
OLR Bill Analysis

HB 6705

Emergency Certification

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HOUSING, HUMAN SERVICES AND PUBLIC HEALTH.

SUMMARY:

This bill makes changes to laws governing state housing, human services, and public health programs. Concerning housing, PA 12-1, June Special Session, established the Department of Housing (DOH) and made it the lead state agency responsible for all housing matters, including housing and neighborhood policy, development, redevelopment, preservation, maintenance, and improvement. The bill completes DOH's establishment by transferring to it various housing-related responsibilities from the Department of Economic and Community Development (DECD), the Office of Policy and Management (OPM), and the Department of Social Services (DSS).

Concerning human services, the bill makes changes in programs that the departments of social services (DSS) and children and families (DCF) administer. The major revisions include:

1. requiring DSS to reimburse acute care hospitals for providing inpatient, outpatient, and emergency room care based on the severity of the patient's diagnosis;
2. eliminates the ConnPACE program, which currently provides pharmacy assistance to elders and individuals with disabilities who do not qualify for Medicare;
3. repeals the Medicaid for Low-Income Adults program;
4. expands the state's False Claims Act to all state programs, not

just DSS medical assistance programs;

5. requires a pilot program to improve the educational outcomes of children in state custody;
6. requires DSS to administer a medication step therapy program for Medicaid recipients; and
7. makes it easier for nursing homes to recover debt and requires these facilities to report certain information to DSS.

Concerning public health, the bill makes changes affecting various health care facilities and professions regulated by the Department of Public Health (DPH), including physicians, surgeons, nurses, nurse-midwives, dentists, home health care agencies, assisted living services agencies, community health centers, nonprofit hospitals, and health care facilities' certificate of need applications.

It also makes changes affecting tattoo artists, DPH technical assistance fees for certain construction projects, the Connecticut Vaccine Program, neonatal intensive care unit transport services, cremation certificate fees, the Tobacco and Health Trust Fund, and the study of high school students' athletic injuries.

Finally, the bill makes several technical and conforming changes.

EFFECTIVE DATE: Various, see below.

§§ 1-69 & 157 — DEPARTMENT OF HOUSING

Under the bill, the DOH commissioner generally assumes responsibility for programs concerning:

1. affordable housing development and financing,
2. individual and group housing,
3. rent subsidies,
4. eviction and foreclosure prevention,
5. shelter provision and transitional living, and

6. homeownership.

The bill does not transfer (1) administration of the federal Low-Income Housing Tax Credit program or (2) compliance oversight for properties in the state housing portfolio, both of which remain with the Connecticut Housing Finance Authority (CHFA). Nor does the bill transfer programs providing clinical services to certain populations (e.g., individuals with mental illness), which remain with DSS and the Department of Mental Health and Addiction Services, for example.

The bill specifies that any DOH or DECD orders or regulations in force on January 1, 2013 remain so until amended, repealed, or superseded by law.

The bill makes numerous conforming and technical changes.

§§ 32-33, 43, 51 & 56-57 — Commissioner

By law, the DOH commissioner is responsible for developing policies and strategies to encourage housing provision in the state, including for very low-, low-, and moderate-income families. The bill adds the commissioner, or his or her designee, to the following entities, increasing their membership by one:

1. Building Accessibility Taskforce, beginning July 1, 2013;
2. CHFA's board of directors;
3. Capital Region Development Authority's (CRDA) board of directors; and
4. Interagency Council for Ending the Achievement Gap.

The bill also adds the housing commissioner to the list of officials the Office of Policy and Management (OPM) secretary must consult with to (1) develop recommendations for the state's priority funding areas for growth-related projects and (2) coordinate state and regional transportation planning with other state planning efforts.

EFFECTIVE DATE: July 1, 2013, except the provision adding the commissioner to CHFA's board of directors takes effect upon passage.

§ 1 — Deputy Commissioner

The bill authorizes the commissioner to appoint a deputy commissioner, whom it exempts from classified service. The appointee must be qualified by training and expertise and assume the commissioner's powers and duties if he or she is unable to perform them, or is disqualified from doing so.

EFFECTIVE DATE: July 1, 2013

§§ 22, 42, 54 – 55, 68 & 69 — Reporting Requirements

The bill generally requires the DOH, rather than the DECD, commissioner to report annually to the governor and the General Assembly on the state's housing and community development activities during the preceding fiscal year. Under the bill, the DOH commissioner must submit the report annually by March 31 and, no more than 30 days later, post it on the department's website.

As under current law, the annual report must cover or include:

1. the department's housing development functions and activities,
2. the state-funded housing development portfolio,
3. an economic impact analysis of the department's housing development efforts and activities,
4. the Housing Trust Fund and Housing Trust Fund Program,
5. the Energy Conservation Program,
6. a summary of the total social and economic impact of the department's community and housing development efforts and activities,
7. an assessment of the department's performance in meeting its stated goals and objectives, and
8. an analysis of the department's community development portfolio.

Existing law, unchanged by the bill, requires DECD's annual report to also include an analysis of its community development portfolio

(i.e., the last reporting requirement listed above) even though, by law, DOH has assumed responsibility for community development activities.

The bill specifies that DOH's annual report to the governor and General Assembly must incorporate any other annual reporting requirements set by statute concerning housing or community development.

EFFECTIVE DATE: July 1, 2013

State-Assisted Housing Sustainability Fund Report. The bill requires DOH to report to the General Assembly by March 31, rather by February 1 as DECD must do under current law, on the State-Assisted Housing Sustainability Fund's operation during the previous calendar year. By law, the report must include an analysis of fund distribution and performance. It may include recommendations for modifying the program.

Rental Rebate Report. The bill requires DOH, rather than OPM, to report annually to the Finance Committee on the rental rebate program for the elderly and people with total permanent disabilities. Current law requires OPM to submit this report by March 1st each year. The bill does not specify when DOH's first report is due.

Rental Assistance Program Report. By January 1, 2014, and annually thereafter, the bill requires the DOH commissioner to report to the Appropriations, Housing, Human Services, and Public Health committees on (1) the number of departmental clients and (2) of those, the number who have been rental assistance certificate recipients. In submitting the report, the commissioner must consult with the commissioners of social services, children and families, and mental health and addiction services, and developmental services. The report must (1) detail voucher utilization under the rental assistance program (known as RAP) and (2) establish targets to ensure that the program's resources are allocated in accordance with legislative intent.

§ 16 — Interagency Council on Affordable Housing

By law, the council is responsible for advising and assisting the DOH commissioner in planning and starting up the department (see BACKGROUND). The bill adds the following four members to the council, bringing its membership to 18: the (1) commissioners of education, developmental services, and aging and (2) president of the Connecticut chapter of the National Association of Housing and Redevelopment Officials (commonly known as CONN-NAHRO), or their designees.

EFFECTIVE DATE: July 1, 2013

§§ 2, 7-11, 13-15, 17-31, 34-35, 43-44 & 67 — DECD Transfers

The bill gives DOH authority over state housing and community development programs. Among other things, it transfers to DOH DECD's responsibilities with respect to:

1. working with and providing financial assistance to CHFA to achieve the state's housing and community development goals;
2. the state supplier diversity program (formerly called the set-aside program);
3. the affordable housing land use appeals procedure, including maintenance of the assisted housing inventory;
4. the state's consolidated plan for housing and community development;
5. the State-Assisted Housing Sustainability Fund;
6. congregate housing for the elderly;
7. independent living for low- and moderate-income individuals with disabilities;
8. rental assistance for elderly people residing in state-assisted rental housing (known as ERAP);
9. the community housing land bank and land trust program;
10. housing development zones;

11. the homeownership loan program;
12. grants-in-aid to municipalities financing low- and moderate-income rental housing;
13. the Energy Conservation Loan Fund;
14. condominium conversion compliance; and
15. the Common Interest Ownership Act.

The bill transfers, from DECD to DOH, the authority to designate a Federal HUD Section 202 or Section 236 elderly housing development to provide assisted living services to individuals otherwise eligible to receive these services under the Connecticut Homecare Program for Elders. It also authorizes DOH to designate more than one development.

The bill requires DOH to consult with the newly established Department on Aging, rather than DSS as DECD must currently do, in providing services to people with disabilities under the congregate housing program (see BACKGROUND).

The law requires DECD to give preference in its grant and loan programs to energy efficient projects. The bill extends this requirement to DOH.

EFFECTIVE DATE: July 1, 2013

§§ 2, 36-42 & 55 — OPM Transfers

Various Programs. The bill transfers, from OPM to DOH, responsibility for administering the (1) Main Street Investment Fund; (2) Housing for Economic Growth Program (i.e., incentive housing zone program); and (3) rental rebate program for the elderly and people with total and permanent disabilities.

OPM remains responsible for administering the Homeowners' Tax Relief Program for the elderly and people with disabilities (known as the Circuit Breaker Program).

Rental Rebate Program. For purposes of determining eligibility

under the program, the bill specifies that an applicant's spouse's Social Security income cannot be included as qualifying income if the spouse (1) is a resident of a health care or nursing home facility and (2) the facility receives Title XIX Medicaid payments for the spouse. It also authorizes an applicant who is legally separated on the December 31 preceding the application filing date to apply as an unmarried person and be regarded as such for purposes of determining qualifying income.

The bill suspends rental rebate program applications. It does this by specifying that an individual who did not receive a grant for CY 11 is not eligible to apply for another grant. An individual who received a CY 11 grant continues to be eligible to apply. But if such an individual does not receive a grant in any subsequent year, he or she is no longer eligible to apply.

