STATE OF CONNECTICUT
Department of Mental Health & Addiction Services

Legislative Update # 24

July 1, 2015

The June 2015 Special Session has ended and what follows is a very brief summary of the actions taken by the House and Senate. I have included the links to the bill summaries in this update for your convenience.

SB 1502 AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2017 CONCERNING GENERAL GOVERNMENT, EDUCATION AND HEALTH AND HUMAN SERVICES.

SUMMARY: (Sections that are relevant)

http://www.cga.ct.gov/2015/BA/2015SB-01502-R00SS1-BA.htm

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES			
Reduction to this account	Other Expenses	430,748	431,292
Reduction to this account	Workers' Compensation Claims	176,884	176,884

43-46 — INSURANCE COVERAGE FOR CERTAIN CONDITIONS PA 15-226 expands the services certain health insurance policies must cover for mental and nervous conditions. **The bill delays, from January 1, 2016 to January 1, 2017**, the requirement to cover the following four services required by the act. EFFECTIVE DATE: January 1, 2016 for the provisions removing required coverage, and January 1, 2017 for the provisions reenacting them.

73 — Deprivation of Rights Based on Mental Disability By law, it is a discriminatory practice to deprive someone of rights, privileges, or immunities secured or protected by state or federal laws or constitutions based on certain factors (such as the person's race, sex, or physical disability). The bill adds mental disability to this list.

139 — KENO PA 15-244 allows the Connecticut Lottery Corporation (CLC) to offer Keno games, but not until the Office of Policy and Management executes separate agreements with the Mashantucket Pequot and Mohegan tribes regarding CLC's Keno operation. The bill limits the total amount of gross Keno revenue the state may give to a tribe under an agreement to 12.5% of that revenue after subtracting prize payments. EFFECTIVE DATE: July 1, 2015

356 — INSURANCE DEPARTMENT DATA COLLECTION WORKING GROUP The bill requires the insurance commissioner, by October 1, 2015, to convene a working group to develop recommendations for uniformly collecting behavioral health utilization and quality measures data from:

1. state agencies that pay health care claims,

2. group hospitalization and medical and surgical plans established by the comptroller for state employees and certain other individuals,

3. the state medical assistance program, and

4. health insurance companies and HMOs that write health insurance policies and health care contracts in Connecticut.

The recommendations' purposes must include protecting behavioral health parity for youth and other populations.

Members

The working group consists of the (1) healthcare advocate, (2) insurance, social services, public health, mental health and addiction services, children and families and developmental services commissioners, and (3) comptroller, or any of their designees. It may also include representatives from health insurance companies or HMOs or any other members the insurance commissioner deems necessary and relevant to carry out the group's duties. EFFECTIVE DATE: Upon passage

357 — PRESCRIPTION DRUG MONITORING PROGRAM Under the prescription drug monitoring program, DCP collects information on controlled substance prescriptions to prevent improper or illegal drug use or improper prescribing. By law, pharmacists and other controlled substance dispensers must generally report certain prescription information to DCP under the program, such as the dispensing date, dispenser identification and prescription number, and patient identifying information.

Currently, they must report this information to the program at least weekly. Starting July 1, 2016, the bill requires them to report to the program immediately after dispensing controlled substances but in no event more than 24 hours after doing so. The bill also requires the information to be submitted electronically according to a DCP-approved format. Current law allows other DCP-approved methods of reporting by pharmacies or outpatient pharmacies that do not maintain electronic records.

As under existing law, these reporting requirements apply to (1) pharmacies; (2) nonresident pharmacies (i.e., out-of-state pharmacies that send prescription drugs into the state); (3) outpatient pharmacies in hospitals or institutions; and (4) practitioners who dispense controlled substances. EFFECTIVE DATE: October 1, 2015

358 — DMHAS ACUTE CARE AND EMERGENCY BEHAVIORAL SERVICES GRANT PROGRAM The bill establishes a grant program in the Department of Mental Health and Addiction Services (DMHAS) to provide funds to organizations providing acute care and emergency behavioral health services.

The grants are for providing community-based behavioral health services, including (1) care coordination and (2) access to information on and referrals to available health care and social service programs. The commissioner must establish eligibility criteria and an application process. EFFECTIVE DATE: July 1, 2015

359 — PSYCHIATRIC SERVICES STUDY The bill requires the DMHAS commissioner to study the current adequacy of psychiatric services. She must do so in consultation with the children and families (DCF) and social services (DSS) commissioners and behavioral health providers, including hospitals and advocacy agencies.

