

OFFICE OF LEGISLATIVE RESEARCH
PUBLIC ACT SUMMARY



PA 11-44 — SB 1240
Emergency Certification

AN ACT CONCERNING THE BUREAU OF REHABILITATIVE SERVICES AND IMPLEMENTATION OF PROVISIONS OF THE BUDGET CONCERNING HUMAN SERVICES AND PUBLIC HEALTH.

SUMMARY: This act creates a new Bureau of Rehabilitative Services (BRS) to provide services to individuals who are blind and visually impaired and deaf and hearing impaired. It transfers all of the administrative and programmatic functions of the Board of Education and Services for the Blind (BESB) and the Commission on Deaf and Hearing Impaired (CDHI) to BRS. The bureau also takes over the functions of the Bureau of Rehabilitation Services, previously within the Department of Social Services (DSS). The act also transfers from the (1) Department of Motor Vehicles (DMV) a unit that evaluates and trains people with disabilities to operate motor vehicles and (2) Labor Department the employee rehabilitation program of the Worker's Compensation Commission to BRS. The BRS director must report on the merger's status by January 2, 2012.

The act also makes numerous changes in the laws governing programs DSS administers. Some of the major provisions include:

1. enabling the state to recover more assistance that DSS and state humane institutions provide (§§ 70-72);
2. freezing the Medicaid rates DSS pays to nursing homes, intermediate care facilities for people with mental retardation (ICF-MR), and other facilities but allowing for increases in certain circumstances (§§ 73-75);
3. reducing the amount DSS reimburses pharmacies for dispensing drugs to people enrolled in DSS' medical assistance programs (§ 76);
4. freezing for the next two years DSS cash assistance (§ 78);
5. decreasing the personal needs allowance for people residing in certain long-term care facilities and eliminating cost-of-living adjustments (COLA) in the allowance (§§ 78 & 79);
6. reducing the state subsidy for people enrolled in the Charter Oak Health Plan and excluding new enrollees from Charter Oak if they are eligible for the Pre-Existing Condition Insurance Plan (§ 80);
7. giving DSS three years to adopt regulations after implementing policies and procedures for new programs;
8. increasing the amount clients in the state-funded portion of the Connecticut Home Care Program for Elders must pay for their services (§ 86);
9. eliminating ConnPACE for anyone eligible for Medicare (§§ 88-90);
10. cutting in half the number of slots for DSS' HIV-AIDS waiver program (§ 93);
11. reducing eyeglass coverage for Medicaid recipients (§ 94);

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12. moving child care and school readiness programs from DSS to the State Department of Education (SDE) (§§ 97-101);
13. providing Medicaid coverage for smoking cessation treatment starting January 1, 2012 (§§ 106 & 107);
14. allowing DSS to establish medical homes as a health care delivery model (§ 110);
15. changing how hospitals receive payments for serving a disproportionate share of low-income residents (§§ 111&174-178);
16. requiring DSS to submit a plan for implementing a cost-neutral, acuity-based method for establishing hospital rates, including a “blended” inpatient rate (§ 112);
17. allowing the DSS commissioner to modify Medicaid payment rates for certain providers to ensure cost neutrality and patient access under the new administrative services organization (ASO) model of care delivery (§ 113);
18. permitting the commissioner to establish an alternative benefit package for people enrolled in the Medicaid for Low-Income Adults (LIA) program (§ 116);
19. subjecting Medicaid state plan amendments to the same legislative oversight as Medicaid waivers (§ 144);
20. postponing for another two years the re-establishment of the Department on Aging (§§ 145 & 146);
21. strengthening the Connecticut False Claims Act for DSS medical assistance programs (§§ 153 & 154);
22. requiring DSS, within available funding, to run a Jobs First pilot program for Temporary Family Assistance (TFA) recipients that includes intensive case management services (§ 165);
23. increasing payments to adult day care providers (§ 166);
24. renaming the council that oversees DSS’ medical assistance program, changing some of the council’s duties, and changing the council’s composition (§§ 167-172);
25. repealing a 2010 law that allowed the community spouse of a person applying for long-term care Medicaid to keep a higher amount of assets (§ 178); and
26. eliminating a Long-Term Care Reinvestment Fund meant to hold enhanced federal funds related to the Money Follows the Person Demonstration Program (§ 178).

The act (1) expands what insurers must cover for medically necessary early interventions for children with autism spectrum disorders (§§ 147 & 148), (2) adds protections to the law governing the dispensing of anti-epileptic drugs (§§ 150 & 151), (3) establishes a task force to determine whether the state should continue to make childhood immunizations universal (§ 163), (4) generally prohibits the Department of Children and Families (DCF) from placing any child under age six in a group home (§ 164), and (5) requires the commissioner of the Department of Public Health (DPH) to issue a request for proposals for an entity to provide financial assistance to sexual assault victims to help pay for HIV

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prophylactic drugs (§ 173).

The act also makes numerous technical and conforming changes.

EFFECTIVE DATE: July 1, 2011 unless otherwise noted below.

§§ 1-69 — CREATION OF BRS

The act creates BRS within DSS for administrative purposes only. The bureau is responsible for providing (1) services to blind and visually impaired and deaf and hearing impaired individuals and (2) rehabilitation services.

The bureau is headed by a director, whom the governor appoints in accordance with the law governing appointments of agency heads. The director has the powers and duties of an agency head. The act requires the director to appoint people he or she deems necessary to administer the act. It directs the administrative services (DAS) commissioner to fix their compensation.

The act permits the director to create administration sections within the bureau, including a disability determination section; 100% of federal funds can be accepted to operate this section in conformance with state and federal regulation. (Previously, DSS' Bureau of Rehabilitation Services had a disability determination section that handled Social Security disability determinations for the federal government.)

§§ 2-4 — FUNCTIONS TRANSFERRED TO NEW BRS

The act transfers all functions, powers, and duties of CDHI and BESB to the new BRS, and makes BRS a successor administrative agency to the commissions with respect to these functions, powers, and duties. Previously, CDHI and BESB were within DSS for administrative purposes only.

BESB was the state's lead agency for providing services for blind residents and offered educational services to children and adults, rehabilitation services, and a program for blind entrepreneurs, among other things. CDHI's main function was to provide interpreters to deaf and hearing impaired citizens in a variety of settings. It also equipped the impaired individuals with telecommunication devices. The new BRS will provide these services.

The act also transfers all functions, powers, and duties of DSS Bureau of Rehabilitation Services to the new BRS.

§ 7 — BESB-SPECIFIC CHANGES

The act changes the role of the BESB oversight board from the central policy-making authority for services provided to the state's blind and visually impaired to an advisor to BRS in fulfilling its responsibilities to provide services to blind and visually impaired residents. The act specifies that the BESB board chairman can call a meeting at the request of two or more members instead of exactly two members.

The act also eliminates the board's function of monitoring the activities of the agency in carrying out its mission to provide educational and rehabilitative services to blind and visually impaired state residents. And it eliminates a

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requirement that the board report annually to the governor, Office of Policy and Management (OPM), and legislature on BESB's compliance with benchmarks.

§ 33 & 35 — CDHI — ROLE OF COMMISSION

Under the act, CDHI retains its role as an advisory body to BRS. But the act eliminates CDHI's role as a statewide coordinating agency and implementer of state policies affecting the deaf and hearing impaired. (It is unclear to what extent, if any, the commission, and not the agency, had these roles previously.)

The act also eliminates the position of CDHI executive director.

§ 38 — DOMESTIC TELEPHONE COMPANY ASSESSMENT

Under prior law, each domestic telephone company serving at least 100,000 customers had to pay \$20,000 into a Special Telecommunications Equipment Fund by July 1, 1992 to help CDHI provide telecommunications equipment for its clients. The act eliminates this deadline; thus, the telephone companies are once again subject to the assessment, but the act does not specify how frequently the assessment must be. (PA 11-48, § 306, repeals the law imposing the assessment.)

§ 45 — HANDICAPPED PLACARD CERTIFICATION

By law, people with disabilities must present certain certifications to the DMV commissioner verifying they are eligible for a handicapped placard. Under prior law, people who are blind and eligible for these placards needed certification of legal blindness from an ophthalmologist, an optometrist, or BESB. The act replaces BESB with BRS and makes technical changes.

§ 46 — HANDICAPPED DRIVER TRAINING PROGRAM

The act moves, from DMV to BRS, a unit that evaluates and trains people with disabilities to operate motor vehicles. It changes the name of the program from the handicapped driver training program to the driver training program for persons with disabilities and makes conforming changes. Under prior law, a handicapped driver consultant under the DMV commissioner's direction oversaw the program. The act renames this person the driver consultant for persons with disabilities, and places him or her under the BRS director's direction. PA 11-61 eliminates the position of driver consultant in BRS for persons with disabilities.

§§ 47-50 — DUTIES OF WORKERS' COMPENSATION CHAIRMAN TRANSFERRED TO BRS DIRECTOR

The act makes a number of conforming and technical changes necessary to transfer the employee rehabilitation program of the Workers' Compensation Commission (WCC) to the new BRS. The changes mean BRS, instead of WCC, will provide employee rehabilitation programs.

The act replaces the WCC chairman with the BRS director, thus requiring the director, rather than the WCC chairman, to establish rehabilitation programs for

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workers whose injuries are compensable under state workers' compensation law.

The act also transfers from the chairman to the BRS director the authority to (1) establish fees, (2) enter into agreements with state and federal agencies, and (3) develop matching programs or activities to secure federal grants and pledge or use funds from the Workers' Compensation Administration Fund.

