitians

| <i>Number of Beds</i> | <i>Code Requirements</i> | <i>Rate of Pay</i> |
|-----------------------|--------------------------|--|
| 60 and under | 8 hours per month | B.S. Degree only \$17.78 per hour B.S. Degree and ADA and RD \$19.71–23.71 per hour |
| 61-90 | 16 hours per month | As Above |
| 91-120 | 24 hours per month | As Above |
| 121-150 | 32 hours per month | As Above |
| 151-180 | 48 hours per month | As Above |
| 181-210 | 64 hours per month | As Above |
| 211 or more | Full Time Dietitian | As Above |

Physicians

\$56.52 – \$80.91 per hour

All other Professional/Technical Personnel Related to the Owner(s)

Salary for full-time work \$17,633

(2) The allowable salary limits for ensuing years shall be determined by applying the percentage increase or decrease of the forecasted implicit price deflator for the gross national product for the appropriate period to the allowable salary limits for the preceding cost year, except that commencing with the rate year beginning July 1, 1983 salaries for directors of nursing unrelated to the owner(s) shall no longer be subject to such limitations and commencing with the rate year beginning July 1, 1986 salaries for other professional/technical personnel unrelated to the owner(s) shall no longer be subject to such limitations but rather must meet the general standard of being reasonable, necessary and directly related to patient care.

(3) Salaries for proprietors or in the case of non-profit facilities persons who exercise the equivalent of proprietorship or management functions and their relatives who claim to provide some or all of the functions required to operate the facility efficiently shall be supported by timekeeping records and other related documentation. For a proprietor or relative licensed by the Connecticut Department of Health Services as the administrator, compensation shall be allowed in accordance with the allowable administrative salary limits referred in the preceding paragraph. For proprietors or in the case of non-profit facilities persons who exercise the equivalent of proprietorship or management functions and their relatives who are not so licensed, allowable compensation for managerial administrative functions shall be limited to 70% of the allowable salary paid to the administrator. The salary allowed for a proprietor or relative shall not exceed the allowable salary limits based on a 40 hour work week.

(c) A separate inflation cost limitation for each of the following cost centers; dietary, laundry, housekeeping and routine nursing care; excluding routine nursing care for non-medical facilities such as homes for the aged.

Each inflation cost limitation shall be the sum of;

(1) Allowable costs per patient day for the prior year for the cost center without consideration of the prior year inflation control disallowance or cost efficiency adjustment, adjusted by the implicit price deflator for the gross national product published in "Economic Indicators" prepared for the joint economic committee by the council of economic advisors for the current cost year divided by the implicit price deflator for the gross national product for the prior cost year.

(2) The portion of real wage growth allowance per patient day for the prior year applicable to the cost center computed in accordance with subsection 16 below.

(3) Significant increases in operating costs of the cost center resulting from the implementation of new standards of care of staff specifically mandated by the Connecticut Department of Health Services and/or the certification requirements of the federal government.

(4) Significant increases in operating costs of the cost center resulting from capital renovation, expansion or replacement required for compliance with new state or federal standards for patient care referred to in (c) above.

(d) An efficiency limitation per patient day established at 160 percent of the median for all allowable costs except those property costs covered by the application of the fair rental value system. The efficiency limitation shall be determined by calculating such costs per patient day for each provider segregated by chronic and convalescent hospitals and homes for the aged. This efficiency limitation shall be cost controlling after application of subsection 3 above and any other disallowances prescribed by these regulations. This efficiency limitation shall decrease by five percentage points per year for each of the next two years. This efficiency limitation shall remain at 150 percent of the median thereafter.

In no event shall the efficiency limitations per patient day computed pursuant to this subsection be less than the allowable operating expense per patient day for the preceding cost year.

This subsection constitutes an overall cap which a facility's allowable costs for reimbursement purposes cannot exceed. All other subsections of the cost related reimbursement system regulations, including but not limited to Section 17-311-57, shall be construed to be subject to this subsection.

(e) For chronic and convalescent hospitals and rest homes with nursing supervision excluding intermediate care facilities for the mentally retarded, a separate cost efficiency adjustment for each of the four cost centers; dietary, laundry, housekeeping and routine nursing care; and for homes for the aged, a separate cost efficiency adjustment for each of the three cost centers; dietary, laundry and housekeeping.

For chronic and convalescent hospital and rest home with nursing supervision excluding intermediate care facilities for the mentally retarded, for the dietary, laundry and housekeeping cost centers, the cost efficiency adjustments shall be 10% of the excess of the 80th percentile of allowable costs per certified bed of all facilities for the cost center for the applicable level of care multiplied by the certified beds of the facility for the level of care, provided such excess exists for at least two cost centers for the applicable level of care and provided such excess is at least \$1,000 for the applicable cost center. For chronic and convalescent hospitals and rest home with nursing supervision, excluding intermediate care facilities for the mentally retarded, for routine nursing cost center, the cost efficiency adjustment shall be 10% of the excess of the 90th percentile of allowable costs per certified bed of all facilities for the cost center for the applicable level of care multiplied by the certified beds of the facility for the level of care over the allowable expense of the facility for the cost center, provided such excess exists for at least two cost centers for the

applicable level of care and provided such excess is at least \$1,000 for the routine nursing cost center.

For homes for the aged, for dietary, laundry and housekeeping cost centers, the cost efficiency adjustment shall be 10% of the excess of the 80th percentile of allowable costs per certified bed of all homes for the aged for the cost center multiplied by the certified beds of the facilities' home for the aged over the allowable expense of the facilities' home for the aged for the cost center, provided such excess is at least \$1,000 for the applicable cost center.

After a facility has received a cost efficiency adjustment for a cost center of a level of care for two years in a row, that is, beginning with the third year, the cost efficiency adjustment shall be increased to 20% of the excess described above.

(f) An allowance for property costs based upon a fair rental value system.

(1) The fair rental value allowance shall be in lieu of interest on mortgages, other property financing costs, depreciation on buildings and non-movable equipment and rental charges (except for leases entered into between unrelated parties prior to December 20, 1976). The allowance shall be computed in the same manner whether the facility is owned or leased (except as provided in subsection c) and whether the facility is operated by an individual owner, partners, or a corporation.

(2) The fair rental value allowance consists of rental allowance of the use of land, buildings and non-movable equipment related to patient care.

(a) The annual fair rental value allowance for the use of land shall be determined by multiplying the base value of the land by a rate of return which is equal to one-third of the medicare rate of return for the cost year, but not more than four percent nor less than two and one-half percent per annum. The base value of the land of a facility first used as a long term care facility after September 30, 1954, shall be the actual cost of the land consisting of the purchase price and the cost of grading, filling and site preparation. For those facilities first used as a long term care facility before October 1, 1954, the base value of the land shall be the actual cost of the land adjusted from the date of acquisition to cost year 1974. The base value in any case shall not vary because of changes in ownership except as provided in section 17-311-57(1), financial arrangements of an owner, or whether the land is owned or leased.

(b) Real property other than land consists of:

- buildings and building improvements;
- all equipment attached to buildings and considered to be real property as distinguished from personal property; and
- land improvements, including parking lots, driveways, sidewalks, sewage systems, walls and pump houses.

The fair rental value allowance is calculated to yield a constant amount each year in lieu of interest and depreciation costs, such allowance for the use of real property other than land shall be determined by amortizing the base value of such property over its remaining useful life and applying a rate of return on the unamortized base value.

The annual rate of return shall be calculated for proprietary facilities on the basis of medicare rates of return as set forth in 42 C.F.R., Section 405.429, and 5/8th of such rates for nonprofit (voluntary and governmental) facilities. The applicable rate of return shall remain constant for each property item for a period of ten years. Thereafter each subsequent ten years, the rate of return shall be adjusted based upon the preceding five year average of the medicare rate of return.

For proprietary facilities, the applicable rate of return for real property other than land, first used for a long term care facility after September 30, 1974 or acquired by new owners between October 1, 1974 and December 20, 1976, shall be the medicare rate of return for the cost year when first used for a long term care facility or acquired by new owners, respectively. The applicable rate of return for all other real property other than land shall be based on the cost year that such property was first used for a long term care facility as follows:

- Cost Year 1974 — 1974 medicare rate of return;
- Cost Year 1973 — average of 1973 and 1974 medicare rates of return;
- Cost Year 1972 — average of 1972, 1973 and 1974 medicare rates of return;
- Cost Year 1971 — average of 1971, 1972, 1973 and 1974 medicare rates of return;
- Cost Years Prior to 1971 — average of 1970, 1971, 1972, 1973, and 1974 medicare rates of return.

For nonprofit (voluntary and governmental) facilities, constructed or acquired after the effective date of this amendment to the regulations, the applicable rate of return utilized in calculating the fair rental value shall be the same rate of return as that used for proprietary facilities.

The base value of real property other than land first used for a long term care facility after September 30, 1974 and December 20, 1976, shall be the actual cost of the property. The base value of all other real property other than land shall be the undepreciated book value of the property as of October 1, 1974; that is, the cost less the accumulated depreciation, from the date of acquisition, allowable under medicare statutes and regulations.

In any situation where book values are incomplete or questionable and therefore may not reflect the value on the date of acquisition, the commissioner may disallow any claim for such unsupported amount or may in his discretion establish a value based on property values of comparable facilities.

A facility transferred to a new owner after December 20, 1976 retains the same base values as existed for the previous owner except as provided in section 17-311-57 (1).

The remaining useful life of buildings first used as a long term care facility after September 30, 1974, or acquired by new owners between October 1, 1974 and December 20, 1976, shall be thirty years. The remaining useful life of all other buildings except those acquired by new owners after December 20, 1976 shall be thirty years minus the number of years between October 1, 1974 and the date of building construction, reconstruction sufficient to extend its useful life to thirty years, or acquisition, whichever is later. The remaining useful life of buildings acquired by new owners after December 20, 1976 shall be the same as if the buildings had not changed ownership after December 20, 1976, except as provided in section 17-311-57 (1).

The remaining useful life of real property other than buildings shall be determined as described herein for buildings with the exception that for such property whose estimated useful life is less than thirty years, such estimated useful life shall be used in all calculations instead of thirty years.

For purposes of reimbursement, a minimum residual value is established for real property other than land at 10% of the cost of such property. The allowance for the use of such property shall not be less than the amount determined by applying the appropriate medicare rate of return to the minimum residual value.

(3) A facility which has entered into a lease with an unrelated party prior to December 20, 1976 may petition the state to recognize the arms-length relationship of the parties and the process and procedure leading to the terms and conditions of an existing lease when the terms and conditions were arrived at through arms-length negotiations with unrelated parties. Any provider who is such a lessee must provide full detailed information, including copies of such leases and proof of arms-length relationship. In addition, a formal written letter requesting the recognition of such an arrangement must be included in the annual report transmitted to the commissioner each year for which such consideration is desired.

Upon acceptance of satisfactory proof of an arms-length relationship and upon review of the terms of said lease for reasonableness, the commissioner may accept the continuation of the rental or lease agreement and may decide not to impose the rules and regulations applicable under the fair rental value system until the lease expires.

(g) Management service fees.

Management fees paid to related parties shall be recognized only to the extent of the actual cost to the related party of providing necessary services related to patient care.

Fees paid to outside organizations for management services shall be allowed for inclusion in the computation of the per diem reimbursement rate provided that such costs are paid under arms-length arrangements to unrelated parties and are approved by the commissioner.

Requests for approval shall be submitted annually by the provider to the commissioner at least three months in advance of entering into arrangements for outside management services. Such requests shall be reviewed as to their reasonableness in relation to the size of the facility and the complexity of its operating structure, and as to their necessity for the effective administration of the facility's operations. The granting of approval will provide the basis for recognition of the costs of the requested management services in the cost year in which they are incurred and inclusion in the rate to be effective July 1 of the following year.

(h) Allowances for membership in professional associations whose function is to improve the competence of administrators and professional staff serving patients up to a maximum of \$24.00 per bed for the cost year ending September 30, 1986. For the cost years ending September 30, 1987, September 30, 1988, and September 30, 1989, increases in such dues paid by providers to professional associations in excess of \$24.00 per bed will be recognized as an allowable cost to the extent that such percentage increase in such association dues does not exceed the percentage increase in the implicit price deflator for the gross national product (GNP) as determined in subsection (c) (1) of this regulation. As a condition precedent for professional dues to be recognized as allowable costs, the professional association must file with the department not later than March 31 of each year an annual report for the fiscal year ending December 31 of the prior year setting forth all revenues received and all expenses incurred during such fiscal year.

(i) Exclusion of unallowable costs.

All costs included in the computation of the per diem reimbursement rate must be reasonable and directly related to the provision of services necessary for patient care. In addition to those costs specifically disallowed pursuant to the medicare statutes and regulations as modified by these regulations, items to be excluded from the calculation of the rate shall include but not be limited to:

- (1) duplications of functions or services.

(2) expenditures made for the protection, enhancement, or promotion of a provider's interests.

(3) educational expenditures to colleges or universities for tuition and related costs for owners or employees.

(4) directors' fees.

(5) expenditures made for the personal comfort, convenience or transportation of owners or employees.

