



Corrected Legislative Update #38 **September 28, 2009**

The Budget passed, but now the legislature is voting on language to implement the budget changes. They passed a few bills last week that the Governor is expected to sign, and they will be meeting again sometime this week to finish their work.

Budget bills that impact the behavioral health community are H.B. 7005 (passed by the House, but awaiting action by the Senate) and S.B. 2051 (passed by the House and Senate). This update will focus on the relevant sections of these two bills, but you can always go on line and get the all the language.

- **H.B. 7005, AN ACT IMPLEMENTING THE PROVISIONS OF THE BUDGET CONCERNING HUMAN SERVICES AND MAKING CHANGES TO VARIOUS SOCIAL SERVICES STATUTES (must still pass the Senate to go into effect)**

Sections 1 through 17 create a Connecticut False Claims Act (FCA) applicable to the medical assistance programs that the Department of Social Services (DSS) administers, including Medicaid, State-Administered General Assistance (SAGA), and HUSKY B. The 2005 federal Deficit Reduction Act permits states that adopt their own act to keep a greater share of any Medicaid funds that they recover under it. Effective from passage.

Section 19 postpones the reestablishment of a state Department on Aging by two years, from July 1, 2008 to July 1, 2010. Effective from passage. (Note: Connecticut disbanded its Department on Aging in 1993 and merged most of its functions and personnel into DSS as the Division of Elderly Services. This division was renamed the Aging Services Division several years ago. In 2005, the legislature reestablished the department effective January 1, 2007, but P.A. 07-2, June Special Session postponed the reestablishment date to July 1, 2008.)

Sections 30, 31, 33 47, MEDICARE PART D—ENROLLMENT IN BENCHMARK PLANS, CO-PAYS, AND ENROLLMENT PERIOD, INCOME LIMIT COLA. Effective from passage.

Benchmark Plans: Connecticut's Medicare Part D recipients can choose one of 47 prescription drug plans to pay for their medications. Currently, people who are eligible for both Medicare and Medicaid (dually eligible) can get help paying for their premiums and co-payments from the federal Low-Income Subsidy (LIS) Program. The annual federal premium payment is limited — it only covers premiums for a “benchmark” prescription plan (\$31.74 per month in 2009). If the dually eligible person picks a plan with a more expensive premium, DSS pays the difference between the federal benchmark payment and the actual premium cost. The bill requires all full-benefit, dually eligible individuals (those for whom DSS provides coverage for services that Medicare does not) to enroll only in one of the benchmark plans (currently there are 12 such plans). A benchmark plan is one that offers basic Part D coverage with

premiums equal to or lower than the regional low-income premium subsidy amount calculated annually. The law makes the DSS commissioner representative to enroll dually eligible individuals in a Part D plan. Under the bill, he can enroll people in a benchmark plan.

Co-Pays:

Under current law, in addition to paying the premiums for the fully dually eligible, DSS also pays all their Part D prescription co-payments. The bill requires these individuals to pay up to \$15 per month in co-payments, with DSS paying anything above that. These co-pays range from \$1.10 to \$6 per prescription in 2009 and are subsidized by the LIS program.

ConnPACE—Benchmark Plans:

The bill also requires ConnPACE applicants and recipients eligible for Medicare Part D to enroll in these benchmark plans. Like it does for the fully dually eligible, the bill authorizes the DSS commissioner to enroll ConnPACE recipients in these plans.

ConnPACE—COLA Freeze, and Increased Annual Fee, and Enrollment Period:

The bill freezes the income limit in the ConnPACE program (currently \$25,100 annually for a single person and \$33,800 for married couples) until January 1, 2012 (these are tied to increases in Social Security benefits, which take effect on January 1). It also increases the ConnPACE annual registration fee from \$30 to \$45. Beginning October 1, 2009, it limits new applications for ConnPACE to the period between November 15 and December 30 of each year. This is the same enrollment period that the Medicare Part D program uses, but people can apply at other times of the year, provided it is within 31 days of either: (1) turning age 65, or (2) becoming eligible for federal Social Security Disability Income (SSDI) or Supplemental Security Income (SSI) benefits.

Repealer:

The bill repeals a provision establishing a council to advise on the implementation of Medicare Part D.

Sections 34 and 38: By law, the DSS commissioner can require prior authorization (PA) for any prescription for a drug covered by the Medicaid, SAGA, and ConnPACE programs. The bill specifies that this applies to drugs prescribed under any medical assistance programs DSS administers, which could also include the HUSKY B program. It makes a parallel change in the law related to maximum oral dosages of drugs dispensed for program clients.