§ 51 — JANITORIAL WORK PILOT PROGRAM

By law, the DAS commissioner runs a seven-year pilot program to create and expand janitorial work job opportunities for individuals with a disability or a "disadvantage," as defined in law. Previously, the DAS commissioner could consult with the DSS and labor commissioners in establishing the program. The act also allows him to consult with the BRS director.

§ 53 — EXEMPTING CERTAIN BRS EMPLOYEES FROM CLASSIFIED SERVICE

Under prior law, professional employees of DSS' Bureau of Rehabilitation Services were exempt from the classified service. The act instead exempts professional employees in the education professions bargaining unit of the new BRS from the classified service.

§ 58 — VOCATIONAL REHABILITATION SERVICES — EMPLOYMENT PLAN

Under prior law, vocational rehabilitation services for individuals with disabilities were provided through an individual written rehabilitation program. Under the act, the services are provided through an individual plan for employment (in conformance with current federal disability law). These plans help individuals reach their work goals.

§ 66 — REPORTING TO COMMITTEES OF COGNIZANCE

Under prior law, DSS had to report annually to the Human Services and Appropriations committees on:

1. DSS' plans to reduce Bureau of Rehabilitation counselor caseloads to the regional average;
2. client information, including age and race, and the nature of their disabilities;
3. DSS' efforts to ensure that the bureau was serving an equivalent proportion of minorities with disabilities as there were within the total disabled population in the state; and
4. the number, nature, and resolution of complaints the bureau received.

DSS also had to provide the committees with copies of federal audits of the bureau.

The act eliminates the requirement that the committees receive this specific data. It instead requires the new BRS, not DSS, starting July 1, 2011 and each year after that, to provide the committees with the data that it provides to the

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federal government on evaluation standards and performance indicators for the vocational rehabilitation services program.

§ 68 — REPORT TO LEGISLATURE

By January 2, 2012, the act requires the BRS director to submit a report to the Appropriations and Human Services committees on:

1. the status of the (a) merger of BESB, CHDI, and DSS' Bureau of Rehabilitation Services and (b) DMV and WCC functions integrated into the new agency;
2. the new bureau's organizational structure;
3. the bureau's places of operation; and
4. any recommendations for further legislative action concerning the merger, including recommendations to increase the efficiency of the new agency and achieve cost savings.

§ 69 — ADMINISTRATIVE FUNCTIONS OF OLD AND NEW AGENCY

Under the act, the personnel, payroll, administrative action, and business office functions of BESB and CDHI will not be merged and consolidated into DAS, as was required by 2005 legislation. Instead, BRS will assume these functions. But, the BRS director may extend the effective date for the transfers for six months, up to June 30, 2012, by submitting written notice to the Appropriations and Human Services committees.

EFFECTIVE DATE: Upon passage

§ 70-72 — RECOVERY OF PUBLIC ASSISTANCE AND OTHER STATE AID

Public Assistance Recipients

By law, the state has a claim against any kind of property or interest in any property acquired by a public assistance recipient. One way the state recovers assistance paid is by placing liens on the property. The state also has a claim against the parents of children who receive certain aid but, under prior law, the state could only place a lien against property of the parent of an Aid to Dependent Children (former name for Aid to Families with Dependent Children (AFDC) program). The act extends this authority to parents of individuals (presumably children) who receive TFA (the current family cash welfare program that replaced AFDC) and State-Administered General Assistance (SAGA).

The state can also make a claim when a public assistance recipient inherits money, and is entitled to 50% of the assets of the estate payable to the recipient or the amount of the assistance, whichever is less. This amount is assignable to the state for payment. The act applies this provision to parents of these assistance recipients. It requires the probate court to accept these new assignments. The act also makes conforming, technical changes.

Patients in State Humane Institutions

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By law, a patient who is receiving or has received care or support in a state humane institution (e.g., Department of Mental Health and Addiction Services (DMHAS) facility) or his or her estate is liable to reimburse the state for its charges to the same extent as public assistance recipients are when it comes to property and estate recoveries, but not recoveries from lawsuits and inheritances. The act applies the law's lawsuit and inheritance recovery provisions to these individuals.

§ 73 — NURSING HOME RATES

The act freezes, for the next two fiscal years, Medicaid reimbursement to nursing homes. By law and regulation, nursing homes should be getting higher rates due to rate re-basing and inflationary adjustments. Under the act, facilities that would have received lower rates in either year due to their interim rate status receive the lower rate.

Currently, facilities that undergo material changes in circumstances related to fair rent (e.g., building an addition) have an additional payment built into their rate. In FYs 10 and 11, these additional payments can be made only if the homes have an approved certificate of need (presumably for these material changes). The act extends this limitation for the next two fiscal years.

Despite this general prohibition on rate increases, the act permits the DSS commissioner, within available appropriations, to increase rates (presumably to reflect increases that result from the budget's increase in the nursing home provider tax).

§§ 74 & 75 — RATES FOR ICF-MR

Under the act, the Medicaid rates for ICF-MR and residential care homes are frozen at the FY 11 rate for FYs 12 and 13. However, during those fiscal years, (1) an ICF-MR assigned a lower rate due to interim rate status or by agreement with DSS gets the lower rate and (2) the DSS commissioner may pay fair rent increases to any facility that has undergone a material change and has an approved certificate of need. Although the act freezes the rates, it authorizes the DSS commissioner to increase rates to ICF-MR within available appropriations. It also authorizes the DSS commissioner to increase residential care rates for reasonable costs associated with initiating a program to certify unlicensed health care personnel to administer non-injectible medication in FY 12 or 13.

§ 76 — REIMBURSEMENTS FOR OUTPATIENT PRESCRIPTION DRUGS DISPENSED TO DSS MEDICAL ASSISTANCE RECIPIENTS

The act reduces the reimbursement DSS pays pharmacists for dispensing most brand name drugs to DSS medical assistance recipients. Previously, DSS paid the average wholesale price (AWP) of the drug minus 14%, plus a \$2.90 dispensing fee. Under the act, the reimbursement falls to the AWP minus 16% plus a \$2 dispensing fee.

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§ 77 — TFA AND SAGA PAYMENTS

The act freezes TFA and SAGA payment standards at the FY 10 rate for the next two fiscal years. It retains the existing formula for calculating increases for future years.

§ 78 — FREEZE IN STATE SUPPLEMENT BENEFITS

The act freezes benefits in the State Supplement to Supplemental Security Income program for the next two fiscal years.

§§ 78 & 79 — DECREASE IN PERSONAL NEEDS ALLOWANCE

Residents of long-term care facilities who receive Medicaid generally must spend all of their monthly income (e.g., Social Security) towards their care costs, but may keep a small portion, called a personal needs allowance, to pay for incidentals. The allowance is increased each year based on any increases in Social Security benefits (COLA), although the statute does not include the updated amounts. Previously, the allowance was \$69 per month. The act reduces the allowance to \$60 and eliminates the Social Security COLA indexing. The covered facilities include nursing homes, chronic disease hospitals, ICF-MRs, and state humane institutions.

§ 80 — CHARTER OAK HEALTH PLAN

The act excludes from coverage in Connecticut's health insurance plan for the uninsured (Charter Oak Health Plan) anyone eligible for the high-risk pool (the Pre-Existing Condition Insurance Plan) established under the federal Patient Protection and Affordable Care Act. The act eliminates a prohibition against excluding preexisting conditions from coverage under the Charter Oak plan.

The act reduces the number of low-income people eligible for premium assistance by closing the program to anyone not enrolled on May 31, 2010. It also reduces the amount of the DSS premium subsidy by lowering the range of its sliding scale, which bases the amounts on the extent to which a person's income is above the federal poverty level (FPL). Currently, the range is between \$50 and \$175; under the act, it is between \$35 and \$115. As under existing law, anyone with income above 300% of the FPL does not qualify for premium assistance.

EFFECTIVE DATE: September 1, 2011

§ 81 — MEDICAID NON-EMERGENCY DENTAL SERVICES

The act directs the DSS commissioner to modify the availability of nonemergency services to adults who do not appear to have a dental disease that is an aggravating factor in their overall health. Modifications must include providing one periodic exam, one dental cleaning, and one set of bitewing x-rays per year.

Policies, Procedures, and Regulations

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The act authorizes the DSS commissioner to implement policies and procedures to administer the program while in the process of adopting them in regulation form, so long as he publishes a notice of intent to adopt regulations in the *Connecticut Law Journal* within 20 days of implementing the policies and procedures. The policies and procedures are valid for three years following the publication date unless the legislature calls for something otherwise.

Notwithstanding a requirement that proposed regulations be submitted within 180 days after adoption, the act requires policies and procedures concerning this program to be submitted in proposed regulation form to the legislative Regulation Review Committee no later than three years after the *Law Journal* notice is published. If the commissioner is unable to submit the proposed regulations by that deadline, he must submit a written notice to the Appropriations, Human Services, and Regulation Review committees at least 35 days before the proposed regulations are due.

Under the act, the notice must indicate why DSS cannot meet the deadline and the date by which it will submit its proposed regulations. The Regulation Review Committee can require the commissioner to appear before the committee at a time it sets to further explain his reasons and to respond to the committee's policy questions. The committee may ask the Human Services Committee to review the (1) DSS policies, (2) reasons why DSS did not submit proposed regulations on time, and (3) date on which it intends to submit them. The Human Services Committee may review this information, schedule a hearing about it, and make a recommendation to the Regulation Review Committee.