Finally, the bill gives the DOH commissioner 120 days, instead of 90 days as OPM has under current law, to approve payments to municipalities, and forward them to the comptroller under the rental rebate program. By law, the comptroller must draw an order on the treasurer no later than 15 days after receiving the list of approved payments.

EFFECTIVE DATE: July 1, 2013 except the provision (1) removing the rental rebate program from OPM's jurisdiction takes effect July 1, 2013 and applies to assessment years commencing on or after October 1, 2012 and (2) suspending rental rebate applications is effective July 1, 2013 and applicable to applications received on and after April 1, 2013.

§§ 2, 12, & 45-50 — DSS Transfers

The bill transfers, from DSS to DOH, responsibility for administering:

1. the federal Housing Choice Voucher and Section 8 programs;
2. RAP, including the transitional and emergency rental assistance programs;
3. homelessness prevention programs, including emergency

shelter services, transitional housing services, and on-site social services;

4. housing for individuals suffering from AIDS;
5. the rent bank program;
6. the assessment and mediation program for certain families at risk of becoming homeless or in imminent danger of eviction or foreclosure; and
7. the security deposit guarantee program.

The bill also transfers, from DSS to DOH, responsibility for administering (1) the homefinders program to help families who are homeless or in danger of eviction or foreclosure and (2) emergency rental assistance for families living in hotels and motels and eligible for the Temporary Family Assistance program. In administering these programs, DOH must consult with DSS. And DSS remains responsible for seeking relief, in accordance with state and federal law, from income garnishment orders when it is in the best interests of children and families.

EFFECTIVE DATE: July 1, 2013

Demonstration Project. The bill requires DSS and CHFA to collaborate with DOH, rather than DECD, to operate a demonstration project to provide subsidized assisted living for people residing in affordable housing. The bill makes people age 65 or older eligible for the program if they are also eligible for the home and community-based program for adults with severe and persistent psychiatric disabilities. Under existing law, unchanged by the bill, people are eligible if they are also eligible for the Connecticut homecare program for the elderly are also eligible.

Access to DSS Information. With certain exceptions, the law prohibits DSS from disclosing information concerning individuals who apply for or receive department assistance, or participate in a department program. The bill requires DSS to disclose to the DOH commissioner's authorized representatives information necessary for

verifying whether an applicant is a recipient of DSS cash assistance, and the amount of any assistance.

§§ 33 & 52 — Miscellaneous

The bill removes the DECD commissioner as the chairperson of CHFA's board, instead requiring the governor to appoint the chair. It also authorizes CRDA to enter into memoranda of understanding as it deems appropriate to carry out its responsibilities.

EFFECTIVE DATE: July 1, 2013

§ 157 — Repealers

The bill repeals the following housing-related provisions:

1. the sale of rental property by a housing authority between October 1, and November 30, 2003 (CGS § 8-45b);
2. a pilot program requiring that certain multifamily housing projects be adaptable for use and occupancy by people with disabilities (CGS § 8-81a);
3. the Housing Advisory Committee (CGS § 8-385);
4. a homeowner loan program that terminated on June 1, 1991 (CGS §§ 8-415 to 8-419);
5. the Home Heating System Loan Fund, which the state treasurer terminated on July 15, 1985 (CGS § 16a-40k); and
6. a pilot project to provide affordable housing and support services to families with children who have ongoing healthcare service needs (CGS § 17a-54a).

EFFECTIVE DATE: July 1, 2013

§ 70 — EDUCATION OF BLIND AND VISUALLY IMPAIRED CHILDREN

Currently, 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 employment of state employee teachers of the visually impaired and providing specialized books, equipment, and materials.

The bill eliminates the \$6,400 per student cap. It also 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

§§ 71 & 72 — DCF POST MAJORITY SERVICES

Under current law, DCF is the guardian of a child or youth committed to its care for the duration of the commitment, or until another guardian is legally appointed, (a) until age 18 or (b) by the child’s consent, until age 21 if he or she is attending a secondary or technical school, college, or state-accredited job training program full-time. The bill instead allows a youth committed to DCF prior to age 18 to remain in department custody up to age 21 if he or she consents and is:

1. enrolled in a full-time approved secondary education program or an approved program leading to an equivalent credential;
2. enrolled full time in an institution that provides postsecondary or vocational education; or
3. participating full time in a program or activity approved by the DCF commissioner that is designed to promote or remove barriers to employment.

The bill allows the commissioner, in her discretion, to waive the full-time enrollment or participation requirement based on compelling

circumstances. It requires DCF, within 120 days after the youth's 18th birthday, to file a motion in juvenile court to determine whether continuation of care is in the youth's best interest and, if so, whether there is an appropriate permanency plan i.e. a plan stating what permanent outcome DCF feels is in the child's best interest and the facts on which DCF bases that position. The bill allows the court, in its discretion, to hold a hearing on the motion.

Permanency Plans

The law gives the commissioner nine months from the time a child or youth under age 18 is placed to file a motion for the court to review the permanency plan. (There is no deadline for the court to approve the plan.) Once the court approves the plan, the law requires the commissioner to file another motion for review within nine months. A hearing must be held within 90 days after the filing. After the initial hearing, subsequent hearings must be held at least once every 12 months. The bill extends this review process to permanency plans for youths age 18 through 20 in voluntary DCF custody.

EFFECTIVE DATE: October 1, 2013

§ 73 — RESIDENTIAL CARE HOME (RCH) RATES

The bill provides that residential care homes that are scheduled to receive a lower rate in FYs 14 or 15 (i.e., State Supplement payment from DSS) due to having an interim rate or other agreement with DSS must receive the lower rate. The bill prohibits DSS from considering a facility having its rates rebased when determining rates.

The bill also provides that for the next two fiscal years, DSS may increase an RCH rate (1) if there are available appropriations, (2) up to a limit that the DSS commissioner determines, and (3) only if the RCH has a calculated rate greater than the rate in effect on June 30, 2013. The bill prohibits DSS from issuing a rate to an RCH that is lower than the rate in effect on June 30, 2013, which is contrary to what is stated above

EFFECTIVE DATE: July 1, 2013

§ 74 — NURSING HOME RATES

For FY 14, the bill requires DSS to determine nursing home rates based on 2011 cost reports, except (1) a 90% minimum occupancy standard is applied, (2) no facility can receive a rate that is higher than the rate in effect on June 30, 2013, (3) no facility can receive a rate that is 4% or more less than the rate in effect on June 30, 2013, and (4) any facility that would have issued a lower rate effective July 1, 2013 due to interim rate status or some other agreement with DSS, must be issued a lower rate for the 2013-14 rate year.

For FY 15, rates in effect on June 30, 2014 remain the same for the year except that facilities that would have been issued lower rates due to interim rate status or other agreement with DSS must receive the lower rate.

The bill permits the commissioner, within available appropriations, to provide pro rata fair rent increases, including for moveable equipment for facilities that have undergone a material change in circumstances related to fair rent additions or moveable equipment placed in service in the 2012 and 2013 cost reports and not otherwise included in their issued rates.

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, depending on available appropriations.

EFFECTIVE DATE: July 1, 2013

§ 75 — INTERMEDIATE CARE FACILITIES FOR PEOPLE WITH INTELLECTUAL DISABILITIES (ICF-MR)

The bill limits to FY 13 levels the rates DSS pays ICF-MRs (group homes) in FYs 14 and 15. But it allows for higher rates if (1) a capital improvement is made to the home during either year for the residents' health or safety and the Department of Developmental Services (DDS) approved it, in consultation with DSS and (2) there is funding available to do so. Facilities that would have received lower rates due to their interim rate status or some other agreement with DSS must receive a lower rate.

The bill also extends DSS' authority for the next two years to pay a fair rent increase to an ICF-MR that has (1) undergone a material change in circumstances related to fair rent and (2) an approved certificate of need for the change.

Under current law, the DSS commissioner may increase an ICF-MR's rate if there are available appropriations, regardless of the circumstances. Under the bill, DSS may also decrease rates, but it limits his ability to raise or lower the rate to a reduction in appropriations or determines.

And the bill prohibits the commissioner from considering a facility rebased costs when determining its rate.

EFFECTIVE DATE: July 1, 2013

§ 76 — HOSPITAL RATES AND COST SHARING FOR NONEMERGENCY USE OF ER

Inpatient Rates – Diagnostic Related Groups

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 episodes of 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 retains the requirement that DSS establish a fee schedule from which it pays for outpatient services. Under current law, these services must be paid on the basis of a cost to charges ratio. The bill (1) limits this provision to those outpatient services that do not have an MAPC code and (2) allows payments to be based on a fixed fee in effect as of January 1, 2013 as an alternative to the ratio.

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 within

six months of implementing the new rate systems.

Cost Sharing for Nonemergency Use of ER

The bill requires the DSS commissioner, to the extent permitted by federal law, to impose cost sharing requirements on Medicaid recipients who use the ER for nonemergent care. The federal Affordable Care Act permits states to impose cost sharing for nonemergency use of ERs.

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

§ 77 — SUPPLEMENTAL HOSPITAL PAYMENTS FOR LOW-COST HOSPITALS

The bill requires DSS to establish, within available appropriations, a supplemental inpatient pool for low-cost hospitals.

EFFECTIVE DATE: July 1, 2013

§ 78 — 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 is cost neutral to home health care agencies and homemaker-home health aide agencies in the aggregate and (2) ensures patient access (see BACKGROUND). The bill makes permanent a provision, which would have expired on June 30, 2013 under current law, that allows the commissioner to take into account how often a particular service was provided (utilization) when determining cost neutrality.

