
OLR Bill Analysis

sHB 6367

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

SUMMARY:

This bill makes several changes to human services programs, many of which the Department of Social Services (DSS) administers. These include:

1. elimination, as of January 1, 2014, of the Charter Oak Health Plan, which serves residents who have been uninsured for at least six months;
2. elimination of the ConnPACE program, which serves elderly and disabled individuals who do not qualify for Medicare, as of January 1, 2014;
3. a freeze on nursing home rates in FYs 14 and 15;
4. creation of diagnosis-related groups to factor the severity of the patient's condition in determining Medicaid rates for inpatient hospital care; and
5. limits on the type of foreign language interpreter services available for Medicaid recipients.

The bill also makes technical changes.

EFFECTIVE DATE: Various; see below.

§ 1 — EDUCATION OF BLIND AND VISUALLY IMPAIRED CHILDREN

The Department of Rehabilitation Services (DORS) provides up to \$6,400 annually to local school districts for the educational needs of each child who is blind or visually impaired. DORS pays for these

services from the Educational Aid for Blind and Visually Handicapped Children Account. The law prioritizes how the funds may be spent, with the top two priorities being the use of state employee teachers of the visually impaired and providing specialized books, equipment, and materials.

The bill eliminates requirements that remaining funds after DORS exhausts spending under the priority categories (1) cover the pro-rated share of the actual cost (including benefits) that school districts use to hire teachers directly instead of using DORS teachers and (2) if there are still funds left, be distributed to school districts on a 2:1 credit ratio of Braille-learning to non-Braille-learning students based on the annual child count data.

EFFECTIVE DATE: July 1, 2013

§ 2 — DEPARTMENT OF REHABILITATIVE SERVICES

PA 11-44 created a new Bureau of Rehabilitative Services (renamed DORS in 2012) to provide services to individuals who are blind and visually impaired and deaf and hearing impaired. DORS took over all the functions of DSS' Bureau of Rehabilitation Services (BRS).

Assistive Technology Revolving Fund

The bill conforms law to practice by authorizing the DORS commissioner, rather than the DSS commissioner, to establish and administer the Assistive Technology Revolving Fund. In practice, BRS administered the fund when it was within DSS and DORS does so currently.

Current law requires that the fund be used to make loans to people with disabilities to purchase assistive equipment. The bill expands loan eligibility to include senior citizens or the family members of both groups. It eliminates loan use for assistive equipment and instead allows the loans to be used for assistive technology and adaptive equipment and services. It also extends terms of the loan from up to five years to up to ten years and caps the interest at no more than 6%. The bill eliminates State Bond Commission authority to set the interest

rate and conforms law to practice by allowing the DORS commissioner to set the rate.

Connecticut Tech Act Project

DORS currently administers the Connecticut Tech Act Project, which helps clients get the assistive technology they need for greater independence at work, school, or in the community. The bill allows the project to provide available assistive technology evaluation and training services upon request. It allows the project to recoup direct and indirect costs by charging a reasonable fee that the DORS commissioner establishes.

EFFECTIVE DATE: July 1, 2013

§ 3 — NURSING HOME RATES

For FYs 14 and 15, the bill limits at FY 13 levels the rates DSS pays nursing homes for their Medicaid-covered residents. Under current law, homes that receive lower rates because DSS has issued them an interim rate receive that lower rate. The bill extends this same exception in FY 13 and FY 14 and extends it to homes whose rates would be lower due to (1) re-basing, (2) available appropriations, or (3) some other agreement with DSS.

By law, DSS must re-base nursing home rates no more frequently than every two years and at least once every four years. The DSS commissioner determines the frequency of the re-basing. When a nursing home has its rates re-based, DSS looks at the home's most recent cost report and bases the rate on those costs, rather than those from an earlier year.

Finally, the bill clarifies that DSS may decrease, as well as increase, nursing home rates regardless of any contrary provision in the nursing home rate setting law, as available appropriations permit.

EFFECTIVE DATE: July 1, 2013

§ 4 — RESIDENTIAL CARE HOMES (RCH)

The bill permits DSS, within available appropriations, to increase or

decrease RCH rates to reflect cost re-basing. The bill provides that RCHs that are to be issued lower rates due to having an interim rate status or some other agreement with DSS must receive such lower rate in FYs 14 and 15.