The study must include:

1. a determination of how many short-term, intermediate, and long-term psychiatric beds are needed in each region of the state;

2. the average wait times for each type of bed;

3. the impact of wait times on people needing inpatient psychiatric services, their families, and providers of this type of care;

4. identification of public and private funding sources to maintain the necessary number of beds;

5. access to outpatient services, including wait times for initial appointments;

6. available housing options; and

7. access to alternatives to hospitalization, including peer-operated respite programs.

The DMHAS commissioner must report on this study to the Appropriations, Human Services, and Public Health committees by January 1, 2017. The report must include recommendations on:

1. expanding utilization criteria to increase access to acute, inpatient psychiatric services statewide;

2. increasing the number of available long-term, inpatient hospital beds for people with recurring needs for inpatient behavioral health services;

3. funding to increase the number of psychiatric beds;

4. placing additional psychiatric beds in health care facilities throughout the state; and

5. funding to increase alternatives to hospitalization, including access to outpatient services, housing, and peer-operated respite programs. EFFECTIVE DATE: July 1, 2015

373 — REDUCTION IN HUSKY A COVERAGE By law, DSS provides Medicaid coverage to children under age 19 and their parents or caretaker relatives through HUSKY A. Under current law, the income limit for this program is 196% of the federal poverty limit (FPL). The bill reduces HUSKY A coverage by lowering the income limit for non-pregnant adults (i.e., parents or caretakers) to 150% FPL. EFFECTIVE DATE: August 1, 2015

374 — TRANSITION FROM HUSKY TO EXCHANGE Under the bill, before terminating coverage for a parent or needy caretaker relative who, beginning August 1, 2015, loses eligibility for Medicaid coverage, DSS must review whether the person remains eligible for Medicaid under his or her current category of coverage or a different category.

The bill requires the DSS commissioner and the Connecticut Health Insurance Exchange (HIX) to ensure that parents or needy caretaker relatives who lose Medicaid eligibility are given an opportunity to enroll in a qualified health plan (QHP) without a gap in coverage. HIX must enlist the assistance of health and social services community-based organizations to contact and advise those parents or needy caretaker relatives of health insurance coverage options.

Beginning November 1, 2015 and ending December 1, 2017, the bill requires DSS and HIX to report quarterly to the Council on Medical Assistance Program Oversight (MAPOC) on the number of parents and caretaker relatives who, due to changes in Medicaid income eligibility effective August 1, 2015:

1. were no longer eligible for Medicaid,

2. remained eligible after DSS' review,

3. lost Medicaid coverage and enrolled in a QHP without a gap in coverage,

4. lost Medicaid coverage and did not enroll in a QHP immediately after such coverage loss, and

5. enrolled in a QHP but were disenrolled for failure to pay premiums.

EFFECTIVE DATE: Upon passage

375 — MEDICAID INCOME ELIGIBILITY CONVERSION The bill converts the income eligibility limit for Medicaid for pregnant women to reflect current DSS practice and requirements of the federal Affordable Care Act. It also eliminates an obsolete requirement. EFFECTIVE DATE: July 1, 2015

376 & 377 — HUSKY B COVERAGE Under current law, HUSKY B provides non-Medicaid health coverage for children in households with incomes over 196% of the FPL, requiring households (a) between 249% FPL and 318% FPL to pay for coverage on a sliding fee scale, (i.e., subsidized coverage) and (b) over 318% to pay full premium, (i.e., unsubsidized coverage). The bill eliminates eligibility for unsubsidized HUSKY B coverage for children with household incomes over 318% FPL. EFFECTIVE DATE: August 1, 2015

378 —TFA AND SAGA RATES The bill freezes TFA and SAGA payment standards at the FY 15 rate for the next two fiscal years. It retains the existing formula for calculating increases for future years. EFFECTIVE DATE: July 1, 2015

379 — STATE SUPPLEMENT PROGRAM RATES Currently, the DSS commissioner must annually increase the amount of unearned income he disregards when determining eligibility and benefits for the State Supplement Program (SSP). The bill freezes SSP payment standards for the next two fiscal years. EFFECTIVE DATE: July 1, 2015

389 — MEDICARE PART D PRESCRIPTION DRUG COPAYMENTS This bill eliminates DSS' obligation to pay any Part D prescription co-payments for those who are eligible for full Medicaid assistance and have Medicare Part D coverage. Under current law, full benefit dually eligible Medicare Part D beneficiaries must pay Part D prescription co-payments of up to $15 per month, and DSS must pay any co-payments in excess of that amount. EFFECTIVE DATE: July 1, 2015

390 — MEDICATION ADMINISTRATION The law permits a registered nurse (RN) to delegate the administration of medications that are not injected into patients to homemaker-home health aides who obtain certification for medication administration. Under the law, administration may not be delegated when the prescribing physician specifies that a nurse must administer the medication.