§ 82 — CAPITAL IMPROVEMENTS TO FACILITIES FOR THE SEVERELY HANDICAPPED

For FYs 12 and 13, the act freezes rates at the FY 11 level for licensed private residential facilities and similar facilities operated by regional educational service centers that provide vocational or functional services for severely handicapped individuals. Any facility that would have gotten a lower rate due to interim rate status or an agreement with DSS gets the lower rate.

The rate may be higher if the facility makes a capital improvement in FY 11 or 12 required by the Department of Developmental Services commissioner for resident health and safety.

§ 83 — DSS REPORT ON SUBMITTING REGULATIONS

The act requires the DSS commissioner, by July 1, 2012, to report to the Appropriations and Human Services committees on the department's regulation process and the status of policies and procedures implemented for which proposed regulations have not been submitted to the Regulation Review Committee. He must report at least on the status of regulations with respect to (1) adult day care services, (2) medical homes, (3) LIAs, and (4) and nursing home and ICF-MR user-fees.

The report must include:

1. the duties of staff assigned to work on the proposed regulations;

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2. the need for additional staff and the duties they would perform;
 3. a timetable for training new staff to assist in the regulation process;
 4. a description of the system supports used and needed for efficiency and delivery of proposed regulations;
 5. a description of departmental policies and procedures that have not been submitted to the Regulation Review Committee, including the dates on which the policies and procedures were implemented; and
 6. a timetable for submitting them to the committee.
- EFFECTIVE DATE: Upon passage

§ 84 — TRANSPORTATION

For emergency medical transportation for people eligible for both Medicaid and Medicare, the act limits reimbursement for Medicare coinsurance and deductibles to ensure that the combined Medicaid and Medicare provider payment does not exceed the maximum allowable under Medicaid plus an additional percentage, which the DSS commissioner must establish.

§ 85 — FOREIGN LANGUAGE INTERPRETERS AND PODIATRY COVERAGE

Interpreters

PA 09-5, September Special Session (SSS), required DSS to amend the Medicaid state plan, by February 1, 2011, to include foreign language interpreter services as a “covered service” to any beneficiary with limited English proficiency. DSS also was supposed to establish billing codes for interpreter services provided under the Medicaid and HUSKY B programs. (DSS has not amended the plan or developed these codes.) This act continues this directive, eliminates its applicability to HUSKY B, and delays its implementation until July 1, 2013.

PA 09-5, SSS, directed each managed care organization (MCO) that contracted with DSS to provide interpreter services to HUSKY A recipients to submit semiannual reports to DSS, which the department submits to the Medicaid Care Management Oversight Council. This act instead requires DSS to report directly to the newly named council (see §§ 167, et. seq., below), effective July 1, 2013.

Federal Medicaid law allows states to receive federal matching funds for limited English proficiency interpreters, either by designating them as a covered state plan service or an administrative cost.

Podiatry

The act restores Medicaid coverage for podiatry services as a state plan service. It directs the DSS commissioner to amend the Medicaid state plan by October 1, 2011, to effect the change. Since 2003, DSS has not paid for podiatry services performed by independent practitioners. It has paid for them when

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provided by physicians (orthopedists) and clinics.

§ 86 — CONNECTICUT HOME CARE PROGRAM FOR ELDERLY — COST SHARING IN STATE FUNDED PORTION OF PROGRAM

The Connecticut Home Care Program for Elders provides home- and community-based services to frail elders as an alternative to nursing home care. The program has state- and Medicaid-funded components. The act increases cost sharing for the state-funded portion of the program from 6% to 7% of service costs. For people with higher incomes, this charge is in addition to any income DSS applies toward the cost of their care.

§ 87 — EMERGENCY MEDICAL SERVICES

The budget act (PA 11-6) requires \$1.45 million to be transferred from the Tobacco and Health Trust Fund for three purposes, one of which is emergency medical services. Currently, \$500,000 in grants is allocated to regional councils for emergency medical services. This act allocates these grants to regional emergency medical services.

§§ 88-90 — CONNPACE FOR PEOPLE INELIGIBLE FOR MEDICARE

The ConnPACE program provides prescription drug assistance to low-income individuals age 65 and older and younger people with disabilities. Its eligibility requirements include enrollment in Medicare Part D (drug assistance) and one of that program's benchmark plans. People with private prescription coverage also become eligible for ConnPACE if they use up their plan's coverage and meet the program's other eligibility criteria.

Under prior law, for people eligible for Medicare, ConnPACE paid any Medicare Part D prescription co-payments over ConnPACE's \$16.25 and any Part D premiums and deductibles. It also paid for prescriptions needed during the coverage gap also known as the "donut hole." (This gap begins when a beneficiary's annual out-of-pocket drug costs reach \$2,840 and continues until they reach \$4,550.) The act eliminates all of this, but it continues to offer drug assistance to people (primarily younger adults with disabilities) who do not qualify for Medicare.

However, most individuals eligible for ConnPACE and Medicare qualify for one of three Medicare Savings programs (see below), which, in turn, makes them eligible for the federal Low-Income Subsidy (LIS) program. LIS offers Part D recipients significant premium and co-payment subsidies and pays for the donut hole coverage gap.

The act also eliminates the Medicare Part D Supplemental Needs Fund, which paid for drugs ConnPACE recipients needed that were not in their Part D plan's formulary. (DSS stopped making payments from this fund in January 2010.) It also removes the statutory formulas DSS could use under prior law to calculate how much it would pay for ConnPACE-covered drugs.

Finally, the act eliminates coverage for drugs excluded from Medicare Part D

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coverage. This includes benzodiazepenes and barbituates.

§ 91 — MEDICARE SAVINGS PROGRAM (MSP)

MSPs use Medicaid funds to help lower-income individuals who are eligible for Medicare Parts A (hospitalization) and B (doctor's visits and outpatient services). In 2009, eligibility for the programs was expanded to enable most ConnPACE recipients to qualify. An individual who qualifies for the MSP is automatically eligible for the prescription drug low-income subsidy, which helps with Part D cost sharing, including payments during the donut hole period.

Under existing law, DSS is required to increase the income disregards used to determine MSP eligibility to equalize the income limits in the MSPs and ConnPACE. The act requires DSS to do the same thing for deductions used to determine eligibility for the programs.

§ 92 — MEDICAID OUTPATIENT FEE SCHEDULE

The act authorizes the DSS commissioner to establish a uniform fee schedule for Medicaid-covered outpatient hospital services. Under the prior methodology, different hospitals were paid different rates for the same services.

§ 93 — AIDS PROGRAM WAIVER

The act reduces, from 100 to 50, the number of slots for Medicaid-enrolled people eligible for DSS' home- and community-based services waiver for people with HIV or AIDS who would otherwise need an institutional level of care. It eliminates a reference to a federal regulation (42 CFR 440.180) that allows the DSS commissioner to decide what services are necessary for a participant's unique needs to avoid institutionalization.

§ 94 — EYEGLASS COVERAGE

The act reduces the frequency with which DSS will pay for eyeglasses from once per year to once every other year. It directs the commissioner to administer eyeglass and contact lens payments as cost effectively as possible. (PA 11-48 permits payment for a second pair of eyeglasses when a Medicaid recipient's health care provider determines that it is necessary because of a change in the recipient's medical condition.)

§ 95 — LIMITATION ON SMALL HOUSE NURSING HOME PROJECTS

Prior law required the DSS commissioner, within available appropriations, to establish a pilot program to support the development of up to 10 licensed small house nursing homes. (These facilities are modeled after private homes and afford residents more privacy, increased support staff, and individualized care.) He could approve one project with up to 280 beds by June 30, 2011.

The act makes the program permissive. It only allows one such small house nursing home and it allows it to have 14 beds instead of 10. In doing so, it repeals

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provisions allowing existing nursing homes to develop their own small house projects and transfer existing beds to them, thus reducing the number of institutional nursing facility beds in the state. It also repeals provisions giving priority to certain locations and facilities that use fuel cell technology.

§ 96 — SECURITY DEPOSIT GUARANTEE PROGRAM

By law and within available appropriations, DSS administers a program that provides landlords a security deposit guarantee when they rent a unit to specified low-income tenants, the homeless, or people subject to eviction proceedings. Under prior law, DSS could deny applications if it had paid two or more damage claims on a tenant's behalf in the past five years. The act allows the department to deny eligibility to tenant-applicants on whose behalf it has ever paid two claims.

Previously, tenants had no obligation to contribute to the security deposit. Under the act, those (1) with income greater than 150% of the federal poverty level (or \$27,745 for a three-person household) and (2) for whom DSS has paid a damage claim, must pay 5% of one month's rent towards the security deposit. The DSS commissioner may waive this requirement for cause.

The act also gives landlords 45 days after the termination of a tenancy to submit a damage claim. DSS will only pay claims that are accompanied by receipts indicating that the repairs have been made. It will not pay when a tenant moves out because a local, state, or federal regulatory agency determines that substandard conditions make the unit uninhabitable.

§§ 97-101 — CHILD CARE AND SCHOOL READINESS PROGRAMS TRANSFERRED FROM DSS TO SDE

Previously, DSS, in consultation with the SDE (1) provided direct subsidies to providers for child care slots and (2) awarded grants to school readiness programs for quality enhancements. The act eliminates DSS' role in these programs and permits, instead of requires, the SDE commissioner to model the direct provider subsidy on the Care4Kids child care subsidy program, which DSS administers. The act requires the SDE commissioner, effective July 1, 2011, to pay funds under the quality grant program to providers on a prospective basis.