EFFECTIVE DATE: July 1, 2013

§ 5 — MEDICAL CODE STANDARDS

In 2009, the federal Department of Health and Human Services (HHS) published a regulation (45 CFR 162.1002) setting the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) medical code as the new Health Insurance Portability and Accountability Act (HIPAA) standard. As HIPAA-covered entities, states must comply with this new standard on October 1, 2014.

The bill requires the DSS commissioner to convert all DSS medical assistance programs from ICD-9 to ICD-10 in compliance with the HHS regulation. It also allows the commissioner to implement necessary policies and procedures while in the process of adopting regulations if he publishes notice of his intent to adopt regulations in the *Connecticut Law Journal* within 20 days after implementing the interim policies and procedures.

EFFECTIVE DATE: October 1, 2014

§§ 6 & 7 — HOSPITAL RATES

Diagnostic-Related Groups—Inpatient Rates

The bill requires DSS, beginning July 1, 2013, to reimburse acute care and children's hospitals for serving Medicaid recipients based on diagnostic-related groups (DRGs) that the DSS commissioner establishes and periodically re-bases. DSS must annually determine the inpatient rates by multiplying DRG relative weights by a base rate. The federal Medicare program uses a DRG-type system when setting the rates it reimburses hospitals for serving Medicare patients. Such a system permits payment to be based on the severity of each patient's illness.

The bill permits the DSS commissioner, within available appropriations, to make additional payments to hospitals based on criteria he establishes.

The bill's provisions replace current law, under which hospitals (including chronic disease hospitals) are reimbursed based on the lower of (1) their reasonable costs or (2) the charge to the general public for ward services or the lowest charge for semiprivate rooms if the hospital has no wards. And it allows these hospitals to receive a higher amount for serving a disproportionate share of indigent patients. In practice, the hospitals receive a flat daily rate per Medicaid patient, along with a payment for serving a disproportionate share of indigent patients.

The bill eliminates a provision requiring DSS to pay hospitals a lower acute care inpatient rate for patients who no longer need an acute level of care. It eliminates obsolete provisions and makes technical changes.

By law, the reimbursement rates may not exceed those that the hospital charges to the general public.

Medicare Ambulatory Payment Classification—Outpatient and Emergency Room Rates

The bill requires DSS, beginning July 1, 2013, to pay hospitals for outpatient and emergency room care based on prospective rates that the DSS commissioner establishes in accordance with the Medicare Ambulatory Payment Classification (MAPC) system, in conjunction with a state conversion factor. The MAPC system must be modified to provide payment for services that Medicare does not normally cover, including pediatric, obstetric, neonatal, and perinatal services. By law and unchanged by the bill, these rates may not exceed those that the hospital charges to the general public.

The bill eliminates a requirement that DSS pay for these services based on a ratio of costs to charges and establish a fee schedule from which it pays hospitals based on the type of visit. Under the bill, those outpatient services that do not have an established MAPC "code" must

be paid on the basis of either a cost to charges ratio or the fixed fee in effect as of July 1, 2014. It is unclear how services that do not have a code will be reimbursed in FY 13.

The bill also makes a technical, conforming change.

Fiscal Impact Report

The bill (1) requires the commissioner to determine the fiscal impact of the new DRG and MAPC systems on each hospital and (2) report his results to the Appropriations and Human Services committees by December 31, 2013.

DSS Authorization to Implement Before Regulations Finalized

The bill permits the DSS commissioner to implement policies and procedures necessary to carry out the above hospital-related provisions while in the process of adopting them in regulation, provided he publishes notice of intent to adopt regulations in the *Connecticut Law Journal* within 20 days of implementation.

Utilization and Cost Neutrality.

By law, DSS can modify the outpatient fee schedule and establish a “blended” inpatient rate if such (1) is needed to ensure that its conversion from a managed care to an administrative services organization (ASO) service delivery model is cost neutral to hospitals in the aggregate and (2) ensures patient access. The bill makes permanent a provision that allows service utilization to be a factor in determining cost neutrality. Under current law, this provision expires on June 30, 2013.

EFFECTIVE DATE: July 1, 2013

§ 8 — HOME HEALTH CARE SERVICES FEE SCHEDULE

The law authorizes the DSS commissioner to annually modify fee schedules for home health care services if doing so (1) is required to ensure that any contract with an ASO (see BACKGROUND) is cost neutral to home health care agencies and homemaker-home health aide agencies in the aggregate and (2) ensures patient access. The bill

makes permanent a provision that would have expired on June 30, 2013, which allows the commissioner to take utilization into account when determining cost neutrality.