(6) travel for purposes of attending conferences or seminars outside of the continental United States. Other out-of-state travel to attend bona fide professional seminars must be limited to no more than one representative from the participating facility and the total dollars expended must meet the medicare definition of reasonableness.

(7) outpatient services, day care services and meals-on-wheels.

(8) costs of residences which are not certified as long term care facilities.

(9) bad debts.

(10) advertising except for help wanted ads.

(11) Expenditures made for salaries, fringe benefits or any type of reimbursement to or for any person who is convicted in any state or federal court of a crime involving fraud in the medicare program or medicaid program or aid to families with dependent children program or state supplement to the federal supplemental security income program or any federal or state energy assistance program or general assistance program and is under a resultant termination or suspension from participation in any of said programs. If such termination or suspension results from a conviction pursuant to Connecticut General Statutes Section 17-83k, such termination or suspension shall be effective with the date of conviction notwithstanding the plea entered prior to conviction.

Costs to be excluded from per diem reimbursement rate determination pursuant to the above should be specifically identified in the appropriate section of the annual report.

(j) Exclusion of costs of legal, accounting and consultant services, and related costs incurred in connection with rehearings, arbitration or judicial proceedings pertaining to the reimbursement rates approved by the commissioner, except that such costs shall be recognized as allowable if the commissioner, the arbitration panel or the court concludes that the facility's request for reimbursement rate adjustment constitutes a valid claim. In such situations, the reasonable aggregate amount of legal, accounting and consultant services, and related costs to be allowed shall be determined by the commissioner.

(k) Disallowance of interest expense except as noted below.

For proprietary facilities, all interest expense on any form of indebtedness shall not be allowed as reimbursable expense, since proprietary facilities are allowed a fair rental allowance for the use of land, buildings, and non-movable equipment and a return on equity pursuant to subsection 12 below for the use of all other assets related to the provision of current patient care.

For non-profit facilities, only interest expense required to obtain necessary working capital shall be allowed as a reimbursable expense, all other interest expense shall be disallowed, since non-profit facilities are allowed a fair rental allowance for the use of land, buildings, and non-movable equipment.

The disallowance of interest expense described in the two preceding paragraphs does not preclude capitalization of interest during the period of construction of a new facility or an addition to an existing facility and the inclusion of such capitalized interest in the cost of construction.

(l) Return on equity.

Proprietary facilities shall be allowed a return on equity which is determined by multiplying the medicare rate of return for the cost year by the average current equity for the cost year and the average non-current equity for the cost year. For facilities which submit an annual report for less than a full year of operation, the return on equity will be adjusted in proportion to the length of the annual report period.

Current equity shall be equal to current assets which are related to current patient care minus current liabilities which are not interest bearing and are not owed to owners or related parties.

Non-current equity shall be equal to non-current assets which are related to current patient care and are not subject to the fair rental value system minus non-current liabilities which are not interest bearing and are not owed to owners or related parties. For some facilities, non-current equity consists of only movable equipment net of depreciation, because other non-current assets are either unrelated to patient care or subject to the fair rental value system, and all non-current liabilities are either interest bearing or are owed to owners or related parties.

For purposes of this section, equity shall not include assets which are not related to current patient care, such as, but not limited to, investments, loans to owners or related parties, marketable securities, cash in excess of average monthly operating requirements (computed by dividing twelve into the annual operating costs related to patient care exclusive of inflation and efficiency adjustments and non-cash items such as, but not limited to, depreciation and amortization), construction-in-progress and monies available for the completion of construction, real property held for future use and goodwill which was not purchased or which was purchased after December 20, 1976. Also, equity shall not include assets which are subject to the fair rental value system, such as, but not limited to, land, buildings, and non-movable equipment since facilities are allowed a fair rental value allowance for the use of such assets.

Since interest is not a reimbursable expense, equity is not reduced by interest-bearing liabilities so that facilities may receive a return on such indebtedness. Also, equity is not reduced by loans from owners or related parties so that facilities receive a return on such indebtedness. The basis for calculating return on equity does not vary whether the facility is fully funded by owners' capital or funded in whole or in part by debt.

All inclusions in, and exclusions from, equity cited in the medicare statutes and regulations which are not discussed above shall be recognized and given full effect in the calculation of equity.

As a minimum, a proprietary facility shall be allowed a return on equity in an amount sufficient to meet the cost of borrowing for working capital needs provided that the working capital loan is one which:

- (1) has a due date no greater than 12 months.
- (2) is payable to a bank or recognized finance company which makes such loans to the general public and is an unrelated entity, and
- (3) is necessary and proper for the current operation and maintenance of the facility as measured by average monthly cash requirements, and is not used for acquisition of fixed assets or for unallowable and non-patient related expenditures.

(m) A limitation of the total allowable costs for each level of care of non-profit long term care facilities.

For non-profit facilities, the aggregate total allowable costs shall not exceed the costs submitted by the provider plus efficiency adjustments, less unallowable costs exclusive of those not required under applicable federal regulations, e.g., inflation and efficiency limitations, salary controls, and the effect of the fair rental value system.

(n) Computation of per diem reimbursement rates for each level of care.

For rate determination purposes, no sub-classifications within levels of care shall be allowed.

(o) The total costs as adjusted by the procedures referred to above divided by the minimum allowable patient days for the applicable cost year.

A patient day is the unit of measurement for lodging provided and services rendered to one inpatient between the census-taking hour on two successive days. In computing patient days, the day of admission shall be counted but the day of discharge shall not. In computing patient days, reserve bed days shall be counted.

For purposes of computing minimum allowable patient days, utilization of a facility's certified beds shall be determined at a minimum of 90% of capacity, except for new facilities and facilities which are certified for additional beds which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure.

(p) An adjustment in the rate for the time lag between the cost period and the rate period.

This adjustment shall be the gross national product (GNP) deflator percentage increase or decrease for the eighteen-month time lag from the cost year ending September 30 to the twelve months ending March 31 of the succeeding rate year. This factor shall be computed annually on or about April 15 preceding computation of annual rates to be effective the following July 1. Because the GNP deflator used in the initial rate calculation is estimated in part, when official quarterly rates are finalized, the rate shall be adjusted, if the absolute difference is more than 5% of the factor and commencing with the July 1, 1984 to June 30, 1985 rate year, if the absolute difference is more than 3 percentage points, with the final adjustment to be made based upon the data available on December 31 following the close of the rate year.

(q) An allowance for real wage growth.

Such allowance shall be predicated upon a factor determined by using a ten-year moving average of the changes in non-manufacturing real wages in Connecticut reported by Chase Econometric Associates, Inc. The ten-year moving average shall extend through the end of the calendar year covered by the annual report used for the determination of the per diem reimbursement rate. The real wage growth allowance is limited to wages paid excluding fringe benefits and applies only to employees paid on an hourly rate basis (excluding salaried employees). Reasonable costs mandated by collective bargaining agreements between the employer and other agreements between the employer and the employees shall be allowed to the extent that such costs are reasonable.

(r) Separate reimbursement for minimum wage increases.

Beginning with the effective date of any legislative action which increases the minimum wage rate for labor, the commissioner shall pay long term care facilities the portion of the resulting increase in wage costs for employees thus affected applicable to medicaid patients and supplemental security income recipients. For this purpose, each provider may submit cost data identifying the wage increase on a quarterly basis in the manner prescribed on such forms provided by the department.

(s) Specified limitations on per diem rates.

(1) per diem rates for facilities caring for recipients under the medicaid program and/or the supplemental security income program shall not exceed the rate of payment for self-pay persons, or the general ceiling for payment for medicare.

(2) per diem rates for homes for the aged and community residences for the mentally retarded shall not be less than the rate determined pursuant to section 17-311-54.

(t) **Related party principle**

42 C.F.R. Sec. 405.427 is incorporated by reference as a minimum standard and hereby made a part of this regulation.

(u) **Adjustment of rates to provide payment for increased reasonable costs or expenditures necessitated by changes in law.**

(1) If changes in federal or state laws, regulations or standards related to the provision of patient care adopted subsequent to June 30, 1985, results in increased costs or expenditures, the commissioner shall adjust rates and provide payment for any such increased reasonable costs or expenditures within a reasonable period of time retroactive to the date of enforcement. Nothing in this subsection shall be construed to require the department of income maintenance to adjust rates and provide payment for any increases in costs resulting from an inspection of a facility by the department of health services.

(2) Any facility which believes itself qualified for rate adjustment pursuant to subsection (1) above must petition the department of income maintenance on forms to be prescribed by the Department specifying the change in federal or state law, regulation or standard adopted subsequent to June 30, 1985, the exact amount of the increased reasonable cost or expenditure incurred to comply with such change in law, and the exact identity of the added staffing, goods or services utilized to come into compliance.

(v) **Nursing Pool Costs.**

(1) For the cost reporting year commencing October 1, 1985, and for subsequent cost reporting years, facilities shall report the cost of using the services of any nursing pool employee by separating said cost into two categories, the portion of the cost equal to the wages of the employee for whom the nursing pool employee is substituting shall be considered a nursing cost and any cost in excess of such wages shall be further divided so that seventy-five percent of the excess cost shall be considered an administrative or general cost and twenty-five percent of the excess cost shall be considered a nursing cost, provided if the total nursing pool costs of a facility for any cost years are equal to or exceed fifteen percent of the total nursing expenditures of the facility for such cost year, no portion of nursing pool costs in excess of fifteen percent shall be classified as administrative or general costs.

(2) Any facility which believes subsection (1) above to be applicable to it must complete the pertinent section of the annual report prescribed by the Department. Failure to complete said section shall result in all nursing expenditures being classified as nursing costs.

(w) **Providers concerning which payment checks are issued directly to patients or residents.**

Concerning all providers whose patients or residents receive payment checks directly from the department (i.e., the beneficiary-resident receives the payment check rather than the provider-vendor), the department is authorized to include as a factor in setting an annual rate any past unallowable costs which resulted in past overpayments so as to recover such past overpayments.

(Effective June 2, 1986)

Sec. 17-311-53. Desk review and field audits

(a) The per diem rate of payment established pursuant to section 17-311-50 et seq. shall be determined by desk review of the submitted annual report which shall subsequently be verified and authenticated by field audit procedures which are approved by the United States Department of Health and Human Services. Facilities shall generally be audited on a biennial basis. This audit cycle may be changed based upon audit experience. A recomputation of rate, based upon field audit adjustments or otherwise, shall be made retroactive to the applicable period. Such retroactive recomputation replaces the originally determined annual Medicaid per diem rate and shall not be construed to constitute a new annual Medicaid per diem rate so as to require the public hearing mandated by Connecticut General Statutes, section 17-314.

(b) Whenever the Commissioner of Income Maintenance renders a rate decision, whether based upon a field audit or otherwise, which decision results in the facility being indebted to the Department of Income Maintenance for past Medicaid overpayments, the department shall recoup said Medicaid overpayments as soon as possible from the department's monthly Medicaid payments to the facility. If the facility submits a rehearing request in compliance with Connecticut General Statutes, section 17-311 (b), the department shall afford the facility a rehearing as soon as practicable after commencement of recoupment of past Medicaid overpayments. Said rehearing request shall not automatically stay the recoupment, which may be stayed in the discretion of the commissioner.

(c) In a recoupment situation, the Department of Income Maintenance shall determine a recoupment schedule of amounts to be recouped from the facility's monthly Medicaid payments after consideration of the following factors:

- (1) The amount of the indebtedness;
- (2) The objective of completion of total recoupment of past Medicaid overpayments as soon as possible;
- (3) The cash flow of the facility; and
- (4) Any other factors brought to the attention of the department by the facility relative to the provider's ability to function after recoupment.

(d) Whenever a facility has received past Medicaid overpayments, the department may recoup the amount of such Medicaid overpayments from the monthly Medicaid payments to the facility regardless of any intervening change in ownership.

(e) A facility may give the commissioner notice of a proposed change in ownership (to include the names and addresses of the proposed buyers) at least nine (9) months before said change in ownership. The department shall then conduct a field audit of the facility and notify both the facility and the prospective buyers of the existence of any indebtedness to the department resulting from past Medicaid overpayments. Following the conclusion of such field audit the department shall determine the recoupment schedule and commence recoupment in accordance with such schedule unless the department, in its discretion agrees to wait until the consummation of the sale. At the time of the consummation of such sale, the seller shall pay in full to the department the total amount of such indebtedness. Failure of the seller to repay at that time will subject the buyer to recoupment as set forth in subsection (d).

(f) If a facility owes money to the department, the department may offset against such indebtedness any liability of the department to another provider which is owned or controlled by the same person or persons who owned or controlled the first facility at the time the indebtedness to the department was incurred. In the case of

the same person or persons owning or controlling two or more facilities but separately incorporating them, whether the person or persons own or control such corporations shall be an issue of fact. Where common ownership or control is found, this subsection shall apply notwithstanding the form of business organization utilized by such persons, e.g. separate corporations, limited partnerships, etc. Findings of common ownership or control does not necessarily require 51% or more ownership or evidence of actual past exercise of control but rather only requires the potential or ability to directly or indirectly exercise influence or control. When the commissioner renders a decision to act pursuant to this subsection, an aggrieved provider which desires to contest the finding of common ownership or control may, within ten days of such decision by the commissioner, obtain, by written request to the commissioner, and administrative hearing within the department on the issue of whether common ownership or control exists. At such an administrative hearing pursuant to this subsection, the department shall have the burden of proof on said issue. For purposes of this subsection only, when an aggrieved provider submits a timely request for administrative hearing as aforesaid, an automatic stay of offset against payments to the second facility pursuant to this subsection shall enter and remain in effect until the department issues its administrative final decision concluding the aforesaid administrative hearing on the issue of whether common ownership or control exists.