The bill also requires pharmacists to provide a 14-day supply of drugs requiring prior authorization (PA) when a pharmacist is unable to obtain the prescribing physician's authorization at the time the prescription is presented for filling. In current practice, when a DSS drug assistance program client goes to the pharmacy with a prescription requiring PA, the pharmacist can immediately dispense a 30-day supply pending receipt of PA. This provision applies both to non-preferred drugs in the classes of drugs included in the PDL and drugs in classes not in the PDL. The bill also permits DSS to require PA for: (1) high-cost prescription individual drugs or drug classes, at the commissioner's discretion, effective July 1, 2009 and (2) "off-label" drugs prescribed for children under the age of 18, beginning July 1, 2010. The bill defines "off-label" as a drug that is approved for a clinical use other than the one for which it is being prescribed.

In general, pharmacists serving DSS pharmacy program clients must obtain PA whenever they dispense a brand-name drug when a chemically equivalent generic is available. If PA is not granted or denied within two hours of PA being requested from DSS, it is deemed approved.

The bill also eliminates mental health-related drugs' blanket exemption from the PDL. Instead, it specifies that PA is not required for these drugs when they have been filled or refilled, in any dosage, at least once in the one-year period before the client presents a prescription for it at the pharmacy. The bill also removes obsolete language related to pharmacy suppliers. Effective from passage

Section 36 freezes the benefit levels in the TFA and SAGA cash assistance programs in FY 10 and FY 11 at FY 09 levels. Effective from passage.

Section 37 freezes the need standards in the State Supplement Program (SSP) at FY 09 levels for FY 10 and FY 11. The SSP provides supplemental cash assistance to aged, blind, and disabled people receiving Social Security or Supplemental Security Income benefits. Current law allows for increases in SSP benefits in two ways. First, it requires DSS to index the unearned income disregard for Social Security cost of living adjustments, if any. This allows any increases in a recipient's SSI benefits, which are considered unearned income, to be passed along and not affect the SSP benefit level. Second, it requires DSS to annually increase, up to 5%, the need standards based on the percentage increase in the Consumer Price Index for Urban Consumers. The need standards have been statutorily frozen since 1993. Effective from passage.

Section 44 requires the DPH commissioner to revise regulations governing medication administration by unlicensed personnel in RCHs that admit residents requiring medication administration assistance to include the following:

1. the requirement that each RCH designate unlicensed personnel to obtain certification and ensure that they do;
2. criteria homes must use to determine the appropriate number of unlicensed personnel who will obtain certification; and
3. required training in identifying the types of medication that unlicensed personnel can administer.

It also requires that by January 1, 2010, each RCH ensure that the number of unlicensed personnel it determined appropriate actually obtain certification to administer medication. Once certified, they can administer medication, except by injection, to RCH residents unless a resident's physician specifies that a medication be administered only by licensed personnel.

The bill permits the DPH commissioner to implement policies and procedures to administer the provisions of this section while in the process of adopting them in regulation, provided notice is published in the Connecticut Law Journal not later than 20 days after they are implemented. The policies and procedures are valid until final regulations are adopted.

Current law requires the commissioner to establish regulations allowing unlicensed personnel in RCHs to obtain certification to administer medication. The regulations must establish ongoing training requirements, including initial orientation, residents' rights, behavioral management, personal care, nutrition and food safety, and general health and safety. Effective from passage.

Sections 48 and 49, PRIOR AUTHORIZATION FOR NONEMERGENCY DENTAL SERVICES FOR DSS CLIENTS. Effective from passage.

The bill subjects all non-emergency dental services provided under DSS' dental program to prior authorization. It also requires the DSS commissioner, at least quarterly, to retrospectively review payments for emergency dental services and restoration procedures for appropriateness of payment, and allows him to recoup payments for services determined not to be for an emergency condition or otherwise exceeding what is medically necessary.

The bill defines an “emergency condition” as a dental condition that manifests itself in acute symptoms, including severe pain, that leads a prudent layperson with an average knowledge of health and medicine to reasonably expect that not getting immediate dental attention would result in: (1) placing the health of the individual, or the health of a pregnant woman's unborn fetus, in serious jeopardy; (2) cause serious impairment to body functions; or (3) cause serious dysfunction of any body organ or part. The bill removes a provision requiring the DSS commissioner to review eliminating prior authorization for basic and routine dental services before implementing a statewide dental plan. Instead, it specifies that non-emergency services, including diagnostic, prevention, basic restoration, and non-surgical extractions that are consistent with standard and reasonable dental practices, must be exempt from PA.