The act also makes the SDE commissioner, rather than both commissioners, responsible for (1) coordinating the development of a range of alternative programs to meet the needs of all children, (2) fostering partnerships between school districts and private organizations, (3) providing information and assistance to parents in selecting school readiness programs, and (4) working to ensure that such programs allow open enrollments.

The act also makes the education commissioner, instead of the DSS commissioner, responsible for administering the child care facilities loan guarantee program and the child care facilities direct revolving loan program.

§§ 102 & 103 — TAX ON HOSPITAL NET REVENUE

Under the budget act (PA 11-6), hospitals are assessed a quarterly tax on net

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patient revenue. Currently, net patient revenue is defined as the amount of a hospital's gross revenue, including any Medicare payments. Under this act, the revenue is the amount of accrued payments a hospital earns for providing inpatient and outpatient services.

Under PA 11-6, other than for the Connecticut Children's Medical Center (CCMC) and John Dempsey Hospital, the tax is 4.6% of hospitals' net patient revenue. This act provides that the amount of the tax is up to the maximum allowed by federal law (6% starting October 1, 2011). It requires the DSS commissioner to determine the base year on which the tax is assessed. And it allows the commissioner, in consultation with the OPM secretary and in accordance with federal law, to exempt a hospital from the tax on payments earned from providing outpatient services based on financial hardship. (PA 11-61, § 79, requires the DSS commissioner to determine the revenue period.)

§ 104 — ASSET TRANSFERS BY NURSING HOME RESIDENTS

The law prohibits institutionalized individuals (under the act, defined as residents of nursing homes or similar facilities or individuals receiving home and community-based services under a Medicaid waiver) from transferring or assigning their assets for less than they are worth in order to shift costs to the Medicaid program. Penalties attach when such transactions occur within five years before the nursing home resident applies for Medicaid. The act sets different penalty trigger dates and penalty periods for some of these transactions depending on their characteristics.

Transfers

Under the act, a resident can be penalized for an asset transfer even if the entire amount is returned if DSS determines that the circumstances surrounding the transaction indicate that the Medicaid recipient or his or her spouse or authorized representative intended from the time the asset was transferred to change the start date of a penalty period or shift nursing facility costs to the Medicaid program. Unless the transferor can prove otherwise by clear and convincing evidence, the entire amount of the returned asset is deemed available from the date of the transfer. If the transferor prevails, the asset is deemed available from the date of its return.

Under the act, a conveyance and subsequent return of an asset for the purpose of shifting costs to the Medicaid program is deemed to be a trust-like device, and the asset will be considered available for the purposes of determining Medicaid eligibility.

The act also specifies that a partial return of a transferred asset will not reduce the penalty period. This includes transfers to the same or different transferees.

EFFECTIVE DATE: Upon passage

§ 105 — SCHOOL-BASED CHILD HEALTH PROGRAM

Federal law requires local education agencies (LEAs) to identify all children with disabilities who need special education and related services. The LEAs must

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provide the related services, which are diagnostic, evaluative, and rehabilitative in nature, and, for Medicaid-eligible students, bill DSS for the cost of providing them. DSS (1) bills the federal government for 100% of what the LEA spends, (2) keeps one-half of the reimbursement, and (3) gives the LEA the other half.

The act requires DSS to amend its Medicaid state plan for this program to maintain and enhance, to the extent allowed, federal matching funds associated with costs through a service-specific, rather than the current “bundling” of services, billing method. The act eliminates an obsolete provision regarding the content of the state plan amendment.

The act requires the DSS commissioner to notify each LEA in writing of any change in policy or billing procedure within 30 days after the effective date of the change.

EFFECTIVE DATE: Upon passage

§§ 106 & 107 — COVERAGE FOR SMOKING CESSATION AND CERTAIN OVER-THE-COUNTER DRUGS; BILLING FOR DIABETIC SUPPLIES

Smoking Cessation Drugs

By law, the DSS commissioner was to have amended the Medicaid state plan to cover smoking cessation treatment for Medicaid patients when prescribed by a licensed health care professional. This was never done. The act continues to require DSS to amend the state plan but removes the requirement that treatment be ordered by a health care professional. Thus, the act allows treatment coverage for all prescription and over-the-counter drugs and counseling.

Previously, if the initial treatment was not successful, all prescriptive options had to be made available to the patient. The act eliminates this provision.

The act adds smoking cessation drugs to the list of drugs that are exempt from the general ban on DSS payments for over-the-counter drugs starting January 1, 2012.

Diabetic Supplies

The act also requires the DSS commissioner, by August 1, 2011, to notify pharmacists participating in any DSS medical assistance program that they may bill DSS for supplies used in diabetes treatment using the durable medical equipment-medical surgical supply fee schedule. Providers currently receive electronic notifications about the fee schedule. The commissioner must provide a copy of the notice to the Human Services and Appropriations committees.

EFFECTIVE DATE: January 1, 2012 for the smoking cessation coverage provisions and July 1, 2011 for the diabetic supplies and over-the-counter drug exception provisions.

§ 108 — SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

By law, certain relatives are legally responsible for repaying the state the amount of public assistance benefits another relative (usually a spouse or minor child) receives. They must report promptly to DSS (1) any increase in income or

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acquisition of property and (2) various other planned changes in their finances.

The act excludes relatives of Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps) recipients from the reporting requirements. SNAP recipients are not required to repay the state for benefits they receive. It requires the DSS commissioner to establish reporting requirements as required by federal law.

EFFECTIVE DATE: Upon passage

§ 109 — HUSKY B COST SHARING

The act eliminates the law's specific premiums that HUSKY B, Band 2 families must pay for their children's care. By law, DSS can charge premiums for families with income greater than 235% of FPL, which is \$52,522 for a family of four in 2011.

Under prior law, families paid \$38 per month with a family cap of \$60, but the federal government recently determined that these premiums, which were increased in 2010, violated federal law (see BACKGROUND – HUSKY B Premium) and DSS is reimbursing families as a result. (Lower income, Band 1 families have only a co-payment obligation.) The act allows DSS, in accordance with federal law, to impose premiums, and for the next four fiscal years, annually increase the premiums based on any increase in the Consumer Price Index for Medical Care Services.

The act also removes a prohibition against DSS imposing a premium requirement on families with incomes between 185% and 235% (Band 1) of the FPL.

EFFECTIVE DATE: Upon passage

§ 110 — MEDICAL HOMES

The act permits the DSS commissioner to establish medical homes as a model for delivering care to recipients of DSS-administered medical assistance programs. The model, as defined by federal law, is for people eligible for Medicaid or a Medicaid waiver who have (1) two chronic conditions, (2) one chronic condition with a risk of developing a second, or (3) a serious and persistent mental health or substance abuse condition. Its components include:

1. comprehensive case management;
2. care coordination and health promotion;
3. comprehensive transitional care, including appropriate follow up, from inpatient to other settings;
4. patient and family support;
5. referral to community and social support services, if relevant; and
6. use of health information technology to link services.

Under the act, the commissioner may implement necessary policies and procedures to implement the medical home model.

In addition, the act allows him to implement policies and procedures to carry out optional provisions of the federal Patient Protection and Affordable Care and Health Care and Education Reconciliation acts relating to:

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1. family planning services,
2. establishing a temporary high-risk pool for individuals with preexisting conditions,
3. establishing an incentive program to prevent chronic diseases,
4. providing health homes to medical assistance beneficiaries with chronic conditions,
5. establishing Medicaid payments to institutions for a mental disease demonstration program,
6. establishing a demonstration program for people eligible for both Medicaid and Medicare,
7. establishing a balancing incentive payment program for home and community-based services,
8. establishing a “Community First Choice Option,”
9. establishing a demonstration project to make bundled payments to hospitals, and
10. establishing a demonstration project to allow pediatric medical providers to organize as accountable care organizations.

Policies, Procedures, and Regulations

The act authorizes the DSS commissioner to implement policies and procedures to administer the program while in the process of adopting them in regulation form, so long as he publishes a notice of his intent to adopt regulations in the *Connecticut Law Journal* within 20 days of implementing the policies and procedures. The policies and procedures expire three years following the publication date unless the legislature calls for something otherwise. (See § 81 for a summary of the procedures the commissioner must follow.)

EFFECTIVE DATE: Upon passage

§§ 111 & 174-178 — DISPROPORTIONATE SHARE (DSH) PAYMENTS TO HOSPITALS

DSH Payments Based on Actual Costs

The act modifies DSH payments to conform to federal law. Under prior law, DSS, within available appropriations, was permitted to make twice monthly payments to short-term general hospitals that serve a disproportionate share of low-income patients and provide uncompensated care. These state payments are eligible for federal matching funds. Previously, the hospitals could receive these “interim payments” based on a prior year’s data without recalculating the payments using the year’s actual data and redistributing the difference between the two through a “settlement” process, and state law prohibited settlements. For FFY 11 and succeeding fiscal years, final DSH payment amounts must be recalculated and reallocated in accordance with federal law (see BACKGROUND – Uncompensated Care).

Under the act, starting July 1, 2011, DSS, within available appropriations, can make interim monthly DSH payments, regardless of any state law to the contrary. The total amount of these payments individually and in the aggregate must

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maximize federal Medicaid matching payments, as DSS determines in consultation with OPM. The act prohibits DSH payments to CCMC or John Dempsey Hospital. DSS determines the DSH payment amount based on information the hospitals submit as required by federal law.

Also starting July 1, 2011, interim DSH payments for the next 15 months must be based on 2009 federal fiscal year data and can be adjusted at the DSS commissioner's discretion for accuracy. Effective October 1, 2012, these payments must be based on the most recent federal fiscal year data available.