(Effective June 2, 1986)

Sec. 17-311-54. Optional rate determination

Homes for the aged and community residences for the mentally retarded shall have the option of complying with section 17-311-50 of the regulations which requires the annual reports and cost data be provided for individual rate determination for each facility or acceptance of the per diem rate determined as explained below. The election to have an individual rate computed shall necessitate the filing of the annual report.

The rate for the year beginning July 1, 1982 for homes for the aged and community residences for the mentally retarded which do not elect to have an individual per diem rate computed shall be predicated on the rate authorized for providers with 10 or less beds for the prior rate year adjusted prospectively by multiplying it by the quotient derived by dividing the GNP deflator for the upcoming rate year by the GNP deflator for the prior rate year. Thereafter the rate for such facilities shall be computed by multiplying the rate for the prior year by the quotient derived by dividing the GNP deflator for the upcoming rate year by the GNP deflator for the prior rate year.

(Effective March 17, 1983)

Sec. 17-311-55. Interim rates

Newly constructed facilities shall receive an interim per diem rate of payment for each level of care computed on the basis of budgetary data (from CHHCFD-4 new 6/75) submitted to the commissioner.

Newly acquired facilities shall receive an interim per diem rate of payment for each level of care based on the existing rate adjusted to reflect any changes in property values pursuant to section 17-311-57(1). In the event that substantive changes in operation have been affected by the new owners materially changing operating costs, additional adjustments to the existing rates may be made to the extent such changes in operations and related costs are specifically identified and documented by the facility.

An interim per diem rate may be authorized for a facility which has undergone changes in level of care or significant changes in licensed bed capacity mandated

or approved by the department of health services and the commission on hospitals and health care.

An interim per diem rate may be revised by the commissioner at any time based on additional information which may become available to him. The interim rate shall remain in effect until the first of the following occurs:

(a) a per diem rate is computed on the basis of an annual report for a full cost year in which the facility achieved ninety percent (90%) occupancy of its certified beds; or

(b) a per diem rate is computed on the basis of the facility's second annual report for a full cost year.

Interim rates shall be replaced by revised per diem rates computed on the basis of actual costs which are allowable as defined in these regulations, and minimum allowable patient days (ninety percent utilization except as provided in section 17-311-52(15) for the period in which the interim rates were in effect. Proper retroactive adjustments, in favor of the provider or the state, shall be made to all amounts paid on the basis of interim rates.

(Effective March 17, 1983)

Sec. 17-311-56. Record maintenance and retention

Through June 30, 2004, each facility shall maintain all supporting records for the ten (10) most recent cost years without regard to change in ownership. Beginning July 1, 2004, each facility shall maintain all supporting records for the seven (7) most recent cost years without regard to change in ownership. At the discretion of the commissioner, any facility which fails to comply with such requirements may be paid at the lowest rate paid to another facility for the same level of care, or the commissioner may disallow those costs for which appropriate documentation has not been maintained. All facilities shall be required to maintain their books of account on the accrual method of accounting and accurate time records shall be maintained for all persons paid salaries or wages. This section does not affect the independent requirement that any medical records must be maintained for the length of time specified in section 19-13-D8t(o) of the Regulations of Connecticut State Agencies.

(Effective March 17, 1983; amended March 1, 2002)

Sec. 17-311-57. Hardship appeals

The commissioner shall consider requests for rate revisions due to hardship for any of the following reasons:

(a) A sale of a facility is contemplated because of the death of the principal owner of a facility, or the principal owner is unable to conduct any business activities due to documented health disability or to advanced age i.e., not less than 65 years. For purposes of these regulations, a principal owner is defined as an individual proprietor or the individual(s) owning the controlling equity in a partnership or corporation.

For those sales which result from the factors mentioned in the preceding paragraph, the property basis used in the application of the fair rental value system, may under certain circumstances be increased as a result of a sale of equity interest in a facility. Sales of partial interests and sales to individuals who are partners or shareholders with the seller in the facility subject to sale or any other long term care facility generally will not provide a basis for property valuation adjustment.

To enable the state to consider a claim for an adjustment in the property basis, the seller must petition the commissioner setting forth all of the pertinent facts of such sale. The commissioner shall examine the transaction and may consider factors

such as the following in reaching a decision as to whether and in what amount the property basis may be adjusted.

- (1) the reasonableness of the selling price.
- (2) the arms-length relationships between the buyer, seller and mortgage lender.
- (3) the cost of the property recorded by the seller and the effect thereon of inflationary cost increases as measured by recognized price indices such as the dodge building cost index and the implicit price deflator for the gross national product.
- (4) the extent to which depreciation and amortization of the assets covered by the sale needs to be adjusted to reflect the inflationary cost increases determined pursuant to (3) above.
- (5) the degree of financing by the seller in relation to the total selling price of the property.

Based on consideration of the foregoing and any other factors as the commissioner deems pertinent, the commissioner may decide that an adjustment in property basis is appropriate, equitable and does not prejudice the interests of the state.

No portion of the purchase price of any facility shall be recognized as purchased goodwill includable in the base for computation of return on equity.

In computing the fair rental value allowance for the revised value of the property, the remaining useful life of the property shall be the greater of:

- (1) the remaining useful life of the principal buildings purchased; or
- (2) longest term of any mortgage on the property.

Once the sale is effectuated, the commissioner must be notified whether the buyer or seller shall be held financially liable for future assets or the liabilities due to rate adjustments not known at the time of the sale. Failure to submit this information at the time of the sale may result in the commissioner not promulgating an interim rate for the new owner.

(b) A facility is unable to meet its debt service obligations to banks and other recognized financing institutions because of the insufficiency of the property fair rental value allowance included in the per diem reimbursement rate. If an adjustment in the rate is requested on this basis, the provider must petition the commissioner for an adjustment and set forth all the pertinent facts for the commissioner's consideration. The commissioner shall examine the following and such other factors as he deems appropriate in reaching a decision as to whether and in what amount the per diem rate may be adjusted.

(1) the financial status of the facility must be considered exclusive of any transactions which are not recognized as allowable for rate computation under these regulations.

(2) The mortgage terms and amount must be reasonable in relation to the useful life and carrying amount of the property of the facility used for patient care, provided that the proceeds of refinancing are devoted to patient care.

(3) The mortgage transactions must have been entered into prior to December 20, 1976.

(c) (1) The commissioner receives an affidavit executed by the appropriate official of the facility swearing that the facility had filed for hardship relief pursuant to Emergency Regulation 17-311-82 (e) dated July 6, 1982. In this event the commissioner shall continue the payments authorized pursuant to the Emergency Regulation through June 30, 1983. In the event that the commissioner learns through audit or by notification of the trustees of the pension plan or otherwise that the money so provided has not been used to make the promised contributions to the pension plan

the facility agrees to the automatic recoupment of the amount paid out by the commissioner pursuant to this subsection without a hearing; or

(2) The commissioner receives an affidavit executed by the appropriate official of the facility swearing that:

(A) The facility has entered into a legally enforceable agreement with its employees and less than twelve (12) months of the pension costs thereof were reflected in the current medicaid rate.

(B) The terms of the agreement include a provision that the facility must make payments to a qualified pension plan governed by ERISA.

(C) The actual payment of the contribution to the pension plan threatens the economic viability of the facility.

(D) Any funds received as a result of the increase in the rate granted by the commissioner as a result of the operation of this subsection will go exclusively toward the payment of the contribution to the qualified pension plan, and

(E) In the event that the commissioner learns through audit or by notification of the trustees of the pension plan or otherwise that the funds so provided have not been used to make the promised contributions to the pension plan the facility agrees to the automatic recoupment of the amount paid out by the commissioner pursuant to this subsection without a hearing.

(3) Upon examination of the above information and consideration of any other factors which he deems pertinent, the commissioner may grant an increase to the current medicaid rate which is the lesser of:

(A) The projected costs of the actual contribution to the pension plan to be incurred for the current medicaid rate year divided by estimated actual and imputed patient days for the medicaid rate year or,

(B) the dollar amount, for the portion of the current medicaid year for which contribution to the pension plan are made, produced by multiplying the facility's projected gross wages by the percentage listed in the most recent Chamber of Commerce of the United States study entitled Employee Benefits for "Pension plan premium and pension payments not covered by insurance-type plan (net)" for hospitals in the chart listing "Employee Benefits as Percent of Payroll," divided by estimated actual and imputed patient days for the current medicaid rate year. The commissioner may, if he deems appropriate, increase the percentage listed therein by the Implicit Price Deflator for the Gross National Product for the period since the study. This subsection shall not be construed to authorize any immediate reimbursement of pension costs which are already reimbursed in the facility's existing medicaid rate.

(C) in the event that the Annual Report of Long Term Care Facility reflects only part of the first year of pension costs, the facility may apply for hardship relief for the unreported portion of said pension costs pursuant to this subsection.

In the event that the Annual Report of Long Term Care Facility reflects twelve (12) months pension costs, the facility shall be ineligible for hardship rate relief pursuant to this subsection.

(4) A facility or a portion of a facility (provided that no portion of a facility will be considered for hardship relief unless it is maintained as a distinct part with fifteen beds or more or unless approved by the Department for 10 to 14 beds under the provisions of subsection (4) (a) (4)) is either providing or proposing to provide care for traumatic brain injury (hereinafter TBI) patients who require extensive care but not acute general hospital care as defined below and seeks a separate TBI rate.

(a) Availability of hardship rate relief for facilities serving traumatically brain injured patients

A chronic and convalescent nursing facility, or a distinct part of a facility, either providing or proposing to provide care for TBI patients who require extensive care but not acute general hospital care may be granted hardship rate relief, at the discretion of the Commissioner of Income Maintenance (provided that no portion of a facility will be considered for hardship relief unless it is maintained as a distinct part with fifteen beds or more or unless approved by the Department for 10 to 14 beds under the provisions of subsection (4) (a) (4)), if such a facility demonstrates that it would suffer financial hardship if not granted rate relief and if the facility meets the requirements for the granting of TBI hardship relief.

For purposes of this Section TBI is any combination of focal and diffuse central nervous system dysfunction, both immediate and delayed, occurring at the brain stem level and above, which results from the interaction of any single or repetitive external force and the body.

In determining whether to grant in whole or part or to deny the request for hardship rate relief for a TBI facility, the Commissioner may consider factors including, but not limited to, the following:

(1) The hardship caused by not having a separate TBI rate calculated for the facility. Each applicant shall file all financial records which the Commissioner, in his discretion, deems necessary to enable the Commissioner to determine if a financial hardship exists or will exist absent the granting of TBI hardship rate relief.

(2) Cost. Each applicant shall file all necessary budgetary data to enable the Commissioner to determine how much the proposed services will cost in excess of the current costs of the facility.

(3) Program Services to be Provided. Each applicant must provide a detailed proposal setting forth specifically what program services will be provided, the quantity of such services, personnel qualifications (specifying the nature of the training and experience of each person providing program services) and the level or levels of TBI patient, using the "Rancho" Scale of Levels of Cognitive Functioning, developed by the Adult Head Trauma Service of Rancho Los Amigos Hospital (hereinafter the "Rancho" scale) for which the services will be appropriate. The proposal must demonstrate that the program requirements set forth in Subsection (c) below will be met and how they will be met.

(4) The Size of the Proposed Unit. Unless granted an exception as provided for below, no unit can be considered for hardship relief unless it is a free standing facility or a distinct part of an existing facility with said distinct part made up of at least fifteen (15) beds. Units with fewer than fifteen (15) beds, but made up of at least ten (10) beds may be approved when it can be shown that the unit will not be more costly than comparable units of fifteen (15) beds or more and that the operation of a larger unit would not be in the best interest of the patients.

(5) Proposed timetable for occupancy of a TBI Unit by TBI patients. Applicant must submit a schedule which details by month, the number of TBI patients and the number of geriatric patients by source of payor that will occupy the distinct part unit. The period of time for which this schedule must be produced is from the date that the first TBI patient is admitted to the date that the unit is fully occupied by TBI patients.

(6) Geographical Location.

(7) The experience of the provider in caring for TBI patients and the experience of the personnel proposed to be utilized in providing the care to the TBI patients.

(8) The number of beds for which TBI hardship relief has already been granted in the same general geographical area.

(9) Any other factors which the Commissioner deems appropriate to consider.

In order to permit the Commissioner to consider an application for TBI hardship rate relief, the applicant shall submit an affidavit sworn to under oath which includes:

(A) the items listed in 1 through 6 above and any other information requested by the Commissioner,

(B) a statement that any funds received as a result of the operation of this subsection will be spent exclusively on the TBI patients and

(C) a statement that in the event that the Commissioner learns through audit or otherwise that the funds so provided have not been used on the TBI patients, the facility agrees to the automatic recoupment of the amount paid out by the Commissioner pursuant to this subsection prior to a hearing.