The bill allows the DSS commissioner to implement policies and procedures needed to carry out these provisions while in the process of adopting them in regulation. He must print notice of intent to publish the regulations in the Connecticut Law Journal within 20 days of implementing them. The policies and procedures are valid until final regulations are adopted.

Since late 2008, all DSS-funded dental services have been provided through the new Connecticut Dental Health Partnership. Previously, dental services were provided either on a fee-for-service basis or through the HUSKY managed care contracts.

Section 50 requires the DSS commissioner to submit notice of any proposed amendment to the Medicaid state plan to the Human Services and Appropriations committees before submitting it to the federal government. Effective from passage.

Section 55. By law, DSS was supposed to apply for a federal waiver by January 1, 2008 to get Medicaid to pay for the state-funded SAGA medical assistance program. It never did. Under the bill, if the commissioner fails to submit the waiver application by February 1, 2010, he must submit a written report to the committees by February 2, 2010 that includes (1) an explanation why the waiver has not been sought and (2) an estimate of the fiscal impact in one calendar year that would result from getting the waiver approved.

In the SAGA medical assistance program, health care is generally provided by the state's network of federally qualified health centers (FQHC) with which DSS contacts. The bill specifies that once the waiver is approved, the DSS commissioner may provide, or may require a contractor, FQHC, or other provider to provide, home care services, school-based services, or other outpatient community-based services when the commissioner has determined that such services are cost effective. The commissioner must contract with FQHCs or other primary care providers as needed to provide these services to SAGA recipients. The bill further provides that DSS, within available appropriations, must pay FQHCs for these services when the FQHC provides them.

The bill also eliminates a provision that would have extended SAGA medical assistance eligibility to anyone with income up to 100% of the federal poverty level (FPL) if the waiver was granted. Currently, income eligibility is just under 60% of the FPL but when a disregard of income is included, that number rises to a little over 70% of the FPL. Effective from passage.

Section 56 establishes a February 1, 2011 deadline for the DSS commissioner to amend the Medicaid state plan to include foreign language interpreter services provided to any beneficiary with limited English proficiency as a “covered service” under the Medicaid program. Public Act 07-185 directed the commissioner to amend the state plan. Public Act 08-1 required him to expedite amending the plan by June 30, 2009. The commissioner has not amended the state plan.

The bill also requires the commissioner, by February 1, 2011, to develop and implement the use of medical billing codes for foreign language interpreter services for the HUSKY Part A and B and fee-for-service Medicaid programs. It requires each managed care organization that contracts with DSS to provide interpreter services under HUSKY Part A to submit semiannual reports to DSS (by June 1st and December 31st) on the interpreter services provided to these beneficiaries. Within 30 days of receiving the report, DSS must submit a copy to the Medicaid Managed Care Council. Effective from passage.

Sections 57 and 58 requires the DSS commissioner, within available appropriations and in collaboration with the Medicaid Managed Care Council, to annually prepare a report about “health care choices” under the HUSKY part A program. The report, at a minimum, must compare performance of each managed care organization (presumably those serving HUSKY Part A clients), primary care case management, and other service delivery choices. The commissioner must provide a copy of each to part to all HUSKY part A recipients.

The bill also requires the Council to make recommendations regarding the HUSKY part A primary care case management pilot program, in addition to its existing charge. It allows the commissioner or the council, in consultation with an educational institution, to apply for available funding, including federal funds, to support Medicaid managed care programs. And it changes the council's composition. Currently, two community providers of health care appointed by the Senate President Pro Tempore appoints sit on the council. Under the bill, a representative of each HUSKY managed care organization (MCO) must be on the council. Currently, three MCOs serve HUSKY recipients. And it adds a representative of a primary care case management provider to the council. Effective from passage.

Section 60 requires the DSS commissioner to contract with one or more entities, either on an at-risk or non-risk basis, to provide administrative services to elderly Medicaid recipients and those who have disabilities, including those (1) dually-eligible for Medicare and (2) enrolled in dually eligible special needs plans. The services the entities may provide include care coordination, utilization management, disease management, provider network management, quality management, and customer service. The bill allows the DSS commissioner to implement policies and procedures needed to carry out these provisions while in the process of adopting them in regulation. He must print notice of intent to publish the regulations in the Connecticut Law Journal within 20 days of implementing them. The policies and procedures are valid until final regulations are adopted.

The bill requires the commissioner to submit a report to the Medicaid Managed Care Council within 30 days of making any policy change with respect to this section. Effective from passage.