The act requires the DSS commissioner to prescribe uniform annual hospital data reporting forms.

Any payments made under these provisions are in addition to Medicaid inpatient hospital rates. The act continues to permit the commissioner to withhold a payment to a hospital to offset any money the hospital may owe the state.

Conforming Changes to Existing Law

In accordance with the above provisions, the act makes a number of changes in existing law. It (1) eliminates obsolete DSH-related provisions in the Department of Public Health's (DPH) Office of Health Care Access division (OHCA) statutes, (2) makes changes in hospital auditing and filing requirements, and (3) makes conforming and technical changes.

Prior law required OHCA, in consultation with DSS, to review annually each hospital's level of uncompensated care to the indigent. Under the act, OHCA does not have to consult with DSS.

The act eliminates a requirement that each hospital get an independent audit of its level of charges, payments, and discharges to government and nongovernment payers and the amount of uncompensated care, although federal law requires this (see BACKGROUND – Uncompensated Care). But each hospital must continue to file its audited financial statements by February 28 annually. The act requires that this filing include a verification of the hospital's net revenue for the most recently completed fiscal year in an OHCA-prescribed format. Previously, the definition of "net revenue" for DSH purposes meant total gross revenue less contractual allowances, less the difference between government charges and government payments, less uncompensated care and other allowances, plus DSS' DSH payments. The act eliminates the DSH payments from the definition.

The act also requires OHCA to report to the Public Health Committee, by September 1 annually. The report must cover its review of hospitals' required annual and 12-month filings concerning uncompensated care, authorized revenue limits, and other hospital data. Under prior law, OHCA had to report each June 1 on the results of an uncompensated care audit for the previous fiscal year.

§ 112 — BLENDED INPATIENT HOSPITAL RATES

The act requires DSS, after consulting with OPM and DMHAS and DPH commissioners, to submit a plan to the Appropriations and Human Services committees for implementing a cost neutral, acuity-based method for establishing hospital rates. The plan is due January 1, 2012 and must be phased in over time.

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Under the act, the DSS commissioner may establish a “blended” inpatient hospital case rate. It must include services provided to all Medicaid recipients and may exclude certain diagnoses if the DSS commissioner determines the rates are necessary to ensure that the planned conversion to an administration services organization (ASO) is, in the aggregate, cost neutral to hospitals and ensures patient access.

By law, the commissioner is authorized to contract with ASOs for care coordination, utilization and disease management, customer service, and grievance reviews for medical assistance recipients.

§ 113 — MODIFIED FEE SCHEDULES FOR CHRONIC DISEASE AND STATE-FUNDED HOSPITALS

The act permits the DSS commissioner to annually modify fee schedules for outpatient services in chronic disease hospitals and hospitals receiving state appropriations. The purpose of the modification is to ensure that the conversion to an ASO is, in the aggregate, cost neutral to hospitals and ensures patient access.

The act also repeals an obsolete reporting requirement.

§ 114 — FEE SCHEDULES FOR HOME HEALTH CARE AGENCIES

The act eliminates the DSS commissioner’s discretionary authority to annually increase a home health care or homemaker-home health agency’s fee schedule for Medicaid services when there is an increase in the cost of services. Instead, he may annually modify the schedule to ensure that the conversion to an ASO is cost-neutral, in the aggregate, to home health care agencies and homemaker-home health agencies and ensure patient access.

§ 115 — MEDICAL SERVICE RATES

The act authorizes the DSS commissioner to establish payment rates for medical service providers if establishing the rates is required to ensure that any contract with an ASO is cost neutral to hospitals in the aggregate and ensures patient access. It requires ASO contracts with medical service providers to include provisions reducing inappropriate use of hospital emergency department services, such as requiring intensive case management services or cost sharing. PA 11-61 (§§ 121-124) prohibits utilization from being considered a factor in determining cost neutrality for inpatient and outpatient hospital services, home health care and homemaker health agencies, and medical service providers.

§ 116 — ALTERNATIVE MEDICAID BENEFIT PACKAGE FOR LOW-INCOME ADULTS

Benefit Package

The act permits the DSS commissioner to amend the Medicaid state plan to establish an “alternative benefit package” for individuals eligible for Medicaid under the Low-Income Adult (LIA) coverage group and to limit medical service

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provider rates. The act allows the package to limit:

1. health care provider office visits;
2. independent therapy services;
3. emergency room services;
4. inpatient and outpatient hospital visits;
5. medical equipment, devices, and supplies;
6. ambulatory surgery center services;
7. pharmacy services;
8. nonemergency medical transportation; and
9. home care agency services.

Effective July 1, 2011, the act prohibits DSS from paying a medical provider for services provided before April 1, 2010 to a LIA recipient. (Before that date, such individuals would have had their services paid for by the SAGA medical assistance program, which LIA replaced.)

Implementation

The act authorizes the DSS commissioner to implement policies and procedures to administer the program while in the process of adopting them in regulation form, so long as he publishes a notice of his intent to adopt regulations in the *Connecticut Law Journal* within 20 days of implementing the policies and procedures. The policies and procedures are valid for three years following the publication date unless the legislature calls for something otherwise. (See § 81 for a summary of the procedures the commissioner must follow.)

§ 117 — RESIDENTIAL FACILITY FOR FORMER PRISONERS AND DMHAS CLIENTS

The act permits the Department of Correction, DSS, and DMHAS commissioners to establish or contract to establish a chronic or convalescent nursing home on state-owned or private property. The facility is for people who (1) require nursing home-level services and are transitioning from prison into the community or (2) are DMHAS clients.

The facility's development is exempt from the state's certificate of need requirements.

§ 118 — LIMITED MEDICAL SERVICES TO ELDERLY LEGAL IMMIGRANTS

In 2009, the legislature virtually eliminated the State Medical Assistance for NonCitizens (SMANC) program and the courts ultimately upheld this. The law continued to allow certain elderly immigrants who were receiving long-term care services to continue to get this care. Under the act, immigrant elders continue to get coverage if they are receiving (1) home care services that are equivalent to those provided under the Medicaid waiver portion of the Connecticut Home Care Program for Elders, rather than just home care; (2) SMANC-funded nursing home care as of June 30, 2011; or (3) care and apply for SMANC before June 1, 2011.

EFFECTIVE DATE: Upon passage

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§ 119 — LIMITED NURSING HOME COVERAGE FOR ILLEGAL IMMIGRANTS

Under existing law, the DSS commissioner, within available appropriations and after consulting with the DMHAS commissioner and the OPM secretary, may provide payments to long-term care facilities for the care of certain illegal immigrants. Under the act, these individuals have to have been admitted to such a facility by July 1, 2011. By law, but for their illegal status, they must otherwise qualify for Medicaid. They must either be ineligible to return to their home country because of the nature of the illness or be the subject of a decision by the Bureau of Immigration and Customs Enforcement not to deport them.

EFFECTIVE DATE: Upon passage

§§ 120-141 — ELIMINATION OF STATE-ADMINISTERED GENERAL ASSISTANCE (SAGA) MEDICAL ASSISTANCE PROGRAM

PA 10-1, June Special Session, created a new Medicaid coverage group for LIAs. Anyone eligible for the SAGA medical assistance program was moved into LIA since the eligibility criteria were the same. This act eliminates the SAGA medical assistance program and most statutory references to it and in some instances, replaces SAGA medical assistance with LIA.

§§ 142 & 178 — ELIMINATION OF MEDICARE PART D SUPPLEMENTAL NEEDS FUND

The act eliminates the Medicare Part D Supplemental Needs Fund, funding for which was eliminated in January 2010. The fund paid for ConnPACE recipients to get drugs that were not on their Part D plan's formulary.

The act makes related technical and conforming changes.

§ 143 — MEDICAID THERAPY MANAGEMENT SERVICES

The act requires the DSS commissioner to contract with a pharmacy organization to provide Medicaid therapy management services. The organization can include a pharmacy school. The services must include (1) a review of the medical and prescription history of Medicaid recipients and (2) the development of patient medication action plans to reduce adverse medical interaction and related health problems. PA 11-61 (§ 127) allows DSS to select a patient-centered medical home or health home in lieu of a pharmacy.

§ 144 — LEGISLATIVE OVERSIGHT OF MEDICAID STATE PLAN AMENDMENTS

By law, the DSS commissioner must submit to the Human Services and Appropriations committees applications DSS is submitting to the federal government to waive any federal assistance program requirements unless the waiver pertains to routine operational issues. The law establishes a process for the legislature to review these waiver requests (see BACKGROUND – Legislative

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Oversight of DSS Waivers).

Under the act, the DSS commissioner must follow this same process when seeking a state plan amendment for any change in program requirements that would have otherwise required a waiver but for the passage of the federal Affordable Care Act. But the act sets up a slightly different time frame for public hearings.

Currently, when the Human Services and Appropriations committee chairpersons receive a waiver application from DSS they must hold a public hearing on it within 30 days and advise the commissioner of their approval, denial, or modification of the waiver. Under the act, if the chairpersons receive a proposed state plan amendment, they must notify the commissioner if they intend to hold a hearing and if so, the date that it will be held, which cannot be more than 60 days after they receive the amendment.

§§ 145 & 146 — DELAY IN REESTABLISHING DEPARTMENT ON AGING

The act postpones the reestablishment of the state Department on Aging, by two years, from July 1, 2011 to July 1, 2013. Connecticut disbanded this department in 1993 and merged most of its functions and personnel into DSS under the Division of Elderly Services.

EFFECTIVE DATE: January 1, 2011, except a conforming change is effective September 1, 2013.