EFFECTIVE DATE: JULY 1, 2013

§ 79 — 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, which would have expired on June 30, 2013 under current law, that permits the commissioner to take utilization into account when determining cost neutrality.

EFFECTIVE DATE: July 1, 2013

§ 80 — 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 would otherwise have been.

EFFECTIVE DATE: July 1, 2013

§ 80 — 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 LEPs, (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

PA 12-1, December Special Session, required the DSS commissioner to amend the Medicaid state plan to limit chiropractic coverage only to the extent required by federal law. The bill eliminates this requirement.

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 (EPSTD) 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

§ 81 — REIMBURSEMENT FOR PRESCRIPTION DRUGS

The bill eliminates the requirement for DSS, contingent upon federal approval, to reimburse independent pharmacies at a higher rate than chain pharmacies. DSS never implemented this provision.

EFFECTIVE DATE: January 1, 2014

§ 82 — 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 federal poverty level (FPL) will qualify for Qualified Medicare Beneficiary program coverage, (2) from 211% FPL up 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

§ 83 — CONNMAP ELIGIBILITY

Currently, to be eligible for the Connecticut Medicare Assistance Program (ConnMAP) 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) (see BACKGROUND). 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 annually 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

§§ 83, 84, 88-90, 94-101, & 155 — ELIMINATION OF CONNPACE PROGRAM

The bill eliminates the ConnPACE program and removes all statutory references to it. This program currently provides pharmacy assistance to the elderly and individuals with disabilities who do not qualify for Medicare.

EFFECTIVE DATE: January 1, 2014

§ 85 — 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.

The bill permits DSS to designate categories of durable medical equipment in addition to customized wheelchairs for which reused equipment, parts, and components are used whenever practicable.

EFFECTIVE DATE: Upon passage

§§ 86-87, 90-93, & 119-120 — 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

§ 102 — LEGISLATIVE OVERSIGHT OF PROPOSED CHANGES RELATIVE TO THE AFFORDABLE CARE ACT – TO CHANGE

Regardless of a provision in law that requires greater oversight, the bill requires the DSS commissioner to submit an eligibility and service plan for the Medicaid Coverage for the Lowest Income Populations program, established pursuant to the federal Affordable Care Act's expansion of the Medicaid program to cover childless adults with income up to 133% of the FPL and in the budget bill (HB 6704), passed by both chambers of the legislature. He must submit the report to the Human Services and Appropriations committees before submitting the plan to the federal government for its approval.

The bill gives the committees 15 days to hold a public hearing or notify the commissioner if they are not planning to hold one. The committees must advise the commissioner of their approval or denial of the plan within 15 days after receiving the plan. The plan is deemed approved if the committees (1) fail to take any action within the time frame or (2) disagree.

EFFECTIVE DATE: July 1, 2013

§§ 103, 158 — REPEAL OF MEDICAID FOR LOW-INCOME ADULTS

The state's Medicaid for Low-Income Adults program (HUSKY D) 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. This program is authorized under the Affordable Care Act, which also requires states to expand their Medicaid programs for this population with income up to 133% of the FPL beginning January 1, 2013. The bill repeals the enabling statutes.

EFFECTIVE DATE: January 1, 2014

§ 104 — FALSE CLAIMS ACT EXPANSION

Current law prohibits anyone from knowingly filing false or fraudulent claims for payment or approval under any DSS medical assistance program.

The bill expands laws that ban the following to apply to all state programs, rather than just the DSS medical assistance program:

1. having possession, custody or control of property or money used, or to be used, by the state and delivering or causing to be delivered less property than the amount for which the person receives a certificate or receipt, intending to defraud the state or wilfully to conceal the property;
2. being authorized to make or deliver a document certifying receipt of property used, or to be used, by the state and make or deliver such document without completely knowing that the information on the document is true with the intent to defraud the state;
3. knowingly buying, or receiving as a pledge of an obligation or debt, public property from an officer or employee of the state who lawfully may not sell or pledge it;
4. knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state; or
5. knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the state.

In 2009, the legislature enacted a state False Claims Act applicable to the medical assistance programs DSS administers, which enables the state to keep a greater share of any Medicaid funds the state recovers

under it. It creates a civil procedure for pursuing fraud, since the state's criminal laws already provide for prosecuting individuals who commit welfare fraud.

EFFECTIVE DATE: Upon passage

§ 105 — ASO SERVICE AUTHORIZATION

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 is in the member's best interest. The bill instead (1) requires the ASO to authorize services based solely on "medical necessity," as defined by statute (see BACKGROUND) and (2) allows it to use the clinical management committee guidelines to inform and guide the authorization decision.

EFFECTIVE DATE: July 1, 2013

§ 106 & 119 — BEHAVIORAL HEALTH PARTNERSHIP

The Behavioral Health Partnership (BHP) is an integrated behavioral health system currently operated by DCF, 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).

EFFECTIVE DATE: July 1, 2013 for the provision requiring the commissioner to implement the BHP for all Medicaid recipients and January 1, 2014 for the provision eliminating BHP assistance for COHP

members.

§ 107 — DSS PAYMENTS TO NON-ICF-MR BOARDING HOMES

The bill extends indefinitely the requirement that DSS pay licensed private residential facilities and similar facilities operated by regional educational service centers that provide vocational or functional services for severely handicapped individuals (non-ICF-MR boarding homes) a reduced rate when it has a significant decrease in land and building costs. Under current law, this requirement is imposed for FY 13 only.

The bill allows these facilities to receive higher payments in FYs 14 and 15 (1) if they make a capital improvement in FY 14 or 15; (2) DDS approves it, in consultation with DSS; (3) it is for resident health and safety; and (4) appropriations are available.

EFFECTIVE DATE: July 1, 2013

§ 108 — STATE OMBUDSMAN PILOT PROGRAM

The bill requires the state ombudsman, beginning July 1, 2015, to personally, or through representatives of her office, implement and administer a pilot program serving home- and community-based care recipients in Hartford County.

EFFECTIVE DATE: July 1, 2013

§ 109 – 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 using the fund 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 the State Bond Commission's 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

§ 110 — DCF COST ANALYSIS

The bill requires the DCF commissioner, by October 1, 2013, to (1) publish on its website an independent cost analysis of full implementation of the federal Fostering Connections to Success and Increasing Adoption Act of 2008 and (2) report the analysis results to the Children and Human Services committees. The commissioner must analyze costs, federal reimbursements, and off-setting savings for DCF to provide post-majority foster care services to all youth who:

1. are age 18 up to age 21;
2. were in foster care when they turned 18 or exited foster care after turning 18 but wish to reenter; and

3. are (a) completing secondary education or a program leading to an equivalent credential, (b) enrolled in a post secondary or vocational education institution, (c) participating in a program or activity designed to promote employment or remove barriers to employment, (d) employed for at least 80 hours per months, or (e) incapable of participating in any of these activities due to a medical condition.

The analysis must consider all available reimbursements as current costs to other state agencies for serving those foster or former foster youth through age 21.

EFFECTIVE DATE: Upon passage

§ 111 — PILOT MEDICAID DRUG THERAPY PROGRAM

The bill requires the DSS commissioner to begin a pilot drug therapy management program in coordination with the Connecticut Pharmacists Association and a community health center in the greater New Haven area. The program is administered by the health center and must be operated in cooperation with the medication therapy management activities of the ASO.

The bill supersedes the current law's requirement that the DSS commissioner must contract with a patient-centered medical home; a health home; or a pharmacy organization, which can include a school of pharmacy, to provide Medicaid therapy management services.

The law, unchanged by the bill, requires the program to include reviewing patients' prescription histories and developing medication action plans to reduce adverse medication interactions and related health problems.

EFFECTIVE DATE: July 1, 2013

§ 112 — STRETCHER VANS FOR NONEMERGENCY TRANSPORTATION

PA 12-1, December Special Session, allowed individuals requiring medically necessary, nonemergency transportation to be transported in

a stretcher van if they had to be transported in a prone position but did not require medical services during the transport and made related changes. The bill eliminates this requirement.

EFFECTIVE DATE: July 1, 2013

§ 113 — NURSING HOME NOTIFICATION REQUIREMENT

The law prohibits nursing facilities from admitting anyone, regardless of payment source, who has not undergone a preadmission screening process by which Department of Mental Health and Addiction Services (DMHAS) determines whether the person is mentally ill and, if so, whether he or she requires nursing facility services. The bill allows the DSS commissioner to require a nursing facility to notify DSS within one business day after the admission of a person who is mentally ill and meets the admission requirements.

EFFECTIVE DATE: Upon passage

§ 114 — AUTHORITY OF DSS COMMISSIONER TO PURSUE INITIATIVE RELATED TO THE FEDERAL AFFORDABLE CARE ACT

By law, DSS may pursue optional initiatives authorized by the federal Affordable Care Act, as amended. The bill permits him to also pursue policies, and expands the scope of these initiative and policies to include (1) implementing the modified adjusted gross income eligibility (MAGI) rules and (2) coordinating an integrated eligibility system with the Connecticut Health Insurance Exchange.

Under the ACA, states must expand their Medicaid programs to childless adults with incomes up to 133% of the federal poverty guidelines (FPL). The ACA also includes a provision that requires states to disregard an additional 5% of income, bringing the MAGI level to 138% of the FPL.