The bill requires the DSS commissioner to monitor Medicaid home health savings that have been achieved since the law's implementation three years ago (PA 12-1 § 11 JSS, effective July 1, 2012). If, by January 1, 2016, the commissioner determines that the savings are less than the amount assumed in the 2016-17 biennial budget, DSS may reduce home health care Medicaid rates for medication administration to the amount necessary to achieve the assumed savings. But before reducing the rate, the bill requires the commissioner to report to the Appropriations and Human Services committees provider specific cost and utilization trend data for patients receiving medication administration in their homes. If DSS determines it is necessary to reduce the medication administration rates, it must examine the possibility of establishing a separate Medicaid supplemental rate or a pay-for-performance program for the providers, as determined by the commissioner, who have successfully delegated medication administration to homemaker-home health aides as described above. EFFECTIVE DATE: July 1, 2015

398-401 — ELIMINATION OF CASE MANAGEMENT REQUIREMENTS FOR MEDICAID PARTICIPANTS The bill eliminates all requirements related to the provision of intensive case management services (ICM) to certain Medicaid recipients. DSS, DCF, and DMHAS contract

with administrative service organizations (ASOs) to administer medical and behavioral health services for those who receive assistance under HUSKY Health. The bill eliminates provisions requiring these ASOs, beginning July 1, 2016, to also provide ICM services that include, among other things:

1. identifying hospital emergency departments with high numbers of "frequent users" (i.e., Medicaid clients with 10 or more annual emergency department visits),

2. creating regional ICM teams to work with emergency department doctors, and

3. assigning at least one ICM team staff member to participating emergency departments during hours of highest use.

It also eliminates requirements for ASOs with access to complete client claim adjudicated history to, beginning July 1, 2016, annually analyze Medicaid clients' use of hospital emergency departments and report on such use to DSS and the Council on Medical Assistance Program Oversight. The bill eliminates DSS' obligation to use the report to monitor ASO performance.

The bill also removes a requirement that DSS ensure that contracts with a medical ASO include provisions requiring the ASO to:

1. conduct assessments of primary care doctors and specialists to determine patient ease and access to services;

2. perform outreach to Medicaid clients to inform them about, and connect them to, primary care providers; and

3. arrange visits by Medicaid clients with primary care providers after the clients visit an emergency department.

The bill instead allows DSS to contract with the behavioral health ASO to provide intensive care management, a term the bill does not define. In practice, DSS defines this term as various services using licensed care managers to help people with complex health care needs better understand and manage their care. By law, contracts with the medical ASO must include a provision to reduce inappropriate use of hospital emergency department services. The bill allows this provision to include intensive care management. Current law requires DSS and DMHAS, in consultation with the Office of Policy and Management, to ensure submission of eligible expenditures for intensive case management to CMS for Medicaid reimbursement. The bill eliminates this requirement and instead requires submission of eligible expenditures for intensive care management. EFFECTIVE DATE: July 1, 2016

403 — MEDICAID PROVIDER AUDITS The bill makes several changes in the DSS Medicaid provider audit process.

Principally, it:

1. modifies the circumstances in which DSS can make findings of over- or under-payment using extrapolation of audited provider claims;

2. prohibits DSS from extrapolating an overpayment or attempting to recover an extrapolated overpayment beyond the payment's original dollar amount if the provider presents credible evidence that a DSS error caused the overpayment;

3. allows providers aggrieved by an audit finding to request a contested case hearing under the Uniform Administrative Procedures Act (UAPA), instead of a review by a DSS designee as under current law;

4. prohibits DSS from recouping a contested provider overpayment based on extrapolation until a final decision is issued after the hearing;

5. requires DSS to give providers (a) that are going to be audited written notification of the statistically valid sampling and extrapolation methodology (SVSEM) the auditors will use and (b) additional information at the start of the audit;