Section 63 requires the DSS commissioner, by February 1, 2010, to apply for a 1915(c) home and community-based services Medicaid waiver to develop and implement a program providing home and community-based services to up to 100 Medicaid beneficiaries who (1) have tested positive for human immunodeficiency virus (HIV) or have immune deficiency syndrome (AIDS) and (2) would remain Medicaid-eligible if admitted to a hospital, nursing home or ICF-MR, or who would require Medicaid-covered care in these facilities without the waiver services. The bill provides that an individual who meets these requirements is eligible to receive services deemed necessary by the commissioner to meet his or her needs in order to avoid institutionalization. If the commissioner does not apply by the deadline, he must submit a written report to the Human Services and Appropriations committees by February 2, 2010 (1) explaining why he did not seek the waiver and (2) estimating the fiscal impact resulting from the waiver approval in one calendar year. Effective from passage.

Section 70. Public Act 09-2 enables more individuals to qualify for the Medicare Part D low-income subsidy (LIS) by loosening the financial eligibility criteria for the Medicare Savings Program MSP. MSP eligibility automatically makes someone eligible for the LIS. It essentially makes the eligibility

criteria the same as for the ConnPACE program. The bill explicitly provides that there is no asset test for MSP (ConnPACE has none). Effective from passage.

Section 83 requires DSS, within available appropriations, to contract with (1) the Center for Medicare Advocacy (CMA) to provide assistance with Medicare Part D Plan appeals relating to medically necessary prescription denials, and (2) a pharmacy association or pharmacist to help clients choose a Medicare Part D Plan that best meets their needs. Current law requires the DSS commissioner to report, by December 1, 2009, to the Appropriations and Human Services committees on its non-formulary exception review and appeal process for dually eligible clients (Medicaid and Medicare Part D). The report must include an explanation of (1) the department's revised process for determining the medical necessity of a non-formulary drug before it pays for it, (2) the conditions under which DSS pursues an appeal with private plans and (3) the criteria for making a referral to CMA for further appeals. Instead of submitting this report, the bill requires the commissioner to provide these committees with a plan concerning its referral process for dually eligible clients. The plan, which must also be submitted by December 1, 2009, must include providing information to clients about appeal rights and available assistance from CMA. Effective from passage.

Section 87 postpones, from January 1, 2009 to January 1, 2012 the date by which the DSS commissioner must submit a plan to implement the Money Follows the Person (MFP) II demonstration program to the Human Services and Appropriations Committees of the Connecticut General Assembly. The bill also delays the implementation date of the program from July 1, 2009 to July 1, 2012.

The federal MFP demonstration program is a five-year program that permits states to move individuals out of nursing homes and other institutional settings and into less-restrictive, community-based settings. Public Act 08-180 required DSS to develop and implement a demonstration program similar to MFP. This program, referred to as "MFP II," must provide home- and community-based long-term care services to adults (age 18 and older) who (1) are institutionalized or at risk of institutionalization and (2) meet CHCPE's financial and level of care eligibility criteria established in regulations. MFP II was created to allow adults who do not meet MFP's federally mandated six-month institutionalization requirement to receive similar services. Effective from passage.

- **S.B. 2051, AN ACT IMPLEMENTING THE PROVISIONS OF THE BUDGET CONCERNING PUBLIC HEALTH AND MAKING CHANGES TO VARIOUS HEALTH STATUTES**

Summary: This bill merges Office of Health Care Access into the Department of Public Health and makes numerous changes to Public Health, Developmental Disabilities', and Mental Health and Addiction Services programs. The changes are described section-by-section below.

Sections 1 thru 38 make a number of changes, primarily technical, to merge the existing Office of Health Care Access (OHCA) with the Department of Public Health (DPH). It establishes an OHCA division, within DPH and under the direction of the DPH commissioner, as a successor to the former OHCA. OHCA would no longer have its own commissioner.

The bill establishes a deputy commissioner position to oversee the OHCA division of DPH. The bill specifies that the current OHCA commissioner serves as this new deputy commissioner and can exercise independent decision-making authority over all certificate of need (CON)-related matters including CON determinations, orders, decisions, and agreed settlements. She is also authorized to designate an executive assistant. By January 1, 2010, this deputy commissioner, in consultation with the DPH

commissioner, must report to the governor and the Public Health Committee on recommendations for CON reform.

The bill specifies that any order, decision, agreed settlement or regulation of OHCA in force as of the bill's passage, continues in force and effect as a DPH order or regulation until amended, repealed, or superseded by law.