EFFECTIVE DATE: July 1, 2013

§ 115 — PILOT TREATMENT PROGRAM

The bill allows the Department of Correction (DOC) to initiate, with

support from DMHAS and the Department of Public Health (DPH), a pilot treatment program for methadone maintenance and other drug therapies at facilities including the New Haven Community Correctional Center. The program must be for 18 months and serve 60 to 80 inmates per month. The bill allows DPH to waive public health code regulations that are not applicable to the pilot program's service model.

The bill requires DOC to report the results of the program by October 1, 2014 and April 1, 2015 to the Appropriations, Human Services, and Judiciary committees.

EFFECTIVE DATE: July 1, 2013

§ 116 — MAXIMIZING PAYMENTS TO HOSPITALS FOR INPATIENT SERVICES

The bill requires the Office of Policy and Management (OPM), subject to federal approval, to determine the amount of revenue that is diverted for purposes of maximizing supplemental payments for inpatient hospital services that the state's acute care hospitals provide to Medicaid patients during FYs 14 and 15.

EFFECTIVE DATE: January 1, 2014

§ 117 — DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Under federal and state law, Medicaid provides additional reimbursement to short-term hospitals that serve a disproportionate share (DSH) of low-income patients. (By state law, the 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 requires that these interim payments be made on a quarterly instead of monthly basis, thus conforming law to current practice.

EFFECTIVE DATE: July 1, 2013

§ 118 — NURSING HOME ADVANCE PAYMENTS

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

EFFECTIVE DATE: Upon passage

§ 121 — CHILDREN’S MENTAL HEALTH TASK FORCE APPOINTMENT

SB 972 of the current session, as amended, establishes a Children’s Mental Health Task Force. The bill requires the House majority leader, instead of the Children’s Committee House chairperson, to appoint to the task force a complementary and alternative medicine or integrative therapy expert specializing in the treatment of physical, mental, emotional, and behavioral health issues in children.

EFFECTIVE DATE: July 1, 2013

§ 122 — MONEY FOLLOWS THE PERSON (MFP) “II” – DSS TO IMPLEMENT POLICIES AND PROCEDURES BEFORE REGULATIONS ADOPTED

By law, DSS must develop a plan to establish and administer a program similar to the MFP demonstration program for individuals who are not institutionalized but at risk of such. The bill authorizes the commissioner to implement policies and procedures to implement it while in the process of adopting regulations.

EFFECTIVE DATE: July 1, 2013

§ 123 — HEALTHY START

The bill (1) establishes in statute the Healthy Start program, which currently (a) is a line item in DSS’ budget, (b) is administered by the Children’s Trust Fund, (c) serves pregnant women with incomes up to 250% of the FPL, and (d) promotes and supports positive maternal and neonatal health outcomes and (2) requires it to be located within the DSS’ Medical Care Administration Division.

The bill requires the DSS commissioner, in consultation with the commissioner of Public Health, to (1) develop a plan to maximize

federal Medicaid reimbursement for the program to the extent permitted under federal law and (2) expand services within available state appropriations. The plan must include (1) a venue-based (e.g., health department, hospital clinics, or federally qualified health centers) payment and billing system under the program services provided by “nonlicensed” staff working with a licensed Medicaid provider can receive Medicaid reimbursement and (2) a funding allocation formula that ensures that all eligible women have access to the program’s core services. The program already receives federal grant funds through DPH.

The core services include (1) a comprehensive medical and psychosocial risk assessment; (2) development of a care plan; and (2) the delivery of care coordination, such as health education and care management services.

By October 1, 2013 and October 1, 2013, the commissioners, within available funds, must review the effectiveness of the state-funded Healthy Start program. The review must determine if the program (1) should continue to be administered by DSS and (2) should be expanded and how.

The commissioners must report their study results to the Human Services, Public Health, and Appropriations committees.

EFFECTIVE DATE: July 1, 2013

§ 124 — RAISE THE GRADE PILOT PROGRAM

The bill requires DCF, in consultation with the State Department of Education (SDE), to establish a two-year, Raise the Grade pilot program in Hartford, Bridgeport, and New Haven to increase the academic achievement of children and youth who are in DCF custody or are being served by the Court Support Services Division (CSSD) of the Judicial Department in these cities.

The program must use full-time coordinators to (1) assist with identifying children or youth who are performing below grade level and are in state custody or under juvenile justice supervision and (2)

develop plans, in collaboration with the child's or youth's legal guardian, education surrogate, or advocate to improve the child's academic performance. The coordinators must help facilitate the prompt transfer and review of educational records and report to DCF and the educational surrogate critical educational information, including (1) progress monitoring, (2) absenteeism, and (3) discipline. The coordinators must also help support educational stability for children placed in out of home care by DCF under an emergency order, an order of temporary custody, or a commitment order.

At the end of the pilot, DCF, in coordination with CSSD and SDE , must report to the Achievement Gap Task Force the number and educational profile of children the program serves and the program's impact on their educational performance, including achievement, absenteeism, and adverse disciplinary measures.

EFFECTIVE DATE: July 1, 2013

§ 125 — ACADEMIC PROGRESS OF CHILDREN IN STATE CUSTODY

The bill requires SDE and DCF to (1) annually track the academic progress of children and youth in state custody from prekindergarten through grade 12 and (2) submit a progress report to the Achievement Gap Task Force. CSSD, in collaboration with SDE, must create an annual aggregate report on the progress of youth in its custody.

For each child or youth in state custody, DCF must include a description of the child's educational status and academic progress in his or her treatment plan. The description must include information regarding the child's current educational performance level, including absenteeism and grade level performance, and the support or services that will or are being provided to improve academic performance.

For children committed to DCF, the educational status information must be included in reports to the Juvenile Court. The court must review the report when making decision regarding the child's well-being in care.

Youth who are in a secure facility run or contracted for by CSSD must have a case plan describing the youth's educational needs and grade-level performance and identifies support and services that are, or will be, provided to support academic performance.

DCF and CSSD must develop a plan to ensure that all facilities and school programs they run or they contract for can meet the academic and related service needs of enrolled children and youth. The plan must ensure the ability to provide:

1. the development of effective practices for acquiring and reviewing the student's educational records, including assessment of his or her present level of academic performance;
2. the youth's identified educational and related service needs;
3. appropriate and ongoing professional development on providing educational and related services to abused, neglected, and juvenile just-involved youth;
4. research-based instruction and standards-based core curriculum for all enrolled youth; and
5. administrative review of all program that DCF and CSSD run.

The plan must be finalized by July 1, 2014 and submitted to the Achievement Gap Task Force.

EFFECTIVE DATE: July 1, 2013

§§ 126— RATES PAID TO COMMUNITY HEALTH CENTERS

The bill requires DSS to distribute funding, within available appropriations, to federally qualified health centers based on cost reports they submit to the DSS commissioner until the Human Services and Appropriations committees approve an alternative payment methodology.

EFFECTIVE DATE: July 1, 2013

§ 127 — MEDICAID STEP THERAPY

This bill authorizes the Department of Social Services (DSS) commissioner to establish a step therapy program for prescription drugs dispensed to Medicaid recipients. (The bill does not define step therapy.) Under the program, DSS may condition Medicaid payments to pharmacies on a patient first trying a drug that is on DSS's preferred drug list (PDL) for 30 days. Under the bill, the step therapy program must:

1. require that the patient try and fail on only one drug on the PDL before another one can be prescribed and be eligible for DSS payment (presumably the other drug would not have to be on the PDL),
2. not apply to any mental health-related drugs, and
3. give the prescriber access to a clear and convenient process to expeditiously request DSS to override the step therapy drug under certain circumstances.

The bill requires DSS to grant an override of the step therapy drug restriction if certain conditions exist. It (1) permits the prescriber to deem the treatment clinically ineffective after the seven days and (2) requires Medicaid to pay for the drug the prescriber prescribes and recommends instead when this occurs.

It appears that the state's prior authorization law would require a pharmacist to dispense, and DSS to reimburse, a 14-day supply of a non-preferred drug when a prescriber has requested an override of the step therapy drug but a decision to grant has not been made by the time the patient is ready to leave the pharmacy (see BACKGROUND).

Conditions for Overriding Step Therapy Restrictions

The bill requires DSS to expeditiously grant an override of the step therapy restriction if the prescriber demonstrates that the step therapy drug:

1. has been ineffective in treating the patient's medical condition in the past (presumably the same medical condition) or is expected

to be ineffective based on the (a) patient's known relevant physical or mental characteristics and (b) drug regimen's known characteristics,

2. will cause or will likely cause an adverse reaction or other physical harm to the patient, or
3. is not in the patient's best interest to provide the recommended drug regimen based on medical necessity.

EFFECTIVE DATE: July 1, 2013

§§ 128-131 — NURSING HOME DEBT RECOVERY

The bill changes how the law treats the (1) assets of Medicaid long-term care applicants and beneficiaries and (2) amount of income Medicaid nursing home residents must apply to their care costs (applied income).

By law, Medicaid long-term care applicants who transfer assets for less than fair market value within five years of applying for coverage are presumed to have done so solely to qualify for Medicaid. People who cannot successfully rebut this presumption face a "penalty period" (period of Medicaid ineligibility). The value of the transferred asset is considered a debt the transferor or transferee owes the Department of Social Services (DSS).