§§ 147 & 148 — BIRTH-TO-THREE SERVICES FOR CHILDREN WITH AUTISM SPECTRUM DISORDERS

The act makes changes to the requirements for individual and group health insurance policies that provide coverage for medically necessary early intervention (birth-to-three services) provided as part of an individualized family service plan. It prohibits these policies from imposing co-insurance, copayments, deductibles, or other out-of-pocket expenses for these services, unless they are high-deductible policies designed to be compatible with federally qualified health savings accounts.

It also increases the annual maximum benefit that group health insurers must provide for children with autism spectrum disorders who receive birth-to-three services.

Coverage Requirements

By law, group health insurance policies must cover medically necessary birth-to-three services provided as part of an individualized family service plan for children with developmental delays. This coverage must include an annual maximum policy benefit of \$6,400 per child, with an aggregate benefit of \$19,200 per child over the three-year period. The act expands these coverage amounts for children with autism spectrum disorders to \$50,000 per child per year and \$150,000 per child over the three-year period. The act specifies that coverage provided through a birth-to-three individualized service plan must (1) be credited toward these coverage amounts in other statutes mandating autism coverage and

(2) not increase these coverage amounts.

Act's Applicability

The act applies to health insurance policies delivered, issued, or renewed in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. Due to the federal Employee Retirement and Income Security Act, state health insurance mandates do not apply to self-insured plans.

EFFECTIVE DATE: January 1, 2012

§ 149 — CHRONIC GAMBLERS TREATMENT REHABILITATION ACCOUNT

Beginning in FY 12, the act increases from \$1.5 million to \$1.9 million, the amount of lottery revenue that the Connecticut Lottery Corporation must annually transfer to the chronic gamblers treatment rehabilitation account (PA 09-3, June Special Session, required the transfer of \$1.9 million in FYs 10 and 11).

This account partially funds DMHAS' compulsive gambling treatment program. The balance of the funding comes from a fee imposed on dog racing, jai alai, and teletheater licensees. The program provides prevention, treatment, and rehabilitation services for chronic gamblers.

§§ 150 & 151 — ANTI-EPILEPTIC PRESCRIPTION DRUGS

The act prohibits retail pharmacists from filling a prescription to treat epilepsy or prevent seizures using a different manufacturer or distributor of the prescribed drug without (1) giving prior notice to the patient and prescribing practitioner and (2) getting the prescriber's written consent. It applies to new and renewal prescriptions that contain an International Classification of Diseases statistical code indicating the drug is used to treat epilepsy or prevent seizures.

The law already permits a prescriber to tell a pharmacist not to substitute a generic name drug for any brand name one.

Banning Manufacturer Substitutions for Anti-Epileptic Drugs

The ban applies to community pharmacies, hospital pharmacies that serve employees and outpatients, and mail order pharmacies licensed to distribute drugs in Connecticut. It does not apply to pharmacies serving hospital in-patients or in (1) long-term care facilities, such as nursing homes, chronic disease hospitals, and ICF-MRs or (2) other institutions.

The act requires the pharmacist to notify the prescriber by email or fax to obtain consent. If the prescriber does not consent, the pharmacist must fill the prescription without substitution or return it to the patient or his or her representative for filling at another pharmacy.

If, after making reasonable efforts, a pharmacist cannot contact the prescriber, he or she may refill a prescription with a 72-hour supply if, in his or her

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professional judgment, failure to do so might interrupt the patient's therapeutic regimen or cause the patient to suffer. When dispensing the refill, the pharmacist must tell the patient or the patient's representative that the prescriber did not authorize it and inform the prescriber that he or she must authorize future refills. The pharmacist may refill a prescription this way just once.

Drug Substitution

Under existing law, which the act does not change, a prescriber may tell a pharmacist not to substitute a generic name for any brand name drug. The prescriber must do this by writing "Brand Medically Necessary" on the prescription form or, if the prescriber calls in the prescription or electronically transmits it in a way that does not reproduce his or her handwriting, by stating so on the communication. For Medicaid and ConnPACE clients, the prescriber must (1) specify why the name brand and dosage are medically necessary and (2) send the "brand medically necessary" certification to the pharmacist in writing within 10 days if it was not on the prescription form. This law applies to all pharmacies.

EFFECTIVE DATE: October 1, 2011

§ 152 — CREMATION CERTIFICATE

By law, cremation certificates are required for the cremation of a body for which a death certificate has been issued. The chief medical examiner, deputy chief medical examiner, associate medical examiner, or an authorized assistant medical examiner must complete the cremation certificate, stating that such person has inquired into the cause and manner of death and believes that no further examination or judicial inquiry is needed. The act adds an authorized designee to those who can complete the certificate.

§§ 153-159 — FALSE CLAIMS ACT FOR MEDICAL ASSISTANCE PROGRAMS

In 2009, the state enacted the Connecticut False Claim Act (CFCA) applicable to the medical assistance programs that DSS administers (Medicaid, SAGA, HUSKY B, and Charter Oak). A false claims act generally allows an individual to bring a civil action in the name of the state to recover fraudulently handled state property or funds. The attorney general may, but need not, join the suit. If successful, the individual is awarded up to 300% of the amount of the state's damages, plus court costs and attorneys fees.

The act broadens the circumstances under which a person is liable for submitting false or materially misleading information in order to obtain or keep funds owed to a state medical assistance provider. It also permits more individuals to file CFCA suits and increases civil penalties.

Definitions

Claim. The act broadens the definition of "claim" by including demands for money or property, regardless of whether it belongs to the state (prior law was

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silent on who holds title to the property or money). Under the act, the demand must be submitted to (1) a state officer, employee, or agent or (2) a contractor, grantee, or other recipient, if the money or property demanded is to be spent or used on the state's behalf or to advance a state program or interest.

The act specifies that a request or demand for money or property that the state has paid to an individual as compensation for state employment or as an income subsidy with no restrictions on that individual's use of the money or property is not a claim.

Other Definitions. The act establishes new definitions of "material" and "obligation." Under the act, something is "material" if it has a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property. An "obligation" is an established duty, whether fixed or not, arising from (1) an express or implied contractual, grantor-grantee, or licensor-licensee relationship; (2) a fee-based or similar relationship; (3) statute or regulation; or (4) the retention of an overpayment.

CFCA Prohibitions

With respect to goods and services provided through all DSS medical assistance programs, the act prohibits anyone from:

1. knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval (existing law covers only claims submitted to state officers or employees);
2. knowingly making, using, or causing to be made or used, a false record or statement material to (rather than to secure payment or approval of) a false or fraudulent claim;
3. conspiring to violate the CFCA (rather than to defraud the state by securing the allowance or payment of a false or fraudulent claim);
4. knowingly making, using, or causing to be made or used, a false record or statement material to (rather than to conceal, avoid, or decrease) an obligation to pay or transmit money or property to the state; and
5. knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the state.

The act retains as prohibitions:

1. having possession, custody, or control of property or money used, or to be used, by the state relative to these programs, and, with intent to defraud the state or willfully conceal the property, delivering or causing to be delivered less property than the amount for which the person receives a receipt or certificate;
2. being authorized to make or deliver a document certifying receipt of property used, or to be used, by the state relative to these programs and, with intent to defraud the state, making or delivering the document without completely knowing that the information in it is true; and
3. knowingly buying or receiving as a pledge of an obligation or debt, public property from a state officer or employee who may not lawfully sell or pledge the property.

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Penalties

The act increases the civil penalties for any of the above violations from: between \$5,000 and \$10,000 to between \$5,500 and \$11,000, or as adjusted from time to time by federal law (28 USC § 2461). Other civil penalties are unchanged. If more than one person commits a violation, the act retains the provision that the judgment can be collected against one, some, or all of the wrongdoers (i.e., they are jointly liable).

Litigation

Under prior law, only the attorney general or an “original source” could bring CFCA actions. The act broadens the definition of original source. Under prior law, an original source was an individual who had direct and independent knowledge of the information on which the allegations were based before they became public and voluntarily provided the information to the state before bringing the action. Under the act, an original source is an individual who (1) has knowledge that is independent of and materially adds to the publicly disclosed allegations, (2) voluntarily discloses the information on which the claims are based, and (3) voluntarily provides the information to the state before filing suit.

Under the act, suits can also be brought, with the attorney general’s acquiescence, by individuals who are not original sources. They may recover, at the court’s discretion, up to 10% of the state’s damages plus court and attorney fees when they bring a CFCA suit based on information that was already publicly disclosed in (1) criminal, civil, or administrative hearings in which the state or its agent was a party; (2) a report, hearing, audit, or investigation conducted by the legislature or a legislative committee, the state auditors, or a state or quasi-public agency; or (3) the media.

The act repeals a related provision that denies courts jurisdiction when the person bringing such an action is not the attorney general or an original source, but it requires the court to dismiss such an action unless the state opposes dismissal.

The act also allows a person to file a claim regardless of whether he or she knew or had reason to know that the attorney general or another state law enforcement official knew of the allegations or transactions before the claimant filed his or her action.

Retroactivity of Attorney General’s Claims. The law authorizes the attorney general to intervene in a CFCA action brought by a private party. When this occurs, the act permits the state to (1) file its own complaint, (2) amend the plaintiff’s complaint to clarify or add detail to claims in which the attorney general is intervening or (3) add any additional claim under which the state contends it is entitled to relief. If the additional pleadings are based on the same conduct, transactions, or occurrences as in the original complaint, under the act, the attorney general’s claims relate back to the date the original complaint was filed (i.e., the statute of limitations for the state’s claims stops running on the date the original complaint was filed).