6. eliminates a requirement that DSS adopt regulations pertaining to its provider audit practices; and

7. requires DSS, by January 1, 2016, to establish audit protocols for homemaker companion services. The law already requires DSS to adopt such protocols for various other providers and services. The bill also makes technical and conforming changes. EFFECTIVE DATE: July 1, 2015

405-410 & 483-488 — DPH LICENSE RENEWAL FEES

PA 15-244, §§ 112-135, (1) increases by $5 license renewal fees for various DPH-licensed professionals and (2) directs the revenue generated to a newly established account to fund the professional assistance program for DPH-regulated professionals (currently, the Health Assistance InterVention Education Network (HAVEN)). The bill makes the:

1. fee increases effective October 1, 2015 and applicable to registration periods on or after that date, rather than effective July 1, 2015 and

2. DPH commissioner's quarterly certification and transfer of revenue received as a result of the fee effective October 1, 2015, rather than July 1, 2015.

Additionally, the bill eliminates the provision in PA 15-244 § 131 that increases, by $5, the fee for renewing a funeral home inspection certificate.

The bill also makes technical and conforming changes. EFFECTIVE DATE: October 1, 2015, except for the provision changing the effective date of the fee increases in PA 15-244, which takes effect June 30, 2015

489-490 — REPORTING OF IMPAIRED HEALTH CARE PROFESSIONALS By law, physicians, physician assistants, and hospitals must notify the DPH if a physician or physician's assistant is or may be unable to practice with skill and safety due to impairment. The law also establishes procedures for DPH to follow when it receives such notice. The bill expands the reporting requirement to cover all licensed or permitted health care professionals.

It establishes similar (1) requirements for hospitals and other licensed or permitted health care professionals to report to DPH suspected impairment that may limit a person's ability to practice with skill and safety and (2) procedures for DPH to follow when it receives such notice.

Under certain circumstances, the bill allows a health care professional or hospital to satisfy the bill's reporting requirements by referring the impaired health care professional for intervention to the professional assistance program for DPH-regulated professionals (currently, the Health Assistance InterVention Education Network (HAVEN)).

Under the bill, covered health care professionals include: chiropractors, naturopaths, podiatrists, athletic trainers, occupational and occupational therapy assistants, physical therapists and physical therapy assistants, radiographers, radiologic technologists, radiologist assistants, nurses, nurse-midwives, dentists, dental hygienists, optometrists, opticians, respiratory care practitioners, psychologists, marriage and family therapists, clinical and master social workers, alcohol and drug counselors, professional counselors, veterinarians, massage therapists, dietitian-nutritionists, acupuncturists, paramedics, embalmers and funeral directors, hearing instrument specialists and speech and language pathologists.

498-501 — CRIMINAL AND JUVENILE JUSTICE PROGRAM INVENTORIES

Program Inventories The bill requires the Judicial Branch's Court Support Services Division (CSSD) and the departments of Correction, Children and Families, and Mental Health and Addiction Services, by January 1, 2016, to (1) compile complete lists of each agency's criminal and juvenile justice programs and (2) categorize them as evidenced-based, research-based, promising, or lacking any evidence. The agencies must also do this by October 1 every even-numbered year after that.

Each designated agency's list must include the following information for the previous fiscal year:

1. a detailed program description and the names of providers,

2. the intended treatment population and outcomes,

3. total annual program expenditures and a description of funding sources,

4. the method for assigning participants,

5. the cost per participant,

6. the annual capacity for and the number of actual participants, and

7. an estimate of the number of people eligible for or needing the program.

CSSD and the departments must submit the program inventories to OPM's Criminal Justice Policy and Planning Division, the Appropriations and Finance, Revenue and Bonding committees, the Office of Fiscal Analysis (OFA), and the Institute for Municipal and Regional Policy (IMRP) at Central Connecticut State University.

Using the program inventory data, IMRP must develop a cost-benefit analysis for each program and submit the report of its analyses to OPM, the Appropriations and Finance, Revenue and Bonding committees, and OFA, by March 1, 2016 and annually by November 1 after that. IMRP's cost-benefit analyses may be included as part of OPM's and OFA's annual fiscal accountability report due by November 15 to the Appropriations and Finance, Revenue and Bonding committees each year. Under the bill, "cost beneficial" means the cost savings and benefits realized over a reasonable period of time are greater than the costs of implementation.