The bill:

1. creates a second debt owed to nursing homes that serve these residents without payment during a penalty period and allows homes to sue to collect this debt;
2. allows the court to award damages and associated court fees for cases brought by the state or nursing homes regarding improper Medicaid asset transfers;
3. allows a court, including a probate court, to order assets or proceeds associated with an improper transfer to be held in a constructive trust to satisfy a debt owed a nursing home;

4. requires DSS to make certain considerations when determining a Medicaid nursing home resident's applied income amount;
5. requires nursing homes to provide written notice of applied income obligations and potential consequences for nonpayment to the resident and any person controlling the resident's income;
6. allows nursing homes to sue to collect applied income they are owed and courts to award both the amount due and associated legal fees;
7. requires nursing homes, when filing an applied income or improper asset transfer suit, and after a court issues a related judgment or decree, to mail copies of the complaint and court documents to the attorney general and DSS commissioner; and
8. prohibits DSS, to the extent federal law allows, from rendering a Medicaid long-term care applicant ineligible for assistance solely based on owning a life insurance policy with a surrender value of less than \$10,000.

EFFECTIVE DATE: October 1, 2013

Medicaid Long-Term Care Asset Transfers

Transfers that Create a Debt. By law, when an asset transfer results in a penalty period, such transfer creates a debt owed to DSS by the person transferring the asset or the transferee. The amount of the debt equals the amount of Medicaid services provided to the transferor beginning on the date the assets are transferred (CGS § 17b-261a).

During a penalty period, DSS does not make Medicaid payments to the nursing home for the transferor's care. The bill creates a statutory debt, due the nursing home, in an amount equaling the unpaid cost of care the facility provides during the penalty period. The debt amount may not exceed the fair market value of the transferred assets subject to the penalty period at the time they are transferred.

Lawsuits. The bill provides that its provisions do not affect any

other rights or remedies the parties may have. It permits a nursing home to sue either the asset's transferor or transferee to collect a debt for the unpaid care if (1) the debt recovery is no more than the transferred asset's fair market value at the time of transfer and (2) the transfer that triggered the penalty period occurred no more than two years before the nursing home resident applied for Medicaid.

The bill allows a court to award actual damages, court costs, and reasonable attorneys' fees to a plaintiff nursing home if it determines, based on clear and convincing evidence, that the defendant caused the debt to the home by (1) willfully transferring assets that are the subject of the penalty period, (2) receiving the assets knowing their purpose, and (3) making a material misrepresentation or omission concerning the assets.

The court costs and attorneys' fee must be awarded as a matter of law to a defendant who successfully defends an action or a counterclaim that is brought.

By law, the DSS and administrative services commissioners and the attorney general may seek administrative, legal, or equitable relief.

The bill further allows the court, including a probate court, to also order the assets or proceeds from the transfer to be held in constructive trust to satisfy the debt.

Under the bill, these provisions do not apply to a conservator who transfers income or principal with the probate court's approval (see BACKGROUND).

Applied Income

Definition. In general, nursing home residents determined Medicaid-eligible must spend any income they have, except for a monthly needs allowance, on their nursing home care. This is commonly referred to as "applied income," which means it is applied to the Medicaid recipient's care costs. If the resident's spouse is living elsewhere, some of the resident's monthly income may go to support that spouse (see below). Under the bill, applied income is also the

amount required to be paid to the home for the cost of care and services after the exhaustion of all appeals and in accordance with federal and state law.

Considering Community Spouse's Needs and Notice. The bill requires DSS, when determining the amount of applied income, to take into consideration any modification to the applied income due to (1) revisions in the community spouse's minimum monthly needs allowance (MMNA, see BACKGROUND) and (2) other modifications allowed by state or federal law.

Under the bill, nursing homes must provide written notice to Medicaid recipients and anyone the law authorizes to control the recipient's applied income. The notice must indicate (1) the amount of applied income due the home and the recipient's legal obligation to pay it and (2) that the recipient's failure to pay it within 90 days of receiving the notice may result in a lawsuit.

Lawsuits

The bill authorizes a nursing home to sue to recover any applied income amount it is owed. But a home may not initiate a suit when a Medicaid recipient has asserted that his or her applied income is needed to increase the recipient's community spouse's MMNA. In this instance, the home must wait until the Medicaid recipient, the community spouse, or their legal representative, exhausts their appeal right before DSS and in court.

The bill allows the home to sue either (1) the Medicaid recipient who owes the money or (2) someone with legal access to the applied income who acted with the intent to deprive the recipient of the income or appropriate it for himself, herself, or a third person.

If, based on clear and convincing evidence, a court finds that a defendant wilfully failed to pay or withheld applied income due and owing to a home for more than 90 days after receiving the notice, it may award the home the amount of debt owed, court costs, and attorneys' fees. The court costs must be awarded as a matter of law to a

defendant who successfully defends an action or a counterclaim brought under the bill's provisions. These provisions do not apply to a conservator who transfers income or principal with the probate court's approval (see BACKGROUND).

A nursing home may not sue to recover applied income until 30 days after providing the applied income notice or, if the resident did not receive the notice, 91 days after providing the resident notice of the suit along with the information in the applied income notice.

Life Insurance Policies

The bill provides that, to the extent permitted under federal law, institutionalized individuals cannot be determined ineligible for Medicaid solely based on having a life insurance policy with a cash surrender value of less than \$10,000, provided (1) the individual is pursuing the policy's surrender and (2) once it is surrendered, the proceeds are used to pay for the individual's long-term care.

Currently, a Medicaid applicant may not have more than \$1,600 in liquid assets to qualify for long-term care assistance. (If the applicant is married, this is after the state performs a spousal assessment and gives the community spouse a share of the combined assets.) DSS counts the cash surrender value of any life insurance policy with a face value of more than \$1,500 towards the asset limit. DSS also excludes certain transfers of such policies to cover funerals. DSS will not grant eligibility until the policy is surrendered and the money is "spent down" to the asset limit on the individual's care.

§§ 132-140 & 159 — TATTOO TECHNICIAN LICENSE

The bill creates a new license category for tattoo artists (called "tattoo technician") administered by the Department of Public Health (DPH). DPH must enforce the licensure program within available appropriations and is authorized to adopt implementing regulations.

Starting July 1, 2014, the bill prohibits anyone from engaging in the practice of tattooing unless they are age 18 or older and obtain a Connecticut tattoo technician license or temporary permit.

§ 132 — Definition

The bill defines “tattooing” as marking or coloring, in an indelible manner, the skin of any person by pricking in coloring matter or by producing scars.

EFFECTIVE DATE: October 1, 2013

§§ 133 & 140 — Licensure Requirements

The bill requires a person who applies for a tattoo technician license on or before July 1, 2014 to provide DPH with satisfactory evidence that he or she:

1. is age 18 or older;
2. successfully completed, within three years preceding the application date, a course on preventing disease transmission and blood-borne pathogens that (a) complies with federal Occupational Safety and Health Administration (OSHA) standards and (b) requires successful completion of a proficiency examination; and
3. is currently certified in basic first aid training by the American Red Cross or the American Heart Association.

An applicant seeking licensure after July 1, 2014 must also provide DPH, in a form and manner the commissioner prescribes, documentation that he or she (1) completed at least 2,000 hours of practical training and experience under the personal supervision and instruction of a tattoo technician or (2) practiced tattooing continuously in Connecticut for at least five years prior to July 1, 2014.

The license application fee is \$250. Licenses must be renewed biennially for a fee of \$200. No license or temporary permit (see below) can be issued if the applicant is facing pending disciplinary action or is the subject of an unresolved complaint in Connecticut or another state or jurisdiction. A person is prohibited from using the title “tattoo technician,” “tattoo artist,” “tattooist,” or similar title unless they have a Connecticut-issued tattoo technician license.

The bill's licensing requirement does not apply to (1) physicians; (2) advanced practice registered nurses (APRNs) working in collaboration with a physician; (3) registered nurses working under the direction of a licensed physician, dentist, or APRN; or (4) physicians assistants working under a physician's supervision, control, or responsibility.

EFFECTIVE DATE: October 1, 2013, except that a conforming change regarding biennial re-licensure takes effect upon passage and applies to registration periods on and after October 1, 2013.

§ 133 — *Licensure Requirements for Out-of-State Licensees*

Notwithstanding the above licensure requirements, the bill allows DPH to issue a license to an applicant who is licensed as a tattoo technician or to perform similar services in another state or jurisdiction who submits to DPH satisfactory evidence that he or she:

1. is currently licensed in good standing to practice tattooing in another state or jurisdiction,
2. has documentation of licensed practice in another state or jurisdiction for at least two years immediately preceding the application date,
3. successfully completed a course on preventing disease transmission and blood-borne pathogens that complies with OSHA standards, and
4. is currently certified in basic first-aid training by the American Red Cross or the American Heart Association.

EFFECTIVE DATE: October 1, 2013

§ 133 — *Continuing Education*

The bill requires tattoo technicians to meet a continuing education requirement to have their licenses renewed. Specifically, it requires licensees to successfully complete a course on preventing disease transmission and blood-borne pathogens that (1) complies with OSHA standards and (2) requires successful completion of a proficiency

examination.

Each licensee must sign a statement attesting that he or she successfully completed the course within six months before the license expires. He or she must obtain a certificate of completion from the continuing education provider and retain it for at least four years after the year of completing the course. The licensee must submit the certificate to DPH within 45 days after the department requests it.

EFFECTIVE DATE: October 1, 2013

§ 133 — Temporary Permits

The bill allows the DPH commissioner to issue a temporary permit to:

1. an applicant who is licensed to practice tattooing in another state and is awaiting DPH approval for his or her license application,
2. an applicant previously licensed in Connecticut whose license is void, or
3. a person licensed or certified to practice tattooing in another state who is in Connecticut to attend an educational event or trade show or to participate in a product demonstration.