Broader Whistleblower Protections

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The law protects employees from adverse job actions when they lawfully participate in a CFCA investigation or action. The act extends these protections to contractors or agents acting in the same manner. And it permits employees, contractors, and agents to sue when adverse actions are taken against them for attempting to stop False Claim Act violations. PA 11-161 adds as potential whistleblowers people associated with employees, contractors, or agents.

The act establishes a three year statute of limitations for bringing a suit based on such adverse job actions. There was no express limitation period under prior law.

EFFECTIVE DATE: Upon passage

§§ 160-162 — DSS TO ANNUALLY CHANGE RESIDENT DAY USER FEES

Prior law required the DSS commissioner to biennially determine the amount of the nursing home and ICF-MR resident day user fee. The act gives him the option to do this annually instead.

The act also authorizes the commissioner to adjust the nursing home user fee as necessary to prevent the state from exceeding the maximum amount allowed under federal law. He may already do this for ICF-MR facilities.

Regulations

The act authorizes the DSS commissioner to implement policies and procedures to administer the fee program so long as he publishes a notice of his intent to adopt regulations in the *Connecticut Law Journal* within 30 days of implementing the policies and procedures. The policies and procedures are valid for three years following the publication date unless the legislature sets a different deadline (see § 81 for a summary of the procedures the commissioner must follow).

§ 163 — CHILDHOOD IMMUNIZATION TASK FORCE

Purpose

The act establishes a 27-member childhood immunization task force consisting of legislative appointees, legislators, and executive branch members to consider whether the state should continue universal childhood immunizations. By law, the DPH commissioner determines the standard of care for childhood immunizations in Connecticut based on the recommended schedules of the (1) National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, (2) American Academy of Pediatrics, and (3) American Academy of Family Physicians. Currently, DPH operates a federal “Vaccine for Children” program and its own immunization program funded by an assessment on health insurers.

The Task Force must also develop a plan to:

1. maintain access to high-quality immunizations for children in the state;
2. determine how to respond to recommendations by the National Centers for Disease Control for new childhood immunizations not currently provided

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- by DPH's immunization program;
3. implement a program permitting health care providers who administer vaccines to children under the federal Vaccines for Children program to select, and DPH to provide, vaccines licensed by the federal Food and Drug Administration; and
 4. determine how best to cover the cost of immunizations for children in the state.

The task force must submit a report on its findings and recommendations, including recommendations for legislation, to the, Appropriations, Human Services, Insurance and Real Estate, and Public Health committees by February 1, 2012. The task force terminates on the date that it submits its report or February 1, 2012, whichever is later.

Membership

Committee members appointed by legislative leadership are:

1. two representatives of the pharmaceutical industry, one each appointed by the House speaker and Senate president pro tempore;
2. two representatives of the insurance industry, one each appointed by the House and Senate minority leaders; and
3. two representatives of the American Academy of Pediatrics, one each appointed by the House and Senate majority leaders.

The legislative members are the chairpersons and ranking members of the Appropriations, Human Services, Insurance and Real Estate, and Public Health committees.

The Executive Branch members are the DSS, DPH, and Insurance commissioner, or their designees; the OPM secretary, or a designee; and a DPH employee, appointed by the commissioner, who is responsible for immunizations.

Administration

All appointments to the task force must be made not later than 30 days after June 13, 2011; vacancies are filled by the appointing authority. The House speaker and the Senate president pro tempore must select the chairpersons from among the task force members. The chairpersons must hold the first meeting not later than August 12, 2011.

The administrative staff of the Public Health Committee and the staff of the Office of Legislative Research serve as administrative staff to the task force.

EFFECTIVE DATE: Upon passage

§ 164 — RESTRICTING RESIDENTS UNDER AGE SIX FROM DCF GROUP HOMES

The act generally prohibits the DCF commissioner from placing any child under age six, or any sibling group including a child under that age, in a child care facility (group home). The prohibition does not apply if the (1) home is designed for children and their parents or (2) child's health needs are so severe that that they can only be met in a group home.

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When a child or a sibling group containing such a child is placed in a group home, the DCF commissioner must certify to the court that specific attempts were made to secure a family-based (foster care) placement. The certification must be filed in court within 96 hours after the group home placement.

If a child or sibling group containing such a child remains in a group home for more than 30 days, the commissioner must petition the court for an emergency placement review hearing. The hearing must be held no sooner than 45 days after the placement to (1) review the commissioner's efforts to find a foster placement and (2) determine whether the child's health needs warrant continued placement in the group home. (PA 11-48, § 305, repeals this provision.)

EFFECTIVE DATE: July 1, 2012

§ 165 — PILOT PROGRAM FOR TFA RECIPIENTS

The act requires the DSS and labor commissioners, within available appropriations, to implement a pilot program, for up to 100 people who (1) receive TFA benefits and (2) participate in the Jobs First Employment Services (JFES) program (see BACKGROUND – Jobs First).

Program Services

The act requires the pilot program to provide participants with:

1. intensive case management services to identify their employment goals and support services (e.g., child care), training, education, and work experience needs;
2. help in accessing the support services, training, education, and work experience; and
3. funding to facilitate their participation in necessary adult basic education, skills training, post-secondary education, or subsidized employment.

Many of these services and supports are already available to JFES clients.

Report

The act requires both commissioners to submit a joint report to the Human Services and Appropriations committees by October 1, 2012. The report must include:

1. the number of program participants;
2. the participants' education, training, and work experience activities;
3. the support services that the case manager determines participants need and those that they actually receive;
4. educational degrees and certificates participants obtain; and
5. a description of jobs that participants get as a result of the pilot.

TFA Extensions for Pilot Participants

The act requires the DSS commissioner to extend TFA program benefits beyond 21 months to pilot program participants who have made a good faith effort to comply with the pilot program's requirements, have not received more than 60 months of TFA benefits, and have not been granted more than two

extensions.

Federal and state laws generally prohibit states from providing assistance to a family for more than 60 months. Currently, DSS grants up to two extensions to families that have made a good faith effort to comply with the Jobs First requirements but have family income less than the TFA benefit. DSS can also grant extensions in other circumstances, including domestic violence. DSS can grant subsequent extensions in certain circumstances.

The act does not (1) specify how long the pilot program runs, (2) specify how participants are selected, or (3) define what is expected of participants for them to be considered in compliance. It also does not specify whether these families are counted in the state's Temporary Assistance for Needy Families (TANF) work participation rate.

§ 166 — INCREASE IN DSS PAYMENTS TO ADULT DAY CARE PROVIDERS

The act requires the DSS commissioner, beginning July 1, 2011, to increase by \$4 per person, the daily fees that DSS pays for adult day care services. The current rates are (1) \$66.22 for a full day with approved medical model providers and (2) \$62.18 for a full day with non-medical model providers. The half-day rate for both types is \$40.54.

The law, unchanged by the act, allows DSS to annually increase these fees, which are set by schedule, based on increases in service costs. The state's rate for these services cannot exceed that charged to the public.

§§ 167-172 — COUNCIL OVERSEEING DSS MEDICAL ASSISTANCE PROGRAMS

Council Duties

By law, the Council on Medicaid Care Management Oversight oversees the HUSKY A program. In practice, the council has overseen HUSKY B and Charter Oak, too. The act renames the council as the Council on Medical Assistance Program Oversight to reflect its larger role, and in light of DSS converting its delivery model from full-risk MCOs to an ASO. Under the act, the council retains its advisory role to the DSS commissioner with regard to implementing HUSKY A, but the act expands the council's role to include all of Medicaid, including low-income adults and aged, blind, and disabled adults; people eligible for both Medicaid and Medicare; and people with preexisting medical conditions.

By law, the council must make recommendations on a wide range of issues. The act expands those requirements and additionally requires the council to monitor them.

The act requires the council to monitor implementation of outcome measures and the issuance of the request for proposals for the ASO, which DSS issued in April 2011.

The act requires the council to monitor, as well as make recommendations concerning, a number of areas. Previously, the council had to assess the sufficiency of provider networks. The act requires the council to assess accessible

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adult and child primary care providers, specialty providers, and hospitals in Medicaid provider networks. It also requires the council to look for an enrollment process that ensures rather than guarantees access to all DSS-administered health care programs.

Previously, the council had to look at the sufficiency of capitated rates, provider payments, financing, and staff resources to guarantee timely access to services. Under the act, the council must monitor and make recommendations regarding provider rates to maintain the Medicaid network of providers and service access. And it must do the same for funding and agency personnel resources to guarantee access to services and effective management of the Medicaid program.

The act also specifies that monitoring and recommending changes concerning care management models includes medical homes and health homes. Also, when reviewing quality assurance, the council must look at outcome measures and continuous quality improvement initiatives that may include provider quality performance incentives and performance targets for ASOs.

Previously, the council looked at how coverage was coordinated under HUSKY and other health care programs. The act requires coordination of coverage without specifying program names and requires the council to look at continuity among Medicaid programs and integration of care, including (1) behavioral health, (2) dental, and (3) pharmacy care that DSS provides. (DSS has excluded these three areas from HUSKY managed care over the last several years.)

The act requires the council chairperson to ensure that a sufficient number of council members participate in the review of any contracts DSS enters into with an ASO.