EFFECTIVE DATE: July 1, 2013

§ 9 — HOSPITAL MEDICAL SERVICE PROVIDER PAYMENT RATES

The law authorizes the DSS commissioner to establish payment rates for medical service providers if establishing the rates (1) is required to ensure that any contract it maintains with an ASO is cost neutral to hospitals in the aggregate and (2) ensures patient access. The bill makes permanent a provision that would have expired on June 30, 2013, which allows the commissioner to take utilization into account when determining cost neutrality.

EFFECTIVE DATE: July 1, 2013

§ 10 — DISPROPORTIONATE SHARE PAYMENTS

Under federal and state law, Medicaid provides additional reimbursement to short-term general hospitals that serve a disproportionate share (DSH) of low-income patients. (By state law, Connecticut Children's Medical Center and UConn Health Center are not eligible for such payments.) Under current law, DSS, within available appropriations, can make interim DSH payments on a monthly basis in order to maximize federal Medicaid matching funds. The bill instead requires that these interim payments be made on a quarterly basis, thus conforming law to current practice.

EFFECTIVE DATE: July 1, 2013

§ 11 — HOSPICE CARE REIMBURSEMENT RATES

PA 12-1, December Special Session, imposed a 5% reduction on Medicaid reimbursement rates (from 100% to 95%) for long-term care facility residents receiving only hospice care from January 1, 2013 through June 30, 2013. The bill makes this reimbursement rate reduction permanent.

Some long-term care facility and hospice agency services provided to residents who have chosen hospice care overlap. In this situation, federal Medicaid law allows state programs to set a facility's per diem rates at 95% of what it otherwise would have been.

EFFECTIVE DATE: July 1, 2013

§ 11 — CHIROPRACTIC AND FOREIGN LANGUAGE INTERPRETER SERVICES FOR MEDICAID RECIPIENTS

Interpreter Services

Federal Medicaid law requires states to provide foreign language interpreter services to individuals with limited English proficiency (LEPs). It allows states to receive federal matching funds for LEP interpreters, either by designating them as a covered state plan service or an administrative cost.

Currently, DSS must, by July 1, 2013 (1) amend the Medicaid state plan to include foreign language interpreter services as a “covered service” to any beneficiary with limited English proficiency, (2) establish billing codes for interpreter services provided under the Medicaid program, and (3) report semi-annually to the Council on Medical Assistance Program Oversight on the foreign language interpreter services provided under this program. The bill eliminates these requirements.

The Medicaid ASO, Community Health Network of Connecticut, Inc., currently provides foreign language interpreter services for Connecticut Medicaid recipients over the phone and in person upon request. Presumably, it will continue to do so as part of its administrative cost.

Chiropractic Services

The bill eliminates a requirement that the DSS commissioner amend the Medicaid state plan to limit chiropractic coverage only to the extent required by federal law.

Federal law provides that chiropractic coverage is an optional service for adult Medicaid recipients and the state does not currently

cover this for adults if the service is provided by an independent chiropractor.

Federal law generally requires that children under age 21 be entitled to receive chiropractic coverage under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions if ordered by a medical professional to treat a condition that a screening reveals. The state reimburses independent chiropractors treating Medicaid-eligible children and provides some limited chiropractic services beyond those required by EPSDT. The bill will enable DSS to continue to provide those services.

EFFECTIVE DATE: July 1, 2013

§§ 12, 39, & 41 — MEDICAID FOR LOW-INCOME ADULTS

The state's Medicaid for Low-Income Adults program (LIA) provides Medicaid coverage to childless adults between the ages of 19 and 64 with income up to about 60% of the federal poverty level (FPL), or \$512.05 per month; there is no asset limit. Beginning January 1, 2014, the income limit rises under federal law (Affordable Care Act) to 133% of the FPL (plus an additional 5%), or about \$1,275 per month using 2013 federal poverty guidelines. To comply with federal law, the bill eliminates the 60% of FPL limit and, linking to federal eligibility requirements, establishes program eligibility by referring to the federal law.

The bill eliminates provisions concerning (1) a \$150 per-month disregard for earnings (which allows applicants to have a higher income and still qualify) and (2) a three-month extension of benefits for someone who loses eligibility solely due to earnings.