Applicants for a temporary permit must submit to DPH a:

1. completed application form;
2. copy of a current license or certification to practice tattooing from another state or jurisdiction;
3. notarized affidavit attesting that the license or certification is valid and belongs to the applicant; and
4. \$100 fee, except for out-of-state licensees awaiting Connecticut licensure approval, who must submit a \$250 fee.

Applicants in Connecticut for the educational and professional purposes specified above must do this at least 45 business days before

the event occurs.

The temporary permit, which is not renewable, authorizes the holder to work as a tattoo technician for up to 120 calendar days except that such permits issued to people licensed in another state who are in Connecticut for educational and professional purposes are valid for up to 14 consecutive calendar days and can be issued once each year.

EFFECTIVE DATE: October 1, 2013

§ 133 — Student Tattoo Technicians

The bill allows a student tattoo technician to practice tattooing under the personal supervision of a licensed tattoo technician for up to two years. The student must register with DPH for purposes of completing the practical training and experience required to obtain a tattoo technician license. The student must submit a registration application to DPH on a form the commissioner prescribes that includes:

1. documentation of the student's successful completion of a course on preventing disease transmission and blood-borne pathogens that (a) complies with OSHA standards and (b) requires successful completion of a proficiency examination,
2. documentation that the student is currently certified in basic first aid training by the American Red Cross or the American Heart Association, and
3. a notarized statement signed by a licensed tattoo technician acknowledging that he or she is personally responsible for supervising the student's practical training and experience.

EFFECTIVE DATE: October 1, 2013

§ 134 — Title Protection

On and after July 1, 2014, the bill prohibits anyone from:

1. buying, selling, or fraudulently obtaining or furnishing any diploma, certificate, license, record, or registration showing that

- a person is qualified or authorized to practice tattooing or participating in such actions;
2. practicing or attempting or offering to practice tattooing (a) under the cover of any of the above documents or (b) under a name other than his or her own;
 3. aiding or abetting tattooing by a person not licensed in Connecticut or whose license is suspended or revoked;
 4. advertising services under the description of tattooing or using the word "tattoo" or "tattooing" without a Connecticut-issued tattoo technician license;
 5. practicing tattooing on an unemancipated minor under age 18 without permission of the minor's parent or guardian; or
 6. during a period of license suspension or revocation, (a) practicing or attempting, offering, or advertising to practice tattooing or (b) working for or assisting a licensed tattoo technician.

A person who violates any of these prohibitions is guilty of a class D misdemeanor, which is punishable by a fine of up to \$250, imprisonment for up to 30 days, or both.

EFFECTIVE DATE: October 1, 2013

§ 135 — Disciplinary Action

The bill allows DPH to take disciplinary action against a licensed tattoo technician for:

1. failing to conform to accepted professional standards;
2. violating the bill's requirements;
3. fraudulent or deceptive tattooing practices;
4. negligent, incompetent, or wrongful conduct in professional activities;

5. emotional, mental, physical, or substance use disorders or illnesses; or
6. willfully falsifying client records.

By law, disciplinary actions available to DPH include license revocation or suspension; censure, a letter of reprimand; probation; or a civil penalty (CGS § 19a-17). Under the bill, the department can also order a licensee to undergo a reasonable physical or mental examination if there is an investigation of his or her physical or mental capacity to practice safely.

The bill allows the DPH commissioner to petition the Hartford Superior Court to enforce any disciplinary action it takes. The department must notify the licensee of any contemplated disciplinary action and its cause, the hearing date on the action, and the opportunity for a hearing under the Uniform Administrative Procedure Act.

EFFECTIVE DATE: October 1, 2013

§ 137 — *Inspections of Tattoo Establishments*

The bill allows local or health district health directors, or their authorized representatives, to annually inspect the sanitary condition of tattoo establishments within their jurisdictions. It grants the director or authorized representative full power to enter and inspect a tattoo establishment during usual business hours.

It allows the health director to collect an inspection fee of up to \$100 from the establishment's owner. If the establishment is found to be unsanitary, the health director must issue a written order that the establishment be placed in sanitary condition.

The bill specifies, notwithstanding any municipal charter, home rule ordinance, or special act, that any inspection fee collected must be used by the local or district health department for conducting these inspections.

EFFECTIVE DATE: October 1, 2013

§§ 136 & 138 — Enforcement

The bill specifies that (1) the DPH commissioner must enforce the bill only if appropriations are available and (2) no new regulatory board is established for tattoo technicians.

EFFECTIVE DATE: October 1, 2013

§§ 139 & 159 — Repealer

The bill repeals a statute regarding tattooing by specified medical professionals or people acting under a physician's supervision in accordance with DPH regulations and makes a related technical change.

EFFECTIVE DATE: July 1, 2014

§ 140 — ONLINE LICENSURE RENEWAL AND INCREASED FEES

Starting October 1, 2013, the bill requires, rather than allows, physicians, surgeons, nurses, nurse-midwives, and dentists to renew their licenses using DPH's online license renewal system, with one exception. DPH may allow a licensee to renew his or her license using a paper form and paying the professional service fees by check or money order if the licensee presents extenuating circumstances. This includes submitting to DPH a notarized affidavit indicating that the licensee does not have access to a credit card.

The bill increases the renewal fees for these professionals by \$5 (presumably to cover the associated credit card transaction fees). It removes the provision in current law allowing the department to charge a \$5 service fee for online license renewals.

It also removes an obsolete DPH reporting requirement regarding the online license renewal system

EFFECTIVE DATE: Upon passage an applicable to registration periods beginning on and after October 1, 2013

§ 141 — LICENSURE FEES FOR HOME HEALTH CARE AGENCIES AND ASSISTED LIVING FACILITIES

The bill establishes a licensing and inspection fee for home health care agencies of \$300 per agency and \$100 per satellite office. The fee must be paid biennially to DPH, except for Medicare- and Medicaid-certified agencies, which are licensed and inspected triennially.

The bill also establishes a \$500 biennial licensing and inspection fee for assisted living services agencies, except those participating in the state's congregate housing pilot program in Norwich.

EFFECTIVE DATE: July 1, 2013

§ 141 — HEALTH CARE FACILITY TECHNICAL ASSISTANCE FEE

By law, the DPH commissioner may charge a \$565 fee for technical assistance the department provides for the design, review, and development of a health care facility's construction, sale, or ownership change. The bill allows the commissioner to also charge this fee for technical assistance provided on a facility's renovation or building alteration.

The bill applies the \$565 fee only to projects costing \$1 million or less. For projects costing more than this amount, the bill requires the commissioner to charge one-quarter of 1% of the total project cost.

The bill specifies that the fee includes all DPH reviews and on-site inspections and does not apply to state-owned facilities.

EFFECTIVE DATE: July 1, 2013

§ 142 — FINANCIAL ASSISTANCE FOR COMMUNITY HEALTH CENTERS

The bill requires the DPH commissioner, within available appropriations, to establish and administer a financial assistance program for community health centers.

The commissioner must develop a formula to disburse program funds to the centers, which must include (1) the number of uninsured patients the center serves and (2) the types of services it provides.

The bill requires the commissioner to report by October 1, 2013 to the Public Health and Appropriations committees on the disbursement formula. The committees must hold a public hearing on the report within 30 days after receiving it, and then advise the commissioner of their approval or denial of the proposed formula. If the committees fail to do this within 30 days, the formula is deemed approved. The commissioner cannot implement the formula without the committees' approval.

The bill allows the commissioner to establish program participation requirements, provided she gives reasonable notice of the requirements to all community health centers. Centers may only use the funds for commissioner-approved purposes.

The bill defines a "community health center" as a public or private nonprofit medical care facility that (1) meets community health center statutory requirements and (2) is designated by the U.S. Department of Health and Human Services as a federally qualified health center (FQHC) or FQHC look-alike (i.e., is eligible for but does not receive federal Public Health Service Act Section 330 grant funds).

EFFECTIVE DATE: July 1, 2013

§§ 143 & 144 — CONNECTICUT VACCINE PROGRAM

The bill requires the OPM secretary, in consultation with the DPH commissioner, to determine annually by September 1 the amount of the General Fund appropriation to administer the Connecticut Vaccine Program (CVP) and inform the insurance commissioner of the amount. The law already requires the secretary to annually determine the appropriated amount to purchase, store, and distribute vaccines under the program and inform the insurance commissioner.

By October 1, 2013, the bill requires DPH, in consultation with OPM, to develop and begin annually implementing a reconciliation and expenditure projection process for the state's childhood immunization budget account. This process must include (1) an accounting of the previous year's expenditures, (2) the process and factors to be used in

determining each future year's assessment, and (3) the establishment of an appropriate notification process for the entities assessed under the account.

The CVP is a state- and federally-funded program that provides certain childhood vaccinations at no cost to health care providers. The state-funded component is funded by an assessment on certain health insurers and third-party administrators.

EFFECTIVE DATE: July 1, 2013

§ 145 — CERTIFICATE OF NEED (CON)

The bill adds to those factors OHCA must consider when evaluating a CON application whether an applicant who failed to provide, or reduced access to, services by Medicaid recipients or indigent people demonstrated good cause for doing so. It specifies that good cause is not demonstrated solely based on differences in reimbursement rates between Medicaid and other health care payers.

By law, OHCA must consider several factors when evaluating a CON application, including the applicant's past and proposed provision of health care services to relevant patient populations and payer mix. The bill specifies that this includes access to services by Medicaid recipients and indigent people.