(b) Effect of granting hardship relief

The Commissioner, at his discretion, may grant in whole or in part an application for hardship rate relief upon terms he deems appropriate, equitable and in the best interest of the State or he may deny an application for hardship rate relief. If TBI hardship rate relief is granted, the efficiency limitation set forth in Section 17-311-52 (4), which controls allowable costs at 150 percent of the median of chronic and convalescent nursing facilities, and the inflation cost limitation provided for in Section 17-311-52 (3) shall not apply to the TBI facility or the TBI portion of the facility.

(1) In the event that the Commissioner grants hardship rate relief, an interim TBI rate will be established. In computing the interim rate, the Department will determine the total cost of the TBI unit and deduct the expected revenue from the other patients who will occupy this unit as determined by the cost proposal and the schedule of occupancy required above. The expected revenue to be deducted will be computed by multiplying the number of days in the TBI unit occupied by non-TBI patients by the prevailing Connecticut Medicaid rate. The resultant amount will be divided by the estimated TBI days and the quotient derived therefrom will be the interim TBI rate. The interim rate will be replaced annually or may be replaced at any time by the Commissioner at his discretion when new information is made available to the Department. Revised interim TBI rates will be determined by dividing the reasonable costs of caring for TBI patients as reported in the Annual Report of Long-Term Care Facility by the number of actual TBI days. Interim TBI rates will be replaced by per diem rates computed on the basis of the reasonable costs incurred in caring for TBI patients for the period in which the interim rates were in effect. The Annual Report of Long-Term Care Facility for the appropriate year ending September 30 will be utilized to report the necessary data and must be filed annually by December 31. Proper retroactive adjustments in favor of the provider or the State shall be made to all amounts paid on an interim basis.

After a period of not more than three years from the effective date of these regulations, the Department will analyze the costs incurred in caring for TBI patients and determine what limitations, if any, will be placed on subsequent TBI rates.

(2) For purposes of calculating a separate TBI rate, whether interim or final, a facility that has been granted a special TBI rate for a distinct part shall allocate its costs to the distinct part as if the distinct part were licensed as a separate level of care.

(3) The purpose of granting TBI hardship rate relief is to provide care to TBI patients. Therefore, any funds received as a result of the operation of this subsection must be spent exclusively for care of the TBI patients and in the event that the

Commissioner learns through audit or otherwise that the funds so provided have not been used on the TBI patients, the facility agrees to the automatic recoupment of the amount paid out by the Commissioner pursuant to this subsection prior to a hearing.

(c) Availability of hardship TBI rate relief

(1) In order to be considered for hardship TBI rate relief, a chronic and convalescent nursing facility applying for such rate relief must comply with applicable state licensure and federal skilled nursing certification requirements for the provision of nursing home care. In addition, the facility must demonstrate:

(A) that the facility has been granted approval by the Commission on Hospitals and Health Care, pursuant to the provisions of Connecticut General Statutes Section 19a-154, to devote the facility, or distinct part of the facility, to providing services on behalf of traumatically brain injured patients. The extent of any hardship rate relief granted pursuant to this section will be limited to any conditions contained in any ruling of the Commission, including any order limiting the number of beds which may be devoted to the care of traumatically brain injured patients. In order to be considered for hardship rate relief, any distinct part of a facility must contain at least 15 beds devoted to the care of TBI patients, unless approved by the Department for 10 to 14 beds under the provisions of subsection (4) (a) (4).

(B) that the facility has adopted policies, and is prepared to implement its policies, governing the provision of nursing care, related medical care including physician services, and rehabilitative services, which reflect awareness of and provision for meeting the special medical and rehabilitative needs of TBI patients. Where TBI hardship rate relief is requested for a distinct part of the facility, the facility must adopt and implement separate policies for the distinct part serving TBI patients. The medical records of the facility must reflect that patient care is being provided TBI patients in accordance with the facility's patient care policies.

(C) that the facility's policies reflect awareness of modern practices of rehabilitative medicine, including the provision of rehabilitative services through an interdisciplinary process. Interdisciplinary teams must be staffed to properly assess and plan for the needs of each individual patient, including at a minimum, a physician, a nurse experienced in providing rehabilitative nursing and skilled nursing services, and a physical therapist, occupational therapist and/or a speech therapist or other professionals depending on the needs of the TBI patient. Notwithstanding the requirement that rehabilitative services be provided through an interdisciplinary process, the facility is obligated to comply with state licensure and federal certification requirements that require that rehabilitative services be provided pursuant to a physician's order.

(D) that the facility's policies grant priority for admission wherever practicable to TBI patients who require extensive nursing or rehabilitative services or to TBI patients who are difficult to place in nursing facilities. For purposes of this regulation, the TBI patients requiring extensive nursing or rehabilitative services means patients requiring the provision of at least two skilled nursing or rehabilitative (physical therapy, occupational therapy, speech therapy) services daily. Daily means seven days a week for skilled nursing services and five days a week for rehabilitation services. TBI patients who are difficult to place in nursing facilities include patients in coma, patients on ventilators and patients exhibiting behavioral disturbances. Any admission policy adopted by a facility serving TBI patients must refer to the "Rancho" scale in describing the type of TBI patients who may be admitted to the facility, or distinct part of a facility, granted TBI hardship rate relief.

(E) that the facility adopt and implement policies requiring that TBI patients be provided cognitive remediation service by occupational therapists, speech pathologists or consulting psychologists, as determined by the interdisciplinary team and pursuant to a physician's order.

(F) that the facility adopt and implement policies requiring that comatose TBI patients receive coma arousal services in conformity with current professional opinion pursuant to a determination of the interdisciplinary team and a physician's order. The facility must furthermore adopt and implement policies requiring and demonstrating how comatose patients will be protected from harm from others, including behaviorally active clients.

(G) that the facility has adopted and implements discharge policies which provide for the discharge of TBI patients from the facility, or distinct part of the facility, when the TBI patient no longer requires the intensity of skilled nursing or rehabilitative services which required the granting of hardship rate relief to the facility. The required discharge policies may allow for transfer of the patient from a distinct part of the facility (granted hardship rate relief under this section) to a bed in the facility that is not subject to the rate relief granted by this section. Any discharge of a TBI patient must comply with the applicable state licensure and federal certification requirements.

(H) that the facility has adopted and implements policies which require that the TBI patient's rehabilitative progress be periodically monitored and objectively assessed. The rehabilitation plan must be amended as necessary. The facility's policies must provide that failure of the TBI patient to make reasonable progress in his rehabilitation plan shall be grounds for his discharge from the facility, or a distinct part of the facility granted hardship rate relief, unless the patient requires intense skilled nursing care or presents major behavioral disturbances which preclude his discharge from the facility. The TBI patient may be readmitted to the facility if he subsequently shows progress in rehabilitation such that the provision of intensive rehabilitative services is indicated.

(I) that the facility has made arrangements with physicians experienced in providing care to TBI patients, e.g., specialists in rehabilitation medicine or physical medicine, to provide for the medical and rehabilitative needs of TBI patients. In addition, the facility must demonstrate that it has arrangements with specialty consulting physicians, depending on the needs of the patients, e.g., neurosurgeons, neurologists, pulmonary disease specialists, urologists and infectious disease specialists.

(J) that the facility has retained sufficient rehabilitative professionals, i.e., physical therapists, occupational therapists, and speech therapists, to meet the rehabilitative needs of the TBI patients. Physical therapists, occupational therapists and speech therapists must have prior experience working with TBI patients or working with patients with similar treatment needs.

(K) that sufficient and appropriate space outside of the patient's bedroom, is available to conduct rehabilitative services.

(L) that the facility has arranged for the provision of consulting psychological services for TBI patients. As an exception to the Departmental policies that otherwise applies to the provision of psychological services on behalf of skilled and intermediate care facility residents, the psychological services required by this subsection may be provided at the facility; however, the cost of such psychological services must be reported on the facility's annual cost report and Title XIX reimbursement for the cost of such services must be claimed exclusively through the facility's per

diem rate instead of by a direct charge by the psychologist to the Department for ancillary psychological services.

(2) A chronic and convalescent nursing facility that is dually certified as both a skilled nursing and intermediate care facility may apply for hardship rate relief for TBI patients requiring intermediate care services. In order for hardship rate relief to apply to TBI patients requiring intermediate care services, the facility must demonstrate:

(A) that the facility complies with applicable state licensure and federal intermediate care certification requirements.

(B) that the facility has adopted and implements policies that reflect awareness of any provision for meeting the needs of TBI patients requiring the intermediate care facility level of services through the use of community services, depending on the needs of such patients. Referrals to such providers as the Division of Vocational Rehabilitation of the Department of Education for vocational rehabilitation services, to community sheltered workshops, to community-based rehabilitation clinics or to community-based day treatment programs must be made depending on the patient's need for such services. The facility must assist the TBI patient in seeking reimbursement for the cost of community services through any available source of payment.

(C) that the facility has adopted and implements admission and discharge policies which provide for the discharge of, or the refusal to admit TBI patients requiring the intermediate care facility level of services unless the TBI intermediate care patient requires the intensity of staff services available as a result of the granting of hardship rate relief to the facility, either because of behavioral disturbances or the need for intense but not skilled rehabilitative services. TBI patients requiring daily rehabilitative services should properly be classified as in need of skilled nursing facility services.

(d) Maintenance of TBI hardship rate relief

(1) As provided in these regulations, the granting of hardship rate relief is discretionary with the Commissioner of Income Maintenance. The Commissioner of Income Maintenance may not exercise his discretion unless the facility, at a minimum, fulfills the requirements of subsection (c) above. Once hardship rate relief is granted, the efficiency limitation of Section 17-311-52 (4) and the inflation cost limitation contained in 17-311-52 (3) shall not apply to the TBI facility or the TBI portion of the facility, provided that the Commissioner does not exercise his discretion by revoking the TBI hardship rate relief granted pursuant to this regulation.

(2) The Commissioner may exercise his discretion and revoke any TBI hardship rate relief for any reason which he deems appropriate, including but not limited to, his finding that the granting of hardship rate relief is not equitable or in the best interests of the State. Noncompliance with applicable state licensure or federal certification requirements shall be cause to revoke TBI hardship rate relief, provided that the facility has had an opportunity to correct said deficiencies and has not done so to the satisfaction of the Commissioner. The retention by the facility of its license or its federal medical certification will not constitute a reason not to revoke hardship rate relief under this section if the Commissioner finds that the facility contains deficiencies which have not been corrected. Noncompliance with the requirements of subsection (c) pertaining to specialized TBI care shall also be cause for the Commissioner to revoke hardship TBI rate relief. Violation of the nondiscrimination provisions set forth in subsection (f) below shall be cause to revoke TBI hardship rate relief. Use of the funds received pursuant to this TBI hardship rate relief provision, other than on the TBI patients shall be cause to revoke TBI hardship rate

relief. This list of causes for revocation is not intended to be all inclusive of reasons for revocation.

Any such revocation of hardship relief shall be effective upon whatever date the Commissioner deems appropriate, equitable and in the best interest of the State.

In revoking TBI hardship rate relief, the Commissioner may rely on any information he deems reliable including but not limited to, findings by the health inspection agency pertaining to state licensure or federal certification and findings of the patient review teams of the Department of Income Maintenance.

(3) The Commissioner shall notify the facility of the denial or revocation of TBI hardship rate relief and the effective date of any revocation. If the facility submits a request for a hearing in compliance with section 17-311 (b) of the Connecticut General Statutes, the Department shall afford the facility a hearing as soon as practicable. Said hearing request shall not automatically stay a revocation, and/or any recoupment, which may be stayed in the discretion of the Commissioner.

(4) Given the discretionary nature of both the granting and the revocation of TBI hardship rate relief and the nature of the relief modifying the rate reimbursement system applied to the other long term care facilities throughout the state, the Commissioner's exercise of discretion modifying, denying or revoking TBI hardship rate relief may be overturned only when the facility has shown by clear and convincing evidence that the Commissioner's decision is arbitrary, capricious or a clearly unwarranted exercise of discretion.

(e) Prior authorization requirements

(1) Any TBI recipient of medical assistance under Part IV of Chapter 302 of the General Statutes must receive the prior authorization of the Department of Income Maintenance prior to his admission to a facility, or distinct part of a facility, granted hardship rate relief under this section. Any individual who was not eligible for medical assistance at the time of admission to such a facility but who subsequently becomes eligible for medical assistance, must receive the prior authorization for such care before a request is made for payment for the cost of such care. Unless prior authorization has been granted, medical assistance for the cost of care provided by the facility will not be paid by the Department of Income Maintenance.

(2) In order to be granted prior authorization for Title XIX payment for the cost of skilled nursing facility services, the TBI applicant must establish not only that he is eligible for the level of care requested but also establish that he requires the intensity of skilled nursing or rehabilitative services required for facilities granted hardship rate relief under this section.

(3) TBI patients requiring intermediate care facility services generally do not require the intensity of services made available by the granting of TBI hardship rate relief. A TBI recipient of medical assistance requiring intermediate care services, who requests prior authorization for Title XIX payment for the cost of care provided by the facility must demonstrate that the required services could not otherwise be provided to the applicant and that the intensity of nursing (including direct care) or rehabilitative services required by the applicant justifies placement in a facility granted TBI hardship rate relief.