Hospitals are currently assessed to fund OHCA. Under this bill, hospitals must make these payments to DPH instead of OHCA. As under current law, they are deposited in the General Fund. OHCA's current responsibilities, including health care facility utilization and planning, certificate of need review, hospital charges and payments, data filings, and adoption of regulations, continue under this bill. Effective from passage.

Sections 43 and 59 of the bill increase membership on the Sustinet Health Partnership board of directors from nine to eleven by adding (1) an individual with expertise in either the reduction of racial, ethnic, cultural and linguistic inequities in health care or multi-cultural competency in the health care workforce, appointed by the Healthcare Advocate and (2) an individual appointed by the Comptroller.

The healthcare advocate and Comptroller must make their appointments within 30 days of the bill's passage. The initial term for these new board members is five years. The bill also increases the number of board members necessary for a quorum from five to six.

Funding Sources:

Under existing law, the board must offer recommendations to the General Assembly on the structure of the entity best suited to oversee and implement the Sustinet Plan. These recommendations can include the creation of a public authority authorized, among other things, to raise funds from private and public sources outside of the state budget to contribute toward support of its mission and operations. The bill specifies that this includes applying for and receiving federal funds. Effective from passage.

Section 53 permits the DMHAS commissioner, after consulting with the Department of Administrative Services (DAS) commissioner, to (1) bill directly for prescriptions under Medicare Part D or contract with a private entity to do so and (2) enter into agreements and contracts, including negotiated reimbursement rates, for Medicare Part D plans. It supersedes existing law that makes the DAS commissioner responsible for billing and collecting money due to the state for public assistance cases. The law authorizes the commissioner or the commissioner's designee to represent a DMHAS client or assistance beneficiary for purposes of (1) enrolling him or her in the Medicare Part D prescription drug program, (2) selecting a Part D drug plan if the person does not select one within a reasonable time after being informed of the opportunity to do so, and (3) applying for the low-income subsidy available under the Medicare drug program. Effective from passage.

Sections 54 and 55 increase fees for both the pretrial alcohol and pretrial drug education programs and makes them more uniform. These programs are available to certain people charged with driving a motor vehicle or a boat under the influence of alcohol or drugs. If a person wants to take advantage of the programs, the court seals the case files to the public and refers the individual to DMHAS for assessment (for alcohol education) and placement in an intervention program or a state-licensed treatment program (for alcohol). Effective January 1, 2010.

Alcohol Education:

The bill renames the pretrial alcohol education system as the pretrial alcohol education program. It increases the program application fee from \$50 to \$100. It retains the \$100 non-refundable evaluation

fee and requires crediting it to the pretrial account. It requires anyone approved for participation to begin within 90 days after the court orders it, unless the court grants a delay. The bill conforms the law to current practice by providing for 10- and 15-weeks intervention programs. It raises the fee for the 10-session program to \$350 from \$325.

The bill establishes procedures for the court to follow in dealing with a person who does not successfully complete an intervention program or is found no longer amenable to treatment. Under current law, if the program provider certifies either of these circumstances, the court must unseal the court record, enter a not guilty plea for the individual, and schedule a trial; in practice, the court reinstates people in intervention programs. Under the bill, if the program provider certifies either of these circumstances, it must, to the extent practicable: (1) recommend to the court whether a 10- or 15-session or placement in a state-licensed alcohol treatment program would best serve the person's needs and (2) indicate whether the person had been in an initial program or had been reinstated. If the person does not pursue reinstatement or if the court denies it, the court must proceed to trial as under current law. The bill imposes a non-refundable \$175 dollar reinstatement fee for a 10-session program and \$250 for 15 sessions. It limits a person to two reinstatements. The fees apparently apply for each reinstatement. The bill allows the court to waive the fee for good cause; otherwise, the person is responsible for the costs. It appears that the law that prohibits excluding an indigent person from a program and requires the pretrial account to pay program costs applies to reinstatements, but it is not clear whether the person must again pay the \$350 or \$500 program fee. The reinstatement fee must be credited to the pretrial account. The bill requires the Court Services Support Division (CSSD) to confirm that the person is eligible for reinstatement and the court to order reinstatement. The bill increases, from seven years to 10, the time the CSSD and the Motor Vehicle and Environmental Protection departments must keep records of people's participation in the program.

Drug Education Program:

The bill creates three program options: 10- and 15-hour intervention programs and drug treatment. The current program runs for 12 hours over eight sessions. Under the bill, once the court allows a person to participate in the program, it must refer him or her to DMHAS for evaluation (presumably to determine which of the three options is most appropriate). It also permits a minor accused of purchasing or possessing alcohol or making a false statement to procure alcohol to participate in the program. The bill establishes a