The law requires OHCA to also consider, among other things, whether the applicant satisfactorily demonstrated how the proposal will improve the quality, accessibility, and cost effectiveness of health care delivery in the region. The bill specifies that this includes the (1) provision of, or change in access to services for Medicaid recipients and indigent people and (2) impact on the cost effectiveness of providing access to Medicaid services.

EFFECTIVE DATE: October 1, 2013

§ 146 — CREMATION CERTIFICATE FEE

The bill allows the OPM secretary, at the Chief Medical Examiner's request, to waive the \$150 cremation certificate fee required for the

cremation of a body for which a death certificate has been issued.

EFFECTIVE DATE: July 1, 2013

§ 147 — UCONN HEALTH CENTER NICU TRANSPORT SERVICES

The bill expressly provides that the University of Connecticut Health Center or a constituent unit, including John Dempsey Hospital (JDH), can discontinue neonatal intensive care unit (NICU) transport services if these services are provided by a qualified transport service.

Existing law established provisions for transferring, from JDH to the Connecticut Children's Medical Center (CCMC), licensure and control of 40 NICU beds after receiving a certificate of need from DPH's Office of Health Care Access. This transfer took place in 2011, and JDH no longer operates a NICU unit. CCMC is scheduled to start NICU transport services in June 2013.

EFFECTIVE DATE: October 1, 2013

§§ 148-150 — NONPROFIT HOSPITAL REPORTING REQUIREMENTS

The bill requires nonprofit hospitals to submit annually to OHCA (1) a complete copy of the hospital's most recent Internal Revenue Service (IRS) Form 990, including all parts and schedules and (2) data compiled to prepare the hospital's community health needs assessment (see BACKGROUND), in the form and manner OHCA prescribes. But they must not include patient-identifiable information or other individual patient information. They also must not include information that (1) the hospital does not own or control, (2) the hospital is contractually required to keep confidential or is prohibited from disclosing by a data use agreement, or (3) concerns research on human subjects as described in federal Health and Human Services (HHS) regulations (see BACKGROUND).

The bill requires nonprofit hospitals to submit the Form 990 and community health needs assessment data along with information they must already report concerning uncompensated care and related matters. By law, anyone who wilfully fails to file required information

with OHCA within the time periods required by law is subject to a civil penalty of up to \$ 1,000 for each day the information is missing, incomplete, or inaccurate.

The bill also allows DPH to impose a \$ 1,000 daily penalty on health care providers or facilities that wilfully fail to complete the questionnaire required as part of OHCA's statewide health care inventory.

By law, hospitals are subject to civil penalties and billing adjustments if a patient's bill conflicts with the hospital's schedule of charges on file with OHCA (i.e., its pricemaster). The bill (1) specifies certain details that patient bills must contain for these purposes and (2) requires hospitals to provide detailed patient bills to DPH or patients upon request.

EFFECTIVE DATE: October 1, 2013

§ 149 — Civil Penalties for Failing to Complete the Inventory Questionnaire

By law, OHCA must conduct a statewide health care facility utilization study, and update its statewide health care facilities and services plan, every two years. As part of this process, OHCA must maintain an inventory of in-state health care facilities, services, and specified equipment. Current law requires health care facilities and providers to complete an OHCA questionnaire to develop the inventory, but exempts them from penalties for failing to complete it.

The bill instead subjects these facilities and providers to the general civil penalties that apply to persons or facilities that fail to file data or information with OHCA as required by law — up to \$ 1,000 per day for wilfully failing to comply.

By law, before DPH can impose such civil penalties, it must notify the party by first class mail or personal service of the violation. The person or entity has 15 business days from the mailing date to apply in writing for a (1) hearing to contest the penalty or (2) time extension to file the data. A final order assessing the civil penalty can be appealed

to New Britain Superior Court.

EFFECTIVE DATE: October 1, 2013

§ 150 — Patient Bills

By law, a hospital must file with OHCA its current pricemaster (detailed schedule of charges). If the billing detail by line item on a patient bill does not agree with the information filed with OHCA, the hospital is subject to a civil penalty of \$ 500 per occurrence, subject to the procedures set forth above (e. g. , the hospital has 15 business days to contest the penalty). OHCA can also order the hospital to adjust the bill to be consistent with the charges on file.

The bill specifically requires hospitals to provide detailed patient bills to either DPH or a patient upon request. It also replaces references to “patient bill” with “detailed patient bill” for the purposes of the provisions noted above. It defines a detailed patient bill as a patient billing statement that includes, for each line item, (1) the hospital's current pricemaster code, (2) a description of the charge, and (3) the billed amount.

EFFECTIVE DATE: October 1, 2013

§ 152 — TOBACCO AND HEALTH TRUST FUND

The bill suspends the operation of the Tobacco and Health Trust Fund’s (THTF) board of trustees from July 1, 2015 to June 30, 2016 and makes related technical changes. The suspension period does not affect any trustee’s term on the board.

Current law allows the trustees to recommend disbursements of up to half of the previous year’s annual disbursement to the THTF from the Tobacco Settlement Fund, up to \$ 6 million. It also allows them to recommend disbursements from the THTF’s annual net earnings on principal.

For FY 14 and FY 15, the bill instead allows the trustees to recommend disbursement of up to \$ 3 million from the THTF annually. (This reflects the FY 14 and FY 15 reduction, from \$ 12

million to \$ 6 million, in the annual disbursement from the Tobacco Settlement Fund to the THTF in HB 6704 as amended.) Starting in FY 17, the bill restores the current disbursement levels described above.

EFFECTIVE DATE: Upon passage

§ 153 — NURSING HOME REPORTING

The bill requires every (1) for-profit chronic and convalescent nursing home (this appears to mean each for-profit nursing home) that receives state funding to include in its annual cost report to the Department of Social Services (DSS) a profit and loss statement from each related party that receives \$10,000 or more a year from the nursing home for goods, “fees,” and services. (Presumably, this means any money the related party receives in fees, not for them.)

The bill also requires all nursing homes, not just for-profit ones, that receive state funding to include detailed information on direct care staff, including (1) regular hours and wages, (2) overtime hours and wages, (3) “benefit” hours and wages (it is not clear what benefit hours are), and (4) employee health and welfare benefits. It requires each direct care and administrative nurse position to be reported as a separate line item.

Cost reports are used to determine the rate DSS pays nursing homes for serving Medicaid-eligible residents.

Under the bill, a “related party” includes any company related to the nursing home through family association, common ownership, control, or business association with any of the home’s owners, operators, or officials. A “profit and loss statement” is the most recent annual statement on profits and losses that the related party finalizes before the annual report the law mandates.

EFFECTIVE DATE: July 1, 2013

§ 154 — PILOT PROGRAM STUDYING HIGH SCHOOL ATHLETIC INJURIES

This bill requires the education (SDE) commissioner, in consultation

with the DPH commissioner, to establish a pilot program to study the incidence of injuries, particularly concussions, to high school students during interscholastic athletic activities. The commissioner must do this only if federal or private funds are available and the state does not incur a cost.

The SDE commissioner must make grants to 20 high schools to (1) monitor these injuries for two years and (2) report the occurrence of these injuries to the SDE commissioner in a manner he prescribes. The commissioner may accept private and federal funds to make these grants.

Under the bill, any school receiving a grant must monitor and report these injuries with the cooperation of the school athletic director, licensed athletic trainers providing services to the school, any physician associated with the school's athletic program, and the Connecticut Interscholastic Athletic Conference.

Within one year of starting the pilot program, the commissioner must report to the Public Health and Education Committees. The report must include (1) a summary of the reports he received from the schools and (2) recommendations for decreasing the number and severity of these injuries.

EFFECTIVE DATE: Upon passage

§ 156 — DCF SCREENINGS FOR DEVELOPMENTAL AND SOCIAL-EMOTIONAL DELAYS

The bill requires DCF to ensure that children age thirty-six months or younger are screened for developmental and social-emotional delays if they are (1) substantiated abuse and neglect victims or (2) receiving DCF differential response program services (see BACKGROUND). The department must do this starting October 1, 2013 for the former and July 1, 2015 for the latter.

The department must refer any child found, through the screening, to exhibit such delays to (1) the Birth-to-Three Program (see BACKGROUND) or if ineligible for this program (2) the Children's

Trust Fund's Help Me Grow prevention program (see BACKGROUND) or a similar program.

Starting by July 1, 2014, the bill requires DCF to begin submitting annual reports on the screenings and referrals to the Children's Committee for inclusion in the committee's annual report card on state policies and programs affecting children.

EFFECTIVE DATE: October 1, 2013

Screenings

The bill requires DCF, within available appropriations, to ensure eligible children age 36 months or younger who are substantiated abuse and neglect victims are screened twice annually, unless the child is found to be eligible for the Birth-to-Three program.

It also requires DCF to ensure eligible children receiving DCF differential response program services are screened, unless the child is found to be eligible for the Birth-to-Three program. But, it does not specify how often these screenings must occur.

The bill requires all screenings to be conducted using validated assessment tools, such as the Ages and Stages and the Ages and Stages-Social/Emotional Questionnaires, or their equivalents.

EFFECTIVE DATE: October 1, 2013

Report

Starting July 1, 2014, DCF must annually report, for the preceding 12 months, the number of Connecticut children age three or younger who (1) were substantiated abuse and neglect victims or (2) received differential response program services. Of these children, DCF must also report the number who:

1. were screened for developmental and social-emotional delays by DCF or a contracted provider;
2. were (a) referred to the Birth-to-Three program for evaluation, (b) actually evaluated by the program, (c) found eligible for

program services and the types of services they were eligible for; and

3. received evidence-based developmental support services through the Birth-to-Three program or a DCF-contracted provider.