(4) Any prior authorization for the cost of care provided by a facility granted hardship rate relief will be limited to no more than six months. Subsequent prior authorizations may be granted for succeeding six month periods provided that the TBI patient demonstrates that he continues to require the intensity of services provided by the facility granted TBI hardship rate relief under this section and that the TBI patient demonstrates sufficient progress to warrant continued placement in a facility granted TBI hardship rate relief.

(5) Prior authorization may be granted for no more than 30 days for Administratively Necessary Days in accordance with the provisions of subsection (f) below.

(f) Administratively necessary days

Administratively Necessary Days are TBI unit days reimbursed by Medicaid for services to a Title XIX eligible patient and to a patient who will eventually be determined eligible. A patient qualifying for ANDs does not require TBI level-of-care. Instead, the patient requires medical services at the skilled nursing or intermediate level-of-care. The patient is forced to remain in the TBI unit because the appropriate medical level-of-care placement in the skilled nursing or intermediate care facility is not available.

If given prior authorization in accordance with subsection (e) above, TBI ANDs will be paid at the TBI rate for up to a maximum of thirty (30) days when the following procedures and conditions are met:

(1) The Medicaid patient is no longer at the acute care level of service but is at a skilled nursing level-of-care or at an intermediate level-of-care;

(2) Discharge to a skilled nursing or intermediate level-of-care bed is impossible due to the unavailability of a bed;

(3) The patient's timely discharge and placement to an appropriate skilled nursing or intermediate care bed is planned and arranged by the facility. Clear evidence of this active and continuous transfer or discharge process is documented in the patient's hospital medical record.

(g) Nondiscrimination

Any facility applying for TBI hardship rate relief or to which TBI hardship rate relief has been granted which receives payments pursuant to the Connecticut Title XIX program must abide by the requirements of Section 19a-533 and 19a-550 of the Connecticut General Statutes and the regulations promulgated thereunder with respect to admission and continuation of stay in the TBI facility or the distinct part of the facility. Violation of said provisions shall be grounds not only for the sanctions imposed therein, but the Commissioner, on this basis alone or in conjunction with other reasons, may modify, deny or revoke TBI hardship relief.

(h) Advisory committee

The Commissioner shall establish an advisory committee of at least a neuropsychiatrist, a rehabilitation nurse with TBI experience, a psychiatrist and a consumer advocate, who shall provide advice and recommendation to the Department in the following areas:

(1) Upon review of the application as specified in this section, the granting or denial of rate relief to the applicant who has applied to the commissioner for rate relief in order to provide services to TBI patients.

(2) The consideration of regulatory or procedural changes which would improve the services provided to TBI patients under this section.

(3) As brought to the committee's attention by the Department, medical opinion about the appropriateness of admission or continued stay of a TBI patient in a bed which has been granted rate relief under this section.

(i) Other provisions

Except as specifically provided in this hardship provision, all other State and Federal statutes and regulations concerning long term care facilities apply to TBI units and patients.

(Effective March 3, 1987)

Sec. 17-311-58.

Repealed, March 17, 1983.

Sec. 17-311-58a. Calculated rates

The rates that were calculated and paid for the rate year commencing July 1, 1983, and calculated and to be paid for the rate year commencing July 1, 1984, which were calculated, based on the skilled nursing facility and intermediate care facility levels of care designations, shall be deemed to have been set based on the State licensure levels of chronic and convalescent home and rest home with nursing supervision, respectively.

(Effective December 19, 1984)

Sec. 17-311-59.

Repealed, March 17, 1983.

Sec. 17-311-59a. Facility beds licensed as

All facility beds licensed as chronic and convalescent nursing home beds by the Connecticut Department of Health Services (“DHS”) pursuant to Sections 19a-493 of the Connecticut General Statutes and 19-13-D8t of the Regulations of Connecticut State Agencies and certified by DHS and HCFA pursuant to the Medicaid program (Title XIX) solely as skilled nursing facility beds prior to the effective date of this regulation, which subsequent to the effective date of this regulation receive an additional or dual certification as intermediate care beds, shall continue to be reimbursed by the DIM pursuant to the provisions of the regulations formerly applicable to skilled nursing facility beds.

(Effective December 19, 1984)

Sec. 17-311-60.

Repealed, March 17, 1983.

Cost Related Reimbursement System for Long-Term Care Facilities

Sec. 17-311-60a. Definitions

The following terms are defined pursuant to Section 17-314 (b), of the Connecticut General Statutes.

(a) “Other allowable services” are defined as those services provided by the types of providers listed below to the extent that the cost of said services are not included in the calculation of the per diem rate of the facility.

- (1) Physicians
- (2) Dentists
- (3) Other practitioners (e.g., podiatrists, and optometrists)
- (4) Laboratories
- (5) Pharmacies
- (6) Physical therapists, speech therapists and occupational therapists
- (7) Providers of transportation to other medical services
- (8) Other medical services except for nursing facility and inpatient hospital care

(b) “Out-of-state per patient day Medicaid rate” is defined as that rate paid by the other state for routine patient care plus any additional amounts paid for by the other state.

(c) A “state” is defined as any state, commonwealth, territory, district or other governmental entity participating in the Medicaid program.

(Effective December 5, 1986)

Sec. 17-311-61.

Repealed, March 17, 1983.

Sec. 17-311-61a. Rate adjustments for charges in excess of reasonable and necessary costs for other allowable services

Pursuant to Section 17-314 (c):

(a) No facility shall accept payment for other allowable services, as defined in Section 17-311-60a, provided by the facility in excess of the rate set by the Commissioner of the Department of Income Maintenance pursuant to paragraph (c) below.

(b) Any facility which accepts payment over the reasonable and necessary costs as determined in accordance with subsection (c) below for other allowable services from any state, as defined in Section 17-311-60a, shall be subject to recovery actions as defined in Connecticut General Statutes 17-314 (d) and subsection (d) below.

(c) Reasonable and necessary costs per patient day for other allowable services, which services are defined in Section 17-311-60a, shall be calculated by multiplying the statewide average costs for other allowable services for Connecticut Medicaid patients for the cost year October 1 through September 30 preceding the rate year by the implicit price deflator for the gross national product for the current cost year divided by the implicit price deflator for the gross national product for the prior cost year and dividing by the number of Connecticut Medicaid patient days. The Commissioner shall notify the facility of the reasonable and necessary costs, per patient day, for other allowable services annually effective July 1.

(d) Any amount received for other allowable services in excess of the reasonable and necessary costs of the other allowable services provided by the facility shall be deducted from the allowable costs of the facility for routine care, as defined in Section 17-311-50 *et seq.*, of the Regulations of Connecticut State Agencies, as follows:

From the facility's out-of-state Medicaid rates shall be deducted the facility's Connecticut Medicaid per diem rate and the statewide average cost per patient day for other allowable services as determined pursuant to subsection (c) above. The result of the computation shall be multiplied by the out-of-state patient days and the product derived therefrom shall be deducted from the facility's allowable costs as defined in Section 17-311-50 *et seq.*, of the Regulations of Connecticut State Agencies.

(e) The facility shall provide the Department with the following information annually with the Annual Report of Long-Term Care Facility:

(1) The out-of-state Medicaid rate(s) applicable to the cost period and the corresponding out-of-state Medicaid patient days by month; and

(2) The Connecticut Medicaid rate(s) applicable to the cost period and the corresponding Connecticut Medicaid patient days by month.

(f) In the event that any facility fails to provide the information requested in (e) of this section, the Commissioner shall make the computation set forth in (d) of this subsection based upon the revenue and patient day sections of the Annual Report of Long Term Care Facility submitted by the facility for the appropriate cost period.

(Effective December 5, 1986)

Sec. 17-311-62.

Repealed, March 17, 1983.

Sec. 17-311-62a. Rate adjustments for facilities subject to the provisions of section 17-314 (e) of the Connecticut general statutes

(a) "Available beds" are defined as the average number of beds occupied by medical assistance patients from this State and the average number of beds that are empty. Available beds are determined as follows:

Multiply certified beds reported in Annual Report of Long Term Care Facility by 365. Subtract from this product the total patient days reported in the Annual Report. To this number add the patient days for Connecticut Medicaid patients. Dividing this sum by 365 will result in the available beds.

(b) "Required number" is defined as the average number of beds occupied by medical assistance patients from this State during the period October 1, 1980 through September 30, 1981 and is determined by dividing the number of Medicaid patient days reported in the Annual Report of Long Term Care Facility for the cost year 1981 by three hundred sixty-five.

(c) Any facility subject to the provisions of Section 17-314 (e) of the Connecticut General Statutes, which as of the effective date of these regulations has less beds available to medical assistance patients from this State than the required number shall petition the Department stating the number of beds available in the facility as of the effective date of the regulations.

(d) If at any time after the effective date of these regulations said facility has fewer available beds than the required number, such facility shall actively solicit Connecticut Medicaid patients for admission by advising out-placement directors at referring hospitals of available vacancies and by accepting referrals of Connecticut Medicaid patients from the Department.

(e) If the average number of available beds in any such facility for the cost year falls below the required number, the provisions of subsections (c) and (d) of Section 17-314 and the regulations promulgated pursuant thereto shall apply. The excess amount shall be determined by multiplying the number of available beds less than the required number by the amount received for other allowable services in excess of the rate approved by the Commissioner and multiplying this product by 365. This amount shall be deducted from the allowable costs establishing rates for the rate period covered by the Annual Report in which the available beds were less than the required number.

(Effective December 5, 1986)

Secs. 17-311-63—17-311-90.

Repealed, March 17, 1983.

Secs. 17-311-91—17-311-100. Reserved

Part IV

Relating to Rules of Practice for the Arbitration of Items of Aggrievement on Rates Determined Pursuant to Section 17-311 through Section 17-314

Sec. 17-311-101. Objective of proceedings

The objective of the rehearing and arbitration proceedings of Sec. 17-311 is to provide a means for the expeditious disposition of disputes relating to rates established by the commissioner for any provider pursuant to his authority under Sec. 17-312 to 17-314 inclusive and the regulations promulgated thereunder.

(Effective June 2, 1986)

Sec. 17-311-102. Designation of tribunal

The arbitration tribunal established according to the procedures set forth in Section 17-311 and the regulations promulgated thereunder, to adjudicate the above disputes, shall be termed the "arbitration tribunal."

(Effective June 2, 1986)

Sec. 17-311-103. Administration

The administration of the arbitration proceedings shall be conducted jointly by the office of the chief court administrator and the clerk of the superior court of the judicial district wherein the state referee who is to serve as an arbitrator has his office and chambers. Requests for arbitration, all correspondence and any other papers or process necessary or proper for the initiation of continuation of an arbitration under these regulations and for any court action therewith or for the entry of judgment on an award made thereunder shall be served, in addition to the commissioner and the provider, on the chief court administrator, the state referee participating as the third arbitrator, and the office of the clerk of the superior court for the judicial district where the state referee has his chambers. All papers, process or notices to the commissioner shall be mailed to by certified mail or served upon the commissioner at 110 Bartholomew Avenue, Hartford, Connecticut.

(Effective June 2, 1986)

I. Rehearings**Sec. 17-311-104. Rehearing procedure**

Any provider to which payments are made by the commissioner pursuant to Sec. 17-312 to 17-314 inclusive, which is aggrieved by any decision of the commissioner, may, within ten days after written notice thereof from the Committee, obtain, by written request to the commissioner, a rehearing on all items of aggrievement. The request for a rehearing shall be accompanied by a detailed statement outlining the items of aggrievement. The commissioner shall, upon the receipt of all papers and documents necessary to determine and evaluate said request, conduct such a rehearing as soon as practicable after the receipt of the same.

(Effective June 2, 1986)

Sec. 17-311-105. Conduct of rehearing

The rehearing shall be deemed a contested case, which means a proceeding in the commissioner's disposition of matters delegated to his jurisdiction by law, in which the legal rights, duties or privileges of the party are determined by the commissioner after an opportunity for a hearing. The definition stated in Section 4-166 (2) of the General Statutes shall further define this term, and all other regulations of the commissioner as appear in the commissioner's description of organization and rules of practice, i.e. Sec. 17-311-27 et seq. shall govern the rehearing procedure. Pursuant to the authority vested in him by Section 17-2, the commissioner may delegate to any deputy, assistant, investigator or supervisor the power to serve as hearing officer or presiding officer and to issue directly the final decision of the department containing findings of fact, conclusions of law and an order. In the alternative, the commissioner may himself preside at the rehearing and issue directly final decision. In the alternative, the commissioner may designate any person to serve as hearing officer or presiding officer and then to submit a proposal for decision to the commissioner pursuant to section 4-179. At such rehearing official notice may be taken of any records maintained in the files of the department, and

the hearing officer or presiding officer is authorized to have the assistance of members or representatives of the agency including but not limited to legal and accounting advisors.

(Effective March 28, 1990)

Sec. 17-311-106. The decision on rehearing

The commissioner shall render his decision in writing, in accordance with the contested case provisions of Chapter 54 of the General Statutes and regulations referred to above within ninety days of close of the proceedings, or after thirty days after the receipt of any data the close of the rehearing, the subsequent submission of a late file, the subsequent submission of a memorandum of law, or the receipt of the hearing transcript, whichever is later.