Council Membership

The act changes the composition of the council, decreasing the number of voting members as of July 1, 2011 as follows:

| <i>Appointing Authority</i> | <i>Prior Law</i> | <i>Act</i> |
|------------------------------|--|--|
| House speaker | One legislator, two insurance industry representatives*, one advocate for DCF foster families | One legislator; one community provider of adult Medicaid; one Medicaid aged, blind, or disabled recipient or his or her advocate; one representative of a federally qualified health center (FQHC) |
| Senate president pro tempore | One legislator, representative from each MCO,* representative of primary care case management (PCCM) provider, | One legislator, one home health care industry representative, one primary care medical home provider, one |

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| <i>Appointing Authority</i> | <i>Prior Law</i> | <i>Act</i> |
|-----------------------------|--|--|
| | advocate for DCF foster families | advocate for DCF foster families |
| House majority leader | Advocate for people with substance abuse disorders, Medicaid recipient | One advocate for people with substance abuse disabilities, one Medicaid dental provider |
| Senate majority leader | Advocate for person receiving Medicaid | One representative of school-based health centers, one HUSKY recipient |
| House minority leader | Advocate for people with psychiatric disabilities, Medicaid recipient | One advocate for people with disabilities, one dually eligible person or his or her advocate |
| Senate minority leader | Advocate for person receiving Medicaid | One Medicaid LIA recipient or his or her advocate, one hospital representative |
| | Chairs and ranking members of Human Services, Public Health, Appropriations committees, or their designees | Same |
| | Executive director of the Commission on Aging, or her designee | Same |
| | Executive director of the Commission on Children, or her designee | Same |
| | Two representatives each from DSS, DPH, DMHAS, DCF, OPM, appointed by agency heads | Commissioners of DSS, DCF, DPH, DDS, DMHAS and OPM secretary, who are ex-officio, nonvoting members |
| | Representative from Comptroller's office that he appoints, ex-officio nonvoting | Comptroller or his designee, who is an ex-officio, nonvoting member |
| | | Representative from ASO contracting with DSS for Medicaid administration, who is an ex-officio, nonvoting member |

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| <i>Appointing Authority</i> | <i>Prior Law</i> | <i>Act</i> |
|-----------------------------|------------------------|---|
| | | Representative of the Long-Term Care Advisory Council |
| TOTAL | 41* (39 actual) | 39 (31 are voting members) |

*There were only three insurance representatives, not five. Previously, The House speaker appointed two MCO representatives and the Senate president pro tempore appointed one.

Reporting

Previously, DSS had to provide monthly reports to the council on HUSKY plans and implementation. The act instead requires him to report on matters that the council monitors and on which it makes recommendations, including policy changes and proposed regulations that affect Medicaid health services. The commissioner must also provide the council with quarterly reports for each covered Medicaid population. These latter reports must include a breakdown of amounts spent for each population.

The act also requires the council to report to the General Assembly biannually instead of quarterly.

§ 173 — ASSISTANCE FOR SEXUAL ASSAULT VICTIMS

The act requires the DPH commissioner to issue a request for proposals seeking an entity to administer a program that provides financial assistance for sexual assault victims. Funding of \$25,000 per year comes from AIDS Services funds.

The program covers drugs prescribed by a physician for non-occupational post-exposure prophylaxis for HIV consistent with the recommendations of the National Centers for Disease Control and Prevention and Connecticut’s Technical Guidelines for Health Care Response to Victims of Sexual Assault.

DPH must give service priority to victims who are under- or uninsured and for whom the program is payer of last resort.

§ 178 — REPEALERS

The act repeals provisions that:

1. require the governor to appoint a BESB executive director (§ 10-294);
2. require the DMHAS commissioner to operate a behavioral health managed care program for SAGA recipients (§§ 17a-453a, 453b, & 17b-200);
3. establish a SAGA medical assistance program (§ 17b-192);
4. require the Office of Health Care Access to establish state hospital rates during a waiver period (§ 17b-240);
5. permit DSS to enter into a contract with a consortium of federally qualified health centers to run the SAGA medical assistance program (§ 17b-256d);
6. allow a long-term care recipient’s spouse who is still living at home to keep the maximum community spouse protected amount instead of one half of the assets, up to the maximum (§ 17b-261k);

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7. require DSS to develop and implement a two-year pilot program for 19- to 21-year-olds with one or more mental disorders (§ 17b-263b);
8. establish the Medicare Part D Supplemental Needs Fund (§ 17b-265e);
9. authorize a Long-Term Care Reinvestment Account that holds enhanced federal Medicaid matching funds the state receives from the Money Follows the Person Demonstration program (§ 17b-371);
10. require DSS to establish an adult foster care program (§ 17b-424);
11. require DSS to maintain a Bureau of Rehabilitation Services (§ 17b-651);
12. transferred the Bureau of Rehabilitation Services into DSS when agencies were reorganized in 1993 (§ 17b-652);
13. limit pharmacists who can participate in ConnPACE to those who accept Medicare Part D drug discount cards (§ 17b-492a);
14. require hospitals that engage in inefficient or inappropriate provisions of uncompensated care to submit cost reports (§ 19a-662);
15. establish a toll-free phone line for use by the Bureau of Rehabilitation and its clients (§ 17b-664);
16. require the OPM secretary to inform OHCA of the maximum DSH payments (§ 19a-669);
17. require DSS to promptly apply to the federal Medicaid agency for any necessary approvals, if needed, to carry out the DSH program (§19a-670a);
18. establish the formula for calculating DSH payments (§ 19a-671);
19. authorize DSS to adjust any DSH overpayments by reducing Medicaid payments to hospitals (§ 19a-671a);
20. provide that DSH appropriations must be used to make DSH payments to hospitals (§ 19a-672);
21. permit the DSS commissioner to make DSH payments to short-term general hospitals that change ownership in the middle of a hospital fiscal year (§ 19a-672a); and
22. establish a DSH reconciliation account in the General Fund (§ 19a-683).

BACKGROUND

HUSKY B Premiums and Federal Stimulus and Health Care Reform Legislation

The federal government recently informed DSS that the HUSKY B premium increases enacted in 2010 were not allowed by either the American Recovery and Reinvestment Act or the federal Affordable Care Act's maintenance of effort (MOE) requirements. DSS is in the process of refunding the increases to families. But the state is permitted to increase premiums prospectively if the increase is based on an increase in the consumer price index (CPI)-Medical Services and the state receives federal approval to do so.

Legislative Oversight of DSS Waivers

When DSS seeks a federal waiver for anything but routine operational issues, it must seek legislative approval, which includes a public hearing.

Once the hearing is concluded, the Human Services and Appropriations

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committees must advise the commissioner of their approval, denial, or modifications, if any, of the proposed waiver. If the committees advise the commissioner that they are denying the amendment, the commissioner may not submit it to the federal government.

If the committees do not agree, the chairpersons must appoint a conference committee composed of three members from each committee. At least one member from each committee must be from the minority party. The conference committee must report to both standing committees, which must vote to accept or reject the report. The report may not be amended.

If either standing committee rejects the conference report, that committee must notify the commissioner and the proposed waiver is deemed approved. If the committees accept the report, the Appropriations Committee must advise the commissioner of their approval, denial, or modifications of the waiver. If the committees do not advise the commissioner within 60 days, the waiver is deemed approved.

Any proposed waiver submitted to the federal government must be in accordance with the approval or modifications of the committees.

Before submitting a waiver to the committees, the DSS commissioner must publish notice in the *Connecticut Law Journal* that he intends to submit the waiver, including a summary of the waiver's provisions and the manner in which individuals may submit comments. The commissioner must allow 15 days for written comments before submitting the waiver to the committees and must include these comments with his submission.

The commissioner, when submitting the proposed waiver to the federal government, must submit (1) written comments received and (2) a complete transcript of the public hearing, including any additional written comments submitted at the hearing. The committees must send any such materials to the commissioner for this purpose.

Jobs First

The Jobs First program is the state's welfare-to-work program under which the state provides cash assistance (TFA) and employment services to enable low-income families to become self-sufficient within the program's 21-month time limit. Able-bodied adults in families receiving TFA work with a case manager to develop an employment plan that includes activities to ensure that they find work and can support their families by the end of the 21-month period. Federal and state laws prescribe the types of work-related activities that count towards the federal TANF work participation rate.

Uncompensated Care, DSH Payments, and New Federal Requirements

The original uncompensated care/DSH program had a settlement process. DSS made payments to hospitals that provided uncompensated care using two-year finalized data. For example, FFY 1998 data was used to make FFY 2000 interim DSH payments. After the FFY 2000 actual data was finalized (hospitals actual uncompensated care costs) the DSH payments were recalculated using the FFY 2000 data. The difference between the actual and interim DSH payments that

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DSS already made was the DSH settlement. State law stopped allowing this settlement process beginning in FFY 2000.

Before FFY 2000, DSS determined what the federal Medicaid agency calls an upper payment limit (UPL) to determine the interim DSH payments and the final payments based on the settlements. If the interim payments were higher than the UPL, the state would recover these and paid half of the recovered amount to the federal government (which reimburses states 50% for DSH payments).

The 2003 Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-73, § 1001) requires states that make DSH payment adjustments to submit annual reports to CMS identifying each hospital that receives a DSH payment and any adjustments as well as other information regarding the payments that CMS determines. It also requires states to submit independent certified audits regarding the DSH payments.

Under the federal act, the UPL must be calculated using the year's actual data. If a hospital's interim payment exceeds the UPL (which is the limit specific to each hospital) using the actual data, the state must recover the balance from the hospital, and half goes to the federal government. But if an approved Medicaid state plan specifies that the excess amounts are to be redistributed to hospitals that have not reached their UPL, as an integral part of the audit process, states do not have to return the excess.

OLR Tracking: RC:JKL:VR:ro