The bill also removes a requirement that DSS seek a federal waiver to (1) impose a \$10,000 liquid asset test on LIA applicants and recipients, (2) count parental income and assets, and (3) limit to 90 days the amount of nursing home care LIA recipients can have covered by the Medicaid program. The federal Medicaid agency denied a DSS waiver application earlier this year.

Finally, it removes a provision that permits DSS to offer an alternative, more limited benefit package to LIA recipients.

EFFECTIVE DATE: January 1, 2014

§ 13 — MEDICARE SAVINGS PROGRAM (MSP) ELIGIBILITY

Current law requires DSS, when determining an individual's eligibility for MSP, to disregard the amount of income that equalizes the program's income limits with the ConnPACE income limits (see BACKGROUND).

The bill instead requires DSS to disregard the amount of income for each MSP sub-group so that a person with an income that is (1) less than 211% of the FPL will qualify for Qualified Medicare Beneficiary program coverage, (2) from 211% FPL to 230% FPL will qualify for the Specified Low-Income Medicare Beneficiary program, and (3) from 231% FPL up to 245% FPL will qualify for the Qualifying Individual program.

The bill does not change the MSP income limits but it does change the mechanism for providing cost of living adjustments.

EFFECTIVE DATE: January 1, 2014

§ 14 — CONNMAP ELIGIBILITY

Currently, to be eligible for the Connecticut Medicare Assistance Program (ConnMAP, see BACKGROUND) a resident must be enrolled in Medicare Part B with an annual income of up to 165% of the ConnPACE qualifying income level (\$43,560 in 2013) or, if married, a combined income of up to 165% of the ConnPACE qualifying income level (\$58,740 in 2013). The bill eliminates the formula for calculating ConnMAP income eligibility and sets the income limits at current levels (\$43,560 for an individual income and \$58,740 for a combined income). The bill requires the DSS commissioner, starting on January 1, 2014, to increase the income limits to the nearest hundred dollars to reflect the annual inflation adjustment in Social Security income. (ConnPACE currently uses the same mechanism to calculate income limit increases).

EFFECTIVE DATE: January 1, 2014

§ 16 — CUSTOMIZED WHEELCHAIRS FOR MEDICAID RECIPIENTS

The law provides that customized wheelchairs must be covered under Medicaid only when (1) a standard wheelchair will not meet an individual's needs, as DSS determines, and (2) when DSS requests an assessment. (DSS regulations permit vendors or nursing homes to perform assessments to determine this need.) The bill removes the requirement that DSS request the assessment.

EFFECTIVE DATE: Upon passage

§ 17 — NURSING HOME ADVANCE PAYMENTS

The bill eliminates a requirement that the DSS commissioner consult with the Office of Policy and Management secretary before providing advance payments to nursing homes that provide services eligible for payment under the medical assistance program.

EFFECTIVE DATE: Upon passage

§§ 18, 19, & 26 — BEHAVIORAL HEALTH PARTNERSHP

The Behavioral Health Partnership (BHP) is an integrated behavioral health system currently operated by the departments of children and families (DCF) and mental health and addiction services (DMHAS), and DSS. BHP's goal is to provide access to complete, coordinated, and effective community-based behavioral health services and supports. The partnership maintains a contract with an ASO, ValueOptions.

The law requires the DCF, DMHAS and DSS commissioners to implement the BHP for HUSKY Plan A and B members and children enrolled in voluntary DCF services. The bill requires, instead of permits, the commissioners to implement the BHP for all Medicaid recipients, not just those in HUSKY Plan Part A. In practice, the BHP already provides assistance to all Medicaid recipients. The bill also eliminates BHP assistance for Charter Oak Health Plan (COHP) members on January 1, 2014 to conform with the provisions

eliminating COHP (see below).

Currently, the ASO must authorize services based solely on the BHP clinical management committee's guidelines. It may make exceptions when a member or the member's legal guardian or service provider requests one and the ASO determines the exception to be in the member's best interest. The bill instead requires the ASO to authorize services based solely on "medical necessity," as defined by statute (see BACKGROUND) and use the clinical management committee guidelines only as a basis for expeditiously approving a service request. If the request for services does not meet the guidelines, the ASO may deny the request only if it is not medically necessary, as defined by statute.