EFFECTIVE DATE: October 1, 2013

§§ 157-159 — REPEALERS

The bill repeals the following statutes:

1. CGS § 17b-260d – requires the DSS commissioner to apply for a Medicaid home- and community-based services waiver for individuals with AIDS or HIV; DSS never applied for the waiver;
2. CSG § 17b-261n – creates the Medicaid for Low-Income Adults Program
3. CGS § 17b-311 – establishes the Charter Oak Health Plan;
4. CGS § 17b-490 – creates ConnPACE definitions;
5. CGS § 17b-491 – establishes ConnPACE program;
6. CGS § 17b-492 – establishes eligibility and other ConnPACE rules;
7. CGS § 17b-493 – requires generic substitution for ConnPACE recipients;
8. CGS § 17b-494 – requires DSS to adopt regulations for both ConnPACE and prior authorization;
9. CGS § 17b-495 – permits DSS to enter into a contract with a fiscal intermediary to administer ConnPACE;
10. CGS § 17b-496 – gives individuals aggrieved by any ConnPace administrative action by DSS commissioner the right to a

hearing;

11. CGS § 17b-497 – imposes penalties on pharmacists and program beneficiaries who defraud or otherwise violate the ConnPACE program and prior authorization laws; and
12. CGS § 17b-498 – directs DSS to undertake educational outreach on the ConnPACE program.

BACKGROUND

§ 16 - Interagency Council on Affordable Housing

PA 12-1, JSS, requires the Interagency Council on Affordable Housing to advise and assist the DOH commissioner in planning and implementing the department. By January 15, 2013 and in consultation with the DOH commissioner, it required the council to report to the governor and the Appropriations, Housing, and Human Services committees with recommendations on:

1. transferring programs to DOH and an implementation timeline,
2. effective changes to the state's housing delivery systems,
3. prioritizing housing resources, and
4. enhanced coordination among housing systems.

§ 26 - Department on Aging

The law established a Department on Aging effective January 1, 2013, and transferred to it all functions, powers, duties, and personnel of the DSS Aging Services Division.

§ 78 - 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.

§ 82 - 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. Qualified 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 during the year instead of having to wait for the Medicare Part D open enrollment period.

§ 83 - 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.)

§ 105 - “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 least 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 (CGS § 17b-259b).

§ 127—Preferred Drug List (PDL)

By law, DSS maintains a PDL, which is a list of drugs for which DSS will reimburse pharmacists when they dispense the drugs to Medicaid recipients. By law, if a practitioner prescribes a drug that is not on the PDL, the pharmacist must receive prior authorization from DSS before it can be paid for dispensing the drug. Prior authorization is not required for any mental health-related drug that has been filled or refilled, in any dosage, at least once in the previous year. When prior

authorization is granted, it is valid for one year from when the drug is filled. (By law, drugs used to treat AIDS and AIDS-related illness may not be on the PDL (CGS § 17b-274d(f).)

If prior authorization is required and the pharmacist is unable to obtain the prescriber's authorization at the time the prescription is presented, the law requires the pharmacist to dispense a one-time 14-day supply. By law, DSS issues a flier to pharmacies to distribute to Medicaid recipients, letting them know that they need to contact the prescriber to get the full amount of the non-preferred drug (CGS § 17b-491a).

§§ 128-131—Constructive Trust

A court can order a constructive trust against someone who, through wrongdoing, fraud, or other unconscionable act, obtains or holds legal property rights to which he or she is not entitled. It is often used to prevent undue enrichment. It can be used to order the person who would otherwise be unjustly enriched to transfer the property to the intended party.

§§ 128-131—Community Spouse Allowance and Monthly Needs Allowance

When one spouse is living in a nursing home and the other spouse lives elsewhere, the spouse who is not living in the nursing home (called the community spouse in Connecticut) is allowed by Medicaid to keep a portion of the institutionalized spouse's income. This income, called the community spouse allowance, is determined by subtracting the community spouse's monthly gross income from the MMNA. The MMNA amount will vary from case to case, but for 2013 the minimum is \$1,892; the maximum is \$2,898. The MMNA takes into account the community spouse's housing costs (e.g., rent, and utilities).

The minimum and maximum are set by federal law and the state must update the amounts each year. The maximum may only be exceeded if a DSS fair hearing orders it.

§§ 128-131—Conservators of the Estates of Medicaid Recipients

The law requires conservators of the estates of individuals receiving Medicaid to apply towards the recipient's cost of care any assets exceeding the limits set in law. Similarly, the law prohibits conservators from applying, and courts from approving, net income of the conserved person to support a community spouse in excess of the federal MMNA, unless such limits would result in significant financial distress.

The law further permits the probate court to authorize a conservator to make gifts or other transfers of income and principal from the conserved person's estate to certain trusts (CGS § 45a-655 (d) and (e)).

§ 148 - IRS Form 990 and Community Health Needs Assessment

The IRS Form 990 is the "Return of Organization Exempt From Income Tax" form. In practice, OHCA currently collects this form from nonprofit hospitals on a voluntary basis.

The federal Patient Protection and Affordable Care Act requires nonprofit hospitals to conduct community health needs assessments at least once every three years, and make the assessments widely available to the public. It also requires such hospitals to include a description of how they are meeting the law's community health needs assessment requirements in their IRS Form 990 filing.

§ 148 - Research on Human Subjects

HHS regulations set various conditions for research involving human subjects conducted or supported by federal agencies or otherwise subject to federal regulation. Certain types of research are exempt from the HHS policy (such as research involving the (1) use of educational tests in certain circumstances or (2) collection or study of existing data that is publicly available or recorded in a way that subjects cannot be identified) (45 C. F. R. § 46. 101).

§ 153—Nursing Home Cost Reports

State law requires nursing homes to submit cost reports to DSS by each December 31. These reports include an accounting by the homes of any related-party transactions that occur during the reporting

period. The report form includes space for the home to indicate, for each related party and regardless of the amount of the transaction:

1. the related individual or company name and address;
2. whether the entity also provides goods and services to non-related parties and the percentage of revenue the entity receives from the non-related parties;
3. a description of the goods and services provided;
4. where (page and line number) on the cost report these costs are shown;
5. the cost reported; and
6. the actual cost to the related party.

§ 153—Federal Requirements

Federal law requires nursing homes that receive Medicaid funding to disclose to the state Medicaid agency information on related parties, including information on:

1. anyone with direct or indirect ownership in the home of 5% or more;
2. officers, director, and partners;
3. managing employees;
4. anyone who is an “additional disclosable party” (defined as any person or entity who (a) exercises operational, financial, or managerial control over the facility or a part thereof, provides policies or procedures for any of the operations, or provides financial or case management services to the facility; (b) leases or subleases real property to the facility, or owns a whole or part interest of 5% of more of the total property value of the facility; or (c) provides management or administrative services, management; or clinical consulting, accounting, or financial

services to the facility (42 USC § 1320a-3).

Federal regulations permit nursing homes to include as allowable costs those they incurred from procuring services, facilities, and supplies furnished by an entity related by common ownership or control. The maximum that is allowed is the actual cost to the related party. But, the regulations allow homes to include the actual charge for goods and services if the home can demonstrate by convincing evidence that:

1. the supplying organization is a bona fide separate organization;
2. a substantial part of its business activity of the type it is carrying on with the home is also transacted with others and that there is an open, competitive market for the type of services, facilities, or supplies the entity provides;
3. the services, facilities, or supplies that institutions commonly obtain from other entities are not a basic element of patient care that the home ordinarily would furnish directly to its residents; and
4. the charge to the home is in line with the charge in the open market and no more than the entity would charge any others for the same goods and services (42 CFR § 413.17).

§ 153—Nursing Home Licensing Designation

By law, nursing homes must be licensed by the Department of Public Health. The license can be for skilled (also called chronic and convalescent) beds, intermediate care (also called rest home with nursing supervision) beds, or both. The Medicaid reimbursement for the skilled beds is higher than that for the intermediate care

§ 156 - Differential Response Program

Through the differential response program, DCF can refer families to appropriate community providers for assessment and services, (1) at any time during an investigation in an abuse or neglect case, or (2) when DCF decides not to investigate such a case that it classifies as

presenting a lower risk. These referrals can only occur when there has been an initial safety assessment of the family's circumstances and criminal background checks have been performed on all adults involved in the report.

§ 156 - Birth-To-Three Program

The Birth-to-Three program is designed to strengthen families' capacities to meet the developmental and health-related needs of their infants and toddlers who have developmental delays or disabilities. Eligible families work with service providers to develop Individualized Family Services Plans, with services starting within 45 days of the plan's completion. The plans are reviewed at least once every six months and rewritten at least annually.

The Department of Developmental Services is the state's lead agency for the Birth-to-Three program, but families may get referrals from it to other state agencies' programs, depending on the number and type of disabilities a child has.

§ 156 - Children's Trust Fund's Help Me Grow Program

The Children's Trust Fund is a division of the Department of Social Services. Its Help Me Grow program helps parents and child health and service providers access community based early identification, prevention, and intervention services for child developmental or behavioral problems through a toll-free number.

Related Bill

sSB 523 (File 19), which passed the Senate, requires the DSS commissioner, to the extent federal law allows, to reduce the penalty period for certain returned assets.