By law, OPM must develop a plan to promote a more effective and cohesive state criminal justice system. Under the bill, to accomplish this, OPM must also review the program inventories and cost benefit analyses and consider incorporating them in its budget recommendations to the legislature. EFFECTIVE DATE: July 1, 2015, except the provision on estimates of agency expenditures on evidence-based programs is effective July 1, 2016.

508-521 — MEDICAL MARIJUANA

The bill makes various changes to the state's medical marijuana program, which the Department of Consumer Protection (DCP) administers.

The bill allows minors to be qualifying patients. In addition to existing requirements for adult patients, the bill requires the consent of the parent or other person with legal custody and a letter by two physicians stating that medical marijuana use is in the minor's best interest.

It adds the following to the list of qualifying conditions for adults: (1) sickle cell disease, (2) Amyotrophic Lateral Sclerosis (ALS, or Lou Gehrig's Disease), (3) severe psoriasis and psoriatic arthritis, (4) Fabry disease, (5) ulcerative colitis, (6) post-laminectomy syndrome with chronic radiculopathy (recurring back pain after surgery), (7) cerebral palsy, and (8) cystic fibrosis. Earlier this year, the Department began the process to adopt regulations to add the first six of these conditions to the list of qualifying conditions, following recommendations by the Board of Physicians.

It allows licensed (1) marijuana dispensaries to distribute marijuana to licensed inpatient care facilities under certain conditions and (2) nurses to administer marijuana in hospitals or other licensed health care facilities.

It allows the DCP commissioner to approve medical marijuana research programs, and requires research program subjects to register with DCP. It requires the commissioner to adopt regulations on licensing (1) research program employees and (2) laboratories and laboratory employees. These employees must be licensed after the regulations take effect; before then, the bill provides for temporary registration certificates.

The bill allows licensed marijuana dispensaries or producers to distribute marijuana to licensed laboratories or organizations conducting approved research programs. It extends legal protections, under certain conditions, to laboratory or research program employees and research program subjects.

508-510 & 512 — MINORS AS QUALIFYING PATIENTS

Under current law, only state residents age 18 or older may be qualifying medical marijuana patients. The bill extends the program to state residents under age 18. As under current law, inmates are ineligible.

As for adult patients under existing law, before using marijuana for medical purposes, minors must have a written certification by a physician, who determined that (1) the patient has a debilitating medical condition which the bill limits for minors (see below) and (2) the potential benefits of the palliative use of marijuana would likely outweigh its health risks. (While the law refers to "palliative" rather than "medical" marijuana use, the program is generally referred to as the medical marijuana program.) Patients, and their primary caregivers, must register with DCP and pay certain fees.

524 — REPEAL OF MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES WORKING GROUP The bill repeals Section 3 of PA 15-226. The repealed provisions required the insurance commissioner and the healthcare advocate to convene a working group to improve the alignment of utilization review procedures and health insurance coverage with the clinical recommendations of treating health care providers. EFFECTIVE DATE: Upon passage

529 — CHIROPRACTIC SERVICES FOR MEDICAID RECIPIENTS The bill eliminates a provision allowing DSS to spend up to $250,000 annually to provide chiropractic services to Medicaid recipients. EFFECTIVE DATE: July 1, 2015

HB 7104 AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2017 CONCERNING GENERAL GOVERNMENT PROVISIONS RELATING TO CRIMINAL JUSTICE.

http://www.cga.ct.gov/2015/BA/2015HB-07104-R00SS1-BA.htm

SUMMARY: This bill replaces the current penalty structure for drug possession crimes, which punishes possession of most types of illegal drug as felonies. It creates a new structure that

punishes possession of .5 ounces or more of marijuana or any amount of another illegal drug as a class A misdemeanor but allows the court to (1) suspend prosecution for a second offense and order treatment for a drug dependent person and (2) punish third-time or subsequent offenders as persistent offenders, which subjects them to the penalties for a class E felony. It also reduces the enhanced penalty for drug possession near schools or day care centers from a two-year mandatory prison sentence to a class A misdemeanor with a required prison and probation sentence.

Accessing Information via the Connecticut General Assembly Web Page:

If you wish to get the details/status on a bill, read the text of a bill, or check on committee agendas or upcoming events in the Bulletin, log onto the Connecticut General Assembly web page at: http://www.cga.ct.gov

The CGA schedule of events can be accessed on that same page by scrolling down and clicking on the appropriate item.