EFFECTIVE DATE: July 1, 2013

§§ 20-21, 24-28, 38, & 41 — CHARTER OAK HEALTH PLAN (COHP) ELIMINATED

The bill eliminates COHP, effective January 1, 2014. COHP is for residents who have been uninsured for at least six months, including those with pre-existing medical conditions. Some individuals currently insured through COHP will be able to enroll in health insurance through the Connecticut Health Insurance Exchange starting in October 2013 and others will be eligible for Medicaid under the new federal income eligibility limits effective January 1, 2014.

EFFECTIVE DATE: January 1, 2014

§§ 15, 22-24, 29-37, & 41 — CONNPACE ELIMINATED

The bill eliminates the ConnPACE program, which serves people over age 65 and younger individuals with disabilities who do not qualify for Medicare. It makes numerous technical, conforming changes.

EFFECTIVE DATE: January 1, 2014

§ 40 — REPEAL OF AIDS WAIVER

The bill eliminates a requirement that the DSS commissioner apply

for a Medicaid home- and community-based services waiver for individuals with AIDS or HIV. DSS has not applied for the waiver.

EFFECTIVE DATE: July 1, 2013

BACKGROUND

Converting Medicaid Program to ASO Model

The law authorizes DSS to contract with one or more ASOs (currently, the Community Health Network of Connecticut, Inc.) to provide a variety of nonmedical services for Medicaid, HUSKY A and B, and Charter Oak Health Plan enrollees. DSS previously contracted with managed care organizations to perform most of these services, which they did as part of a risk-sharing capitation payment that covered medical services. The ASO performs the services for a set fee and does not share any risk for the provision of medical services.

ConnPACE and MSP

For over 25 years, the Connecticut Pharmaceutical Contract to the Elderly and Disabled (ConnPACE) program subsidized seniors' prescription drug costs. When Congress added prescription drug coverage to Medicare in 2006 (Part D), ConnPACE became a wrap-around program for seniors eligible for Medicare and helped with co-payments, premium assistance, the Part D coverage gap ("donut hole"), and coverage for drugs that were not in a participant's Part D plan's formulary. As of July 1, 2011, ConnPACE was eliminated for anyone eligible for Medicare, but these individuals can get drug coverage by enrolling in the Medicare Savings Program (MSP).

The MSP is a mandatory Medicaid coverage group that essentially allows Medicare recipients who would not otherwise qualify for Medicaid to receive limited help with their Medicare Part A and B cost sharing. The MSP consists of three sub-groups:

1. Qualified Medicare Beneficiaries,
2. Specified Low-Income Medicare Beneficiaries, and
3. Qualifying Individuals.

Eligibility for MSP also makes individuals eligible for the Medicare Part D Low-Income Subsidy (LIS). The LIS reduces the co-payments seniors must pay and covers the Part D donut hole. People enrolled in the LIS can move from one Part D plan to another at any time of the year instead of having to wait for the Medicare Part D open enrollment period.

ConnMAP

ConnMAP prohibits medical providers from billing enrollees for charges beyond what the federal Medicare program determines is a “reasonable and necessary” rate, of which Medicare pays 80% (a practice called “balance billing.”) Thus, any provider accepting Medicare patients may not balance bill ConnMAP enrollees beyond the 20% co-payment for the service. (Patients are also responsible for Medicare Part B premiums and deductibles.)

“Medical Necessity” Definition

The law defines medical necessity as those health services required to prevent, identify, diagnose, treat, rehabilitate, or ameliorate a person’s medical condition, including mental illness, or its effects, in order to attain or maintain the person’s achievable health and independent functioning. The services must be consistent with generally-accepted medical practice standards that are based on (1) credible scientific evidence published in recognized peer-reviewed medical literature, (2) physician-specialty society recommendations, (3) the views of physicians practicing in relevant clinical areas, and (4) any other relevant factors. The services must also be:

1. clinically appropriate in terms of type, frequency, timing, extent, and duration and considered effective for the person’s illness, injury, or disease;
2. not primarily for the convenience of the person, the person’s health care provider, or other health care providers;
3. not more costly than an alternative service or services at least as likely to produce equivalent therapeutic or diagnostic results for

the person's illness, injury, or disease; and

4. based on an assessment of the person and his or her medical condition.

COMMITTEE ACTION

Appropriations Committee

Joint Favorable Substitute

Yea 35 Nay 17 (04/22/2013)