(Effective June 2, 1986)

II. Arbitration Proceedings

Sec. 17-311-107. Commencement of arbitration

In the event that items of aggrievement are not resolved at the rehearing to the satisfaction of both the commissioner and the provider, then said items shall be submitted to binding arbitration to an arbitration board consisting of one member appointed by the provider, one member appointed by the commissioner, and one member appointed by the chief court administrator from among the retired judges of said 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 Sec. 52-434.

(Effective June 2, 1986)

Sec. 17-311-108. Institution of arbitration

Proceedings for arbitration shall be instituted by filing a request for arbitration in the form of a pleading as prescribed by applicable provisions of the Connecticut Practice Book and the Connecticut General Statutes within thirty days after the mailing of the notice of the final decision of the commissioner with respect to the rehearing. Copies of the request for arbitration shall be sent to the chief court administrator, and to the commissioner at the address provided for in these regulations and in the rules of practice of the commissioner.

(Effective June 2, 1986)

Sec. 17-311-109. Position paper of party requesting arbitration; filing of record; memorandum in response

The provider requesting arbitration shall file together with its request for arbitration a memorandum setting forth its position and contentions concerning each of the items of aggrievement which have not been resolved in a satisfactory manner by the decision on the rehearing. Within thirty (30) days of the receipt of such position paper and memorandum, the commissioner shall file the original or a certified copy of the entire record of the rehearing appealed from, which shall include the department's findings of fact and conclusions of law, separately stated. By stipulation of all parties to such appeal proceedings, the record may be shortened. The arbitration board may require or permit subsequent corrections or additions to the record. Within thirty days of the filing of the record, the department shall file its memorandum in response.

(Effective June 2, 1986)

Sec. 17-311-110. Appointment of arbitrators by the parties

Each of the parties shall file the name of the person which the provider and the commissioner has designated as the arbitrator. Each of the parties will file together with the name of the arbitrator a request to the chief court administrator for the designation of a state referee as the third arbitrator. The chief court administrator shall appoint from a panel of referees designated by the chief court administrator one arbitrator to serve as the third member of the panel, provided that the appointment shall be made no later than thirty days from the receipt of a copy of the request for arbitration as described above.

(Effective June 2, 1986)

Sec. 17-311-111. Appointment of arbitrator; qualifications

The chief court administrator may appoint one or more state referees as permanent arbitrators to serve in the arbitration of disputes referred to arbitration panels in accordance with the procedure set forth herein. The provider and the commissioner shall be required to name persons as their choice for their representative arbitrator who have had knowledge of the matters which are the subject of the arbitration issues. The commissioner may not serve as arbitrator.

(Effective June 2, 1986)

Sec. 17-311-112. Scope of review

The arbitration board shall confine itself to a review of the record. The arbitration board shall not substitute its judgment for that of the department as to the weight of the evidence on questions of fact. The arbitration board may affirm the decision of the department or remand the case to the department to reopen the rehearing. The arbitration board may reverse the department's rehearing decision and remand it to the department for a new rehearing if substantial rights of the provider have been prejudiced because the administrative findings, inferences, conclusions, or decisions are: 1. In violation of constitutional or statutory provisions; 2. In excess of the statutory authority of the agency; 3. Made upon unlawful procedure; 4. Affected by other error of law; 5. Clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; 6. Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(Effective June 2, 1986)

Sec. 17-311-113. Oral argument; time and place; adjournment

The arbitrators shall appoint a time and place for oral argument based on the record and notify the parties thereof and, on application of either party and for good cause shown, shall postpone the time of the oral argument. They may also adjourn the oral argument, from time to time, as may be necessary, but no postponement or adjournment shall extend the time, if any, fixed in the arbitration agreement or by these rules for rendering the review of the record decision.

(Effective June 2, 1986)

Sec. 17-311-114. Stay of department rehearing decision pending arbitration board's review of the record

The institution of the arbitration proceeding pursuant to these regulations shall not of itself stay enforcement of the department's rehearing decision. The department, or the arbitration board, may order a stay upon appropriate terms in its discretion.

(Effective June 2, 1986)

Sec. 17-311-115. Representation by counsel

Either party may be represented in the arbitration proceeding by counsel or by other authorized representatives.

(Effective June 2, 1986)

Sec. 17-311-116. Stenographic record

Whenever a stenographic record is requested by one or more parties, the arbitration panel will arrange for a stenographer. The total cost of the transcript shall be paid by the requesting party.

(Effective June 2, 1986)

Sec. 17-311-117. Attendance at hearings

Persons having a direct interest in the arbitration, including representatives of certified collective bargaining agents at the institution are entitled to attend and observe arbitration proceedings.

(Effective June 2, 1986)

Sec. 17-311-118. Majority decision

All decisions of the arbitrators shall be by majority vote.

(Effective June 2, 1986)

Sec. 17-311-119. Subsequent court proceedings

The provisions of section 52-417 through section 52-424, inclusive, are herewith incorporated by reference as if fully set forth for the purpose of governing any judicial proceedings subsequent to the entry of the final decision based upon review of the rehearing record by the arbitration board.

(Effective June 2, 1986)

Sec. 17-311-120. Aggrieved provider's choice of remedy to contest Sec. 17-311 (b) final administrative rate rehearing decision

As an alternative remedy to the arbitration process set forth in Sec. 17-311-107 to Sec. 17-311-119 supra, a provider aggrieved by a final decision of the commissioner pursuant to a rate rehearing conducted pursuant to the provisions of Sec. 17-311 (b) as a contested case in accordance with the provisions of Sec. 4-177 et seq. of the Connecticut General Statutes may pursue its administrative appeal in the Connecticut Superior Court pursuant to the provisions of Sec. 4-183 Conn. Gen. Stat. The provider will not be required to pursue the arbitration process included herein as a remedy available within the agency for the purposes of exhaustion of administrative remedies but may proceed, subsequent to the final rate rehearing decision pursuant to Sec. 17-311 (b) to the superior court. The filing of an administrative appeal without the pursuit of the arbitration process available herein shall not be the ground of objection to said administrative appeal by the department. When a provider elects to invoke this subsection and bring a Sec. 4-183 appeal of Sec. 17-311 (b) rate rehearing final decision directly to the Connecticut superior court, the provider waives any right to simultaneously or subsequently initiate the aforesaid arbitration process to appeal said Sec. 17-311 (b) rate rehearing final decision. Likewise, when the provider elects to initiate the aforesaid arbitration process to appeal a Sec. 17-311 (b) rate rehearing final decision, the provider waives any right to simultaneously or subsequently bring a Sec. 4-183 appeal of said Sec. 17-311 (b) rate rehearing final decision.

(Effective June 2, 1986)

Secs. 17-311-121—17-311-126.

Repealed, June 2, 1986.

Secs. 17-311-127—17-311-159. Reserved**Self-pay Charges for Patients in Long-Term Care Health Facilities****Sec. 17-311-160. Maximum allowable charges to self-pay patients**

(a) Effective July 1, 1980, and annually thereafter, the Commissioner of Income Maintenance (hereinafter referred to as Commissioner) shall authorize the maximum allowable charges to self-pay patients (hereinafter referred to as self-pay charges) for routine services as defined in Section 17-311-161 below in private and semi-private accommodations of licensed chronic and convalescent hospitals, rest homes with nursing supervision and licensed homes for the aged, as defined in Section 19-576 of the general statutes (hereinafter referred to as facilities). The self-pay charges shall be determined on the basis of the cost related reimbursement system used for determining per diem rates of payment to long-term care facilities in the State of Connecticut as set forth in Section 17-311-50 through Section 17-311-57 of these regulations, (hereinafter referred to as State rates), except as prescribed by the regulations below.

(b) Notwithstanding section 17-311-161 below, self-pay charges authorized by the commissioner may not be less than the state rates established for each facility. Therefore, a facility must increase its self-pay charge to the state rate or the state rate shall be lowered to the self-pay charge.

(c) Self-pay charges determined pursuant to the regulations herein shall be deemed to constitute reimbursement for all reasonable costs related to patient care plus a profit or an operating surplus and a fair rate of return on invested capital or equity. Therefore, no request for an increase, except as provided in section 17-311-167 shall be heard by the commissioner.

(d) No facility may charge its self-pay patients more than permitted by emergency regulation 17-311-159 until the July 1, 1980 self-pay charges become effective.

(Effective March 17, 1983)

Sec. 17-311-161. Self-pay charges for routine services

Self-pay charges for routine services shall be established for each facility individually and for each level of care provided by such facility in accordance with the following method:

(a) Routine services means the per diem charge by a nursing home for services and items includable in the facility's state rate calculated for purposes of Section 17-311-161 (b) (1) and shall include but not be limited to room accommodations, nursing care rendered by non-private duty nursing personnel, food, institutional laundry services, housekeeping services, services related to the use and maintenance of real property, social and recreation services, and all other allied and customary services offered pursuant to an express or implied agreement between the provider and the patient. Routine services shall not include those services defined below as ancillary services. Other than by charging up to the maximum allowable self-pay rates determined by the commissioner, under no circumstances shall a facility impose any additional charge upon any of its self-pay patients for any routine services.

(b) The Commissioner shall determine once during the period no less than thirty nor more than ninety days prior to the effective date of each new rate year the statewide median medicaid or public assistance rate for patients cared for by the

State of Connecticut at each level of care, e.g., chronic and convalescent hospital, rest home with nursing supervision, and homes for the aged. Once such median for a new rate year is computed, it shall not be subsequently recomputed. The self-pay charge that may be imposed by each facility for routine services for each level of care shall be computed by adding:

- (1) The facility's state rate as calculated for the purposes of these regulations, and
- (2) The amount derived by applying the specific percentages of the statewide median state rate for each level of care (expressed in dollars and cents rounded to the nearest whole cent), as set forth in the schedule below:

| <u>Room Accommodations</u> | <u>Percentage to be applied to Statewide Median State Rate</u> |
|--|--|
| Private (one patient in a room) | 50% |
| Semi-Private (two patients in a room) | 25% |
| Semi-Private (three or more patients in a room) | 12% |

Except that the commissioner has the discretion to promulgate a self-pay rate to be charged to a patient who at the patient's request enters into a contract with a facility for special accommodations larger than the facility's private (one patient to a room) accommodation.

(c) The self-pay charges for those facilities which charge a uniform single rate for a given level of care regardless of room accommodation shall be determined using a weighted bed average as follows: multiply the maximum allowable self-pay charges as computed in accordance with subsection (b) above by the number of beds in each class of room accommodation, and divide the total of these products by the total number of licensed beds available for use in the level of care.

(d) For purposes of determining self-pay charges the provisions of section 17-311-52(4) and 17-311-52(13) shall not apply.

(e) The calculation of self-pay charges shall be predicated upon the provision of all services including those necessary to provide an adequate level of quality of care. If the commissioner finds after a formal administrative hearing that a facility has not provided an adequate level of quality of care;

(1) The Commissioner shall not include in the state rates any cost efficiency adjustment pursuant to section 17-311-52 in the computation of the self-pay charges.

(2) Self-pay charges shall not be greater than self-pay charges for the previous rate year except as required by section 17-311-160 above.

The commissioner has the discretion to refer quality of care complaints and issues to the department of health services for investigation and either appropriate action by said agency or recommendations to the department of income maintenance.

(f) For the purposes of computing self-pay charges for the rate year beginning July 1, 1980, for those facilities which do not have a state rate, the dollar amounts used in subsection (b) (2) above shall be added to the facility's existing legal self-pay charge for each type of accommodation and level of care. In subsequent years, the facility shall file an annual report pursuant to section 17-311-168 and state rates shall be computed in accordance with the cost related reimbursement system as the basis for computing the self-pay charges.

(g) In the event that the increase permitted pursuant to subsection (b) above, is less than 104% of the previously approved self-pay charge, the self-pay charge may be increased to 104% of the previously approved self-pay charge, except as provided in section 17-311-163.

(h) In no event shall the self-pay charge computed pursuant to subsection (b) above be permitted to exceed 124% of the previously approved self-pay charge except as required by section 17-311-160 (b).

(i) For purposes of computing a facility's maximum allowable self-pay charges only, the commissioner shall include as a factor in such computations past self-pay rate adjustments in favor of the provider resulting from field audit adjustments or adjustments pursuant to Sec. 17-311-52 (p) (Gross National Product deflator adjustments) which constituted uncollectable retroactive self-pay rate increases due to the thirty day notice of self-pay rate increase requirement of Conn. Gen. Stat. Sec. 17-314a. This subsection shall apply to all such field audit adjustments in favor of the provider and Sec. 17-311-52 (p) adjustments in favor of the provider for periods subsequent to the effective date of this subsection.

(Effective June 2, 1986)

Sec. 17-311-162. Self-pay charges for ancillary services

(a) Ancillary services means those charges to patients which are directly identifiable as customary medical services rendered to individual patients, and furnished at the direction of a physician because of specific medical need and are either not reusable or represent a cost for each preparation (e.g., physical therapy, speech therapy, catheters, colostomy bags, prosthetic devices, and all other similar services or devices), provided that with respect to services, such services are rendered by employees of the Facility. Services rendered by outside consultants or independent contractors who establish and determine the charges to the patient for such services, and to which charges the facility does not add a mark-up for overhead or profit, shall not be considered ancillary services for the purposes of this regulation. Ancillary services shall not be construed to include any good or service for which the department reimburses a facility in the medicaid rate for the care of Title XIX patients.

(b) Effective July 1, 1980, self-pay charges for ancillary services shall be the ancillary charges in effect on December 1, 1979 increased by the percentage factor used in section 17-311-161 (b) for semi-private 2-bed room accommodations. Thereafter, for each ensuing rate year, self-pay charges for ancillary services shall be the prior year's self-pay charges for ancillary services increased by the percentage factor used in section 17-311-161 (b) for semi-private 2-bed room accommodations. Each self-pay patient shall receive an itemized statement of the ancillary services for which the patient is charged. Effective with the rate year commencing July 1, 1986, self-pay charges for ancillary services shall be the ancillary charges in effect on July 1, 1985 increased by the percentage factor by which the facility's self-pay rates for semi-private 2-bed room accommodations increased from the preceding rate year. Thereafter, for each ensuing rate year, self-pay charges for ancillary charges shall be the ancillary charges in effect on June 30 of the preceding rate year increased by the percentage factor by which the facility's self-pay rates for semi-private 2-bed room accommodations increased from the preceding rate year.

(Effective June 2, 1986)

Sec. 17-311-163. Unauthorized charges to self-pay patients

(a) Any facility which is found by the commissioner to have overcharged its self-pay patients, is issued a demand by the commissioner pursuant to subsection (c), and fails to rectify its violation upon demand by the commissioner, shall not be permitted any increase pursuant to Section 17-311-161 of these regulations.

(b) Any facility which charges a self-pay patient or the self-pay patient's legal guardian or conservator an amount greater than that permitted by the commissioner

shall either refund the excess amount paid or credit the account of the self-pay patient for the excess amount paid. In the event that the full amount of the overcharge cannot be returned to the patient through the use of the credit, the remaining amount of the overcharge shall be refunded to the patient, the patient's legal guardian or conservator, of his/her estate.

(c) If the Commissioner is notified that a facility has failed to meet the obligations of subsection (b), he shall cause the matter to be investigated for verification of the overcharges. If an overcharge is found to have been made, he shall make demand upon the facility in writing by certified mail demanding that the facility comply with the requirements of subsection (b). If after thirty-one (31) days, the facility has not complied with the demand made by the Commissioner of Income Maintenance, the matter shall be referred to the Office of the attorney general for enforcement of the rate determination pursuant to subsection (e) of section 17-314a of the Connecticut General Statutes.

(Effective June 2, 1986)

Sec. 17-311-164. Field audit and other rate adjustments

(a) Every facility for which self-pay charges are established may be audited as deemed necessary by the commissioner. Therefore, each facility shall maintain all supporting expenditure records up-to-date and available for review for a minimum period of ten years from date of previous audit, regardless whether the facility has changed ownership or not.

(b) In the event that a recomputation of a facility's state rate due to field audits or otherwise requires a change in a state rate which has served as the basis for a prior computation of the facility's self-pay charges, the self-pay charges shall be recomputed. However the recomputation shall only be implemented retroactively if it constitutes a downward self-pay rate adjustment. Increases in self-pay rate may only be implemented after all self-pay patients in the facility have been given notice of the rate increase, as determined by the commissioner, at least thirty days prior to the effective date of such rate increase. The facility shall be required to make appropriate refund as provided in section 17-311-163 (b).

(Effective June 2, 1986)

Sec. 17-311-165. Hearings

(a) Prior to the setting of the self-pay charges on July 1 each year, the Commissioner shall hold public hearings at various locations around the state after first giving notice as provided hereinafter. The Commissioner shall publish a notice of the hearing in the Connecticut Law Journal, mail a notice to the Commissioner on Aging and the Commissioner of Health Services and to all facilities for which he established rates pursuant to Section 17-314a, announcing the date, time, place and purpose of the hearing. Each facility shall post such notice in a place conspicuous to the patients within the facility and each facility shall provide copies of the notice immediately to the residents of the facility or to their legal guardians or conservators.

(b) At the public hearing, in addition to any matters relevant to rate setting, the commissioner shall receive any complaint of alleged overcharges of self-pay patients, or violations of state or federal law which allegedly occurred within the past twelve months relating to the quality of patient care provided by a facility. A transcript of the hearing shall be made and a copy shall be given to the commissioner of the department of health services or his designee for appropriate review and/or investigation by that department.

(Effective June 2, 1986)

Sec. 17-311-166. Notification and hearings

(a) The commissioner shall send a notice by mail to each facility, informing the facility of the commissioner's decision with respect to the self-pay charges approved, and the percentage of increase approved for self-pay charges for ancillary services for the prospective fiscal year beginning July 1st. Immediately upon receipt of the self-pay charges decision, each facility shall provide a written notice of the decision to any self-pay patient affected, or to his guardian or conservator. Any facility, self-pay patient, or the guardian or conservator of a self-pay patient, aggrieved by the decision with respect to the self-pay charges, may obtain by request in writing to the commissioner, a hearing with respect to the self-pay charges decision, provided that such written request is made not later than ten (10) days after the date that the written notice of the decision is provided by the commissioner to the facility.

(b) Notices shall be sent by the facility by regular mail, postage prepaid, to the last known address of the self-pay patient, guardian, or conservator, and the facility shall certify to the commissioner the date upon which the notices were mailed to the self-pay patients.

(c) Notices sent by the facility to self-pay patients, guardians, or conservators regarding the self-pay charges established by the commissioner must contain the following information:

(1) The self-pay charge established by the commissioner for the level of care and type of room occupied by the patient.

(2) The date of the decision by the commissioner.

(3) The manner in which the patient, guardian or conservator may contest the self-pay charge, i.e., by mailing to the commissioner a written request for a hearing within ten days of the date of the decision by the commissioner.

(4) The address of the commissioner.

(d) Upon the receipt of a request for a hearing with respect to the self-pay charges, the Commissioner shall schedule a hearing in accordance with the provisions of sections 4-177 to 4-181, inclusive, and in accordance with section 17-311-27 through 17-311-40 of the rules of practice of the Commissioner. The hearing shall be held as soon as practicable after the receipt of such request by the Commissioner. The Commissioner shall provide notice to the facility of the date, time and place of the self-pay rate hearing. The facility must provide written notice, postage prepaid, of such date, time and place of the self-pay hearing to the last known address of any self-pay patient affected or to his guardian or conservator. The facility must also conspicuously post such notice on its premises. Failure of the facility to provide such notice to its self-pay patients shall constitute cause for a default of the facility at the self-pay rate hearing.

(e) The Commissioner shall proceed with reasonable dispatch to conclude the hearing pending before him with respect to the establishment of the self-pay charges and shall render final decision not later than ninety days following the close of the hearing, the filing of the briefs, the filing of late file exhibits, or the receipt by the department of the hearing transcript, whichever last occurs.

(f) Pursuant to any hearing with respect to self-pay charges requested by a patient, guardian, or conservator, the facility, pending receipt of the commissioner's final decision, shall be permitted to charge and collect any amounts equal to or less than the self-pay charges established by the commissioner. If the present self-pay charge is greater than the self-pay charge established by the commissioner for the prior fiscal year, the facility shall escrow 20% of the difference, of the aggrieved patient's charges.

(g) Any final decision rendered by the commissioner pursuant to any hearing with respect to establishing self-pay charges requested by a patient, guardian or conservator, shall apply to all other similarly situated self-pay patients.

(Effective June 2, 1986)

Sec. 17-311-167. Requests for increases in self-pay charges

(a) In the event of any unforeseen or material change in circumstances, a facility may submit an application for an increase in the self-pay charges established by the commissioner pursuant to the procedure set forth in section 17-311-160 through 17-311-163, supra, by making application for permission to impose charges to self-pay patients in excess of the authorized self-pay charges. Such application must clearly set forth that the application is made pursuant to subsection 1 (c) of Public Act 79-182.

(b) In reviewing and evaluating a facility's request for permission to impose self-pay charges in excess of those authorized by the commissioner pursuant to section 17-311-160, et seq. supra, whenever applicable the commissioner shall consider, but not be limited to, the following:

(1) The cost impact of compliance with any statute, regulation, ordinance, or tax, lawfully promulgated or imposed by any federal, state or local governmental authority having jurisdiction over the operations of the facility, including but not limited to increases in local real estate taxes and changes in the public health code mandated by the Connecticut department of health services;

(2) Changes in the level of care provided by the facility;

(3) The cost of substantial additions, renovations, and improvements to real property not included in the cost year base data used to establish the facility's self-pay charges;

(4) Unforeseen changes in the general economy significantly affecting the system under which the state rates were determined as the basis for establishing the self-pay charges;

(5) In the case of a facility where self-pay charges were determined pursuant to section 17-311-161 (e) above, evidence from the department of health services establishing that the conditions which led to the imposition of the provisions of section 17-311-161 (e) have been remedied.

(c) The considerations set forth in subsection (b), above, shall be used by the commissioner whenever applicable to determine a facility's need for a self-pay charge in excess of the self-pay charges established annually by the commissioner, and shall not be applicable to a facility's request for an increase in its state rates.

(d) In addition to the requirements herein above stated, each rate application shall, if required by the commissioner, contain either in the statement of application or as exhibits annexed thereto and accompanying the application, data such as, but not limited to, the following:

(1) The date on which each proposed charge would become effective.

(2) The levels of care or accommodations to which each proposed charge would apply.

(3) Statements of financial operations for the prior fiscal year, the current year, and the budgeted year at the present and at the proposed charges.

(4) A schedule of existing charges in effect prior to the date of application showing actual revenues and numbers of patients and other users of the facility, categorized by rates, by classification of patient and by other appropriate classification for the periods covered by the prior year and by the current year. The schedule will show such revenues at the existing charges and budgeted at the proposed charges.

(5) Statement of the proposed increased charges or changes which will result in increased self-pay charges which the applicant proposed to make effective. Such statement shall also set forth the proposed charge structure with reasonable clarity and with appropriate rate classifications, where applicable.

(6) Actual and budgeted expenses with supporting detail set forth by the accounts affected.

(e) The applicant may file as prefiled testimony and as exhibits any data which it offers the commissioner as proof in support for the proposed rate application. Such evidence shall not be incorporated in any of the prescribed components but shall be presented separately as annexed materials and received as offers of proof to the extent such evidence is relevant to the applicant's case.

(f) The commissioner may decide on such an application with or without a hearing in accordance with section 1 (c) of Public Act 79-182.

(Effective May 15, 1980)

Sec. 17-311-168. Requirements for filing annual reports

(a) All facilities having 10 or more beds must file the annual report utilized by the commissioner of income maintenance in determining rates pursuant to section 17-314 of the general statutes. This annual report must be filled out completely and filed with the commissioner no later than the 31st day of December of each year.

(b) Any facility which fails to file the annual report will not be granted an increase in its previously approved self-pay charges.

(Effective May 15, 1980)

Sec. 17-311-169. Self-pay charges for newly constructed or acquired facilities

(a) Self-pay charges for newly constructed or acquired facilities shall be established in accordance with section 17-311-161 on the basis of the State rates for such facilities determined in accordance with section 17-311-55 of the regulations governing state agencies. Any facility which does not serve state patients must nevertheless provide the Commissioner with the necessary data to determine state rates, so that the state rates can be used as the basis for determining self-pay charges.

(b) At such time as the state rates for a facility are changed, the self-pay charges shall also be redetermined in accordance with section 17-311-161.

(Effective March 17, 1983)

Nursing Home Discrimination Against Applicants for Admission

Secs. 17-311-170—17-311-199. Reserved

Sec. 17-311-200. Definitions

For purposes of the enforcement of Section 19a-533 of the General Statutes of Connecticut, and as implemented by Sections 17-311-200 through 17-311-209 of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(a) "nursing home" means any chronic disease hospital, chronic and convalescent facility or any rest home with nursing supervision, as defined by section 19a-521, which has a provider agreement with the Department of Income Maintenance to provide services to recipients of medical assistance pursuant to Part IV of chapter 302 of the Connecticut General Statutes and to accept reimbursement for the cost of such services pursuant to said program, or which receives payment from the state for rendering care to indigent persons.

(b) “indigent person” means any person who is eligible for or who is receiving medical assistance benefits from the state or general assistance benefits from a town;

(c) “applicant for admission” means any person who either himself or through any representative, including but not limited to his guardian, conservator, family member, physician, social worker or discharge planner, indicates a desire to the nursing home to be admitted into such nursing home.

Such indication of desire for admission to the nursing home may be communicated to the facility by a person or his representative in person, by mail or by telephone. Nursing homes may not restrict applicant for admission status to those persons who have personally visited the facility, completed and signed application forms, submitted medical, social or financial information, or in any other way not expressly permitted by this section.

(d) “dated list of applications” shall constitute an inquiry list, i.e. a chronological dated list indicating in order the name of each person who indicated a desire to the nursing home to be admitted into such nursing home as indicated in subsection (c) above.

(e) “waiting list” shall constitute a chronological list of persons who have substantially completed and returned to the nursing home the written application for admission. The names of such persons shall appear on the waiting list in the order in which such persons return their substantially completed applications to the facility.

(Effective October 1, 1988)

Sec. 17-311-201. Prohibition of discrimination against indigent applicants

A nursing home which receives payment from the state for rendering care to indigent persons shall be prohibited from discriminating against indigent persons who apply for admission to such facility on the basis of source of payment.

(Effective October 1, 1988)

Sec. 17-311-202. Admission in order of application of all applicants

A nursing home which receives payment from the state for rendering care to indigent persons shall admit all applicants for admission to such facility (i.e. indigents, Self-Pay, Medicare, V.A., etc.) in the order in which such applicants appear on the waiting list, unless a statute or regulation otherwise provides.

(Effective October 1, 1988)

Sec. 17-311-203. Provision of receipts

Each nursing home shall provide a receipt to all applicants for admission as defined *supra*. Nursing homes shall ask all applicants whether they desire to receive a receipt and be placed on the dated list of applicants at such time as the applicant indicates a desire to be admitted into such nursing home. Receipts shall be provided to applicants stating the date and time of the aforesaid initial contact of the nursing home by the applicant or his representative. Each receipt shall be consecutively numbered and shall state the name and address of the applicant for admission and the date and time of such application. Receipts shall be provided immediately to a person or his representative who personally appeared at the facility or mailed within two business days to a person or his representative who applied to the facility by mail or by telephone. Facilities may require that requests for receipts and the issuance thereof be effected during normal business hours, provided that such requirement is applied to all applicants for admission in a non-discriminatory manner.

(Effective October 1, 1988)

Sec. 17-311-204. Maintenance of dated list of applications

When a person indicates a desire to be admitted into a nursing home, his name shall be placed immediately on the facility's dated list of applications. Such dated list of applications shall be in a bound volume and shall be in the chronological order in which persons contacted the facility and indicated a desire to be admitted with the date and time of initial contact indicated by the person's name.

(Effective October 1, 1988)

Sec. 17-311-205. Mailing of written application to persons on dated list of applications

(a) Within two (2) business days after such initial contact, the facility shall mail its written application form to such person or his representative. At the beginning of the front page of such written application the following wording shall appear in capital letters in bold face type and/or underlined:

YOU HAVE CONTACTED THIS NURSING HOME AND INDICATED A DESIRE TO BE ADMITTED AS A PATIENT TO THIS FACILITY. BECAUSE OF THIS, YOU HAVE ALREADY BEEN ISSUED A RECEIPT INDICATING THE DATE AND TIME OF YOUR INITIAL REQUEST AND YOUR NAME HAS BEEN PLACED ON OUR DATED LIST OF APPLICATIONS OR INQUIRY LIST.

PLEASE FIND ENCLOSED THIS FACILITY'S WRITTEN APPLICATION FORM. AS SOON AS YOU SUBSTANTIALLY COMPLETE AND RETURN THE FORM TO THE FACILITY, YOUR NAME WILL BE PLACED ON OUR WAITING LIST FOR ADMISSION TO THE FACILITY. YOUR NAME WILL ONLY BE PLACED ON OUR WAITING LIST AFTER YOU SUBSTANTIALLY COMPLETE AND RETURN THIS WRITTEN APPLICATION FORM TO US.

(b) In determining whether a returned written application is "substantially complete," a nursing home may not reject as incomplete a written application when said facility has accepted as "substantially complete" other written applications which are equal to or lesser than the rejected written application in their completeness.

(Effective October 1, 1988)

Sec. 17-311-206. Maintenance of a waiting list

(a) Each nursing home shall maintain a "waiting list for admission" which shall constitute a single, bound volume of the names of persons who have substantially completed and returned to the facility the written application form. Looseleaf binders, or any other volume which is subject to additions, deletions or other changes, shall not constitute compliance with this requirement. Once an applicant's name is placed on the waiting list for admission, said name may not be removed until such person has been admitted to the nursing home, such person expires, or such person or his representative gives the nursing home written notice of the withdrawal of the application, or pursuant to subsection (b) of this section.

An offer to admit an applicant on a specific day which is refused by the applicant shall not justify the deletion of the applicant's name from the waiting list. Whenever a nursing home passes over the name of an applicant on its waiting list and admits

another, a dated notation must be made on the waiting list indicating why such applicant was not admitted and supporting documentation of the reason must be maintained and readily available.

Nursing homes shall inform an applicant for admission of his/her place on the waiting list whenever the applicant requests such information during normal business hours.

(b) If a nursing home desires to remove an applicant's name from its waiting list who is unresponsive to facility telephone calls and letters, the nursing home may no sooner than 120 days after initial placement of the person's name on its waiting list inquire by letter to such applicant as to whether or not he desires continuation of his name on the waiting list. If such applicant does not respond to such letter and at least an additional 120 days pass, the facility may send a second such letter. If such applicant still does not respond and at least an additional 30 days pass, the facility may remove such applicant's name from its waiting list.

(Effective October 1, 1988)

Sec. 17-311-207. Daily logs

Each nursing home shall maintain a "daily log" in a single bound volume for each calendar year which must be completed on a daily basis by indicating, for each day, the number of applications for admission, the number of indigent persons applying for admission, the number of vacancies, the number of persons admitted to the facility and the number of indigent persons admitted to the facility, and the number of individuals readmitted to the nursing home after a period of hospitalization. Daily logs for the last three calendar years shall be maintained in a single location in the nursing home. Looseleaf binders, or any other volume which is subject to additions, deletions or other changes, shall not constitute compliance with this requirement.

(Effective October 1, 1988)

Sec. 17-311-208. Enforcement of statute regardless of intervening change in ownership

Since, as per Conn. Gen. Stat. § 19a-533 (d) statutory rate sanctions apply to the rate year resulting from the cost report for the twelve month fiscal year during which violations of the statute took place, Conn. Gen. Stat. § 19a-533 rate sanctions are part of the rate history of a nursing home into which a buyer steps. Therefore, such rate sanctions shall be implemented regardless of any intervening change in ownership.

(Effective October 1, 1988)

Sec. 17-311-209. Admissions

(a) Nursing homes may not discriminate against indigent persons and shall admit all applicants for admission in the order in which the names of such applicants appear on the waiting list, except as otherwise provided by statute or these regulations.

(b) A facility may admit applicants other than in the order in which their names appear on the waiting list, provided that the following exceptions are uniformly and consistently applied without regard to source of payment, only if:

(1) An applicant has yet to provide medical, social or financial information requisite to determine the individual's eligibility for admission provided that the nursing home had previously notified the applicant what specific medical, social and financial information was required and can document such notification. In such case, a dated notation must be made on the waiting list.

(2) An applicant for admission fails to meet the applicable level of care requirements contained in the Public Health Code, Reg. Ct. St. Ag. § 19-13-D8T (d) (1) (A), and/or the applicant requires care or services without which the patient is at risk which the facility is unable to provide as certified by its Medical Director in accordance with Reg. Ct. St. Ag. § 19-13-D8T (h) (2) (D) and 19-13-D8T (i) (4) (D) (iii). It shall constitute unlawful discrimination forbidden by this section, however, if a nursing home fails to properly and consistently apply the applicable level of care requirements or if it improperly determines that the applicant requires care or services beyond its capability as set forth *supra*, having the effect of denying admission of an indigent person to the nursing home.

(3) A person had previously been a resident of a nursing home who was absent from the nursing home for a reason of hospitalization and is entitled to priority admission as per Conn. Gen. Stat. § 19a-537. Any person so admitted shall have a notation to that effect made on the daily log.

(4) Transfers of patients from one level of care to another within a facility licensed to offer more than one level of care, i.e., chronic disease hospital, chronic and convalescent nursing home, rest home with nursing supervision, home for the aged, are not subject to the provisions of Conn. Gen. Stat. § 19a-533 or these regulations, provided that such intrafacility transfers are for bona fide medical reasons.

(5) The nursing home admits a patient who has been determined by an appropriate state agency to be in need of protective services and is referred to the facility for admission by an appropriate state agency pursuant to the provisions of Conn. Gen. Stat. § 46a-14 *et seq.*

(6) Due to decertification or license revocation of another facility or some other public health reason, the Commissioner of Health Services or his representative refers a patient to the facility.

(7) The nursing home has been granted permission by the Connecticut Commission on Hospitals and Health Care to withdraw from the Medicaid program by terminating its provider agreement pursuant to the provisions of Conn. Gen. Stat. § 19a-154. In order to be excused from the admission requirements of this section, the facility must comply with the terms and conditions of any order entered by the Commission allowing a withdrawal from the program by appropriate discharge and transfer of all Medicaid patients provided that any withdrawal from the Medicaid program must be accomplished within (3) months of the order granting permission to withdraw, unless the order of the Commission allows the facility more than three months to withdraw from the program, except that if the Medical Director of the nursing home certifies that specific Medicaid patient(s) would suffer serious harm as a result of a discharge or transfer, the Department of Income Maintenance, may, if it concurs with the determination of the facility's Medical Director, enter into a limited provider agreement with the facility covering only such patients—which will otherwise excuse the facility from complying with the admission requirements of this section.

(8) The applicant (A) has entered into a continuing care contract in accordance with Conn. Gen. Stat. § 17-535 and regulations promulgated thereunder, and is a resident of a continuing care facility that provides for care to be given by the nursing home; or (B) resides in a residential facility for the elderly that offers meals, and some combination of housekeeping, emergency medical call systems and other social supports, and two or more health-related benefits in addition to shelter and is controlled, owned or operated by the owner or operator of a nursing home which is located on the same or an adjacent site or in the immediate geographic proximity.

Health-related benefits include priority access to the nursing home without regard to source of payment, health care provided by a nursing home or by a home-health agency as defined in Conn. Gen. Stat. § 19a-490, or the services of any licensed health professional on a regular, ongoing basis, either on staff or on contract.

(9) A designated number of beds set aside for respite care with a maximum stay of 30 consecutive days with such applicants admitted in the order in which their names appear on the waiting list;

(10) A designated number of beds set aside for short term rehabilitation with a 90 day maximum stay with such applicants admitted in the order in which their names appear on the waiting list;

(11) A designated number of beds set aside for the terminally ill with applicants in such condition accepted in the order in which their names appear on the waiting list;

(12) A designated number of beds in a specialized unit (e.g. Alzheimer's Unit, TBI Unit) and applicants with that condition accepted in the order in which their names appear on the waiting list;

(13) A spouse of the applicant is a patient in the nursing home;

(14) The applicant was discharged from the nursing home to the community within fifteen days of his/her request for readmission;

(15) A municipally owned and operated facility with residency requirement with resident applicants admitted in the order in which their names appear on the waiting list;

(16) The facility offers any of the following specialized medical treatments: nasogastric tubes with pump, respiratory therapy with or without a ventilator or other specialized tracheostomy care, intravenous therapy including hyperalimentation, Clinitron-type beds, Hubbard-type tanks, provided that patients in need of the treatment(s) are admitted in the order in which their names appear on the waiting list. A facility offering any such treatment shall designate a maximum number of beds for which such treatments will be offered;

(17) The facility is owned or operated by a religious organization exempt from taxation for federal income tax purposes which exists to provide long term care to members of its religion provided that all applicants who are members of such religion are admitted in their order of application without regard to their source of payment and without regard to any other factor including but not limited to either their own or their families' past financial contributions and/or volunteer efforts to such religion and/or its related organizations.

(18) The facility is owned, operated by or affiliated with a fraternal organization exempt from taxation for federal income tax purposes which exists to provide long term care to members of its fraternal organization provided that all applicants who are members of such fraternal organization are admitted in the order of application without regard to their source of payment and without regard to any other factor including but not limited to either their own or their families' past financial contributions and/or volunteer efforts to such fraternal organization and/or its related organizations.

(19) The facility is owned or operated by a non-stock, non-profit corporation exempt from taxation for federal income tax purposes which (1) provides now and provided in its original charter or certificate of incorporation that it is established for the benefit of the municipality in which it is located, and (2) receives financial assistance through grants or donations from the municipality in which it is located and/or the residents thereof, provided that all applicants who are residents of such municipality are admitted in the order of application without regard to their source

of payment and without regard to any other factor including but not limited to either their own or their families' past financial contributions and/or volunteer efforts to such facility and/or its related organizations.

(20) The nursing home has entered into a contract or contracts with a hospital or hospitals pursuant to which patients to be discharged from the hospital are given priority in admission to no more than fifteen percent of the nursing home's beds as such beds become vacant, with said fifteen percent limitation referring to all such contracts combined. Such contracts may only be entered into when the municipality in which the nursing home is located is within forty (40) miles of the hospital. Such agreements shall provide that patients shall be referred by the hospital to the nursing home in the order in which such patients are medically ready for discharge without regard to their source of payment. Once a nursing home admits a patient pursuant to this subsection, it may not accept any payment in excess of the Title XIX Medicaid rate in the case of a Medicaid patient and it may not accept any payment in excess of the facility's applicable maximum allowable self-pay rate in the case of a private-pay patient. Whenever a nursing home has a vacant bed and the hospital does not have a patient to be referred pursuant to this subsection, the nursing home must immediately fill such vacancy from its waiting list for admission, provided that if the hospital has identified a patient whose discharge will be completed within four working days, the nursing home may hold the bed for this period under arrangement with the hospital.

(Effective March 28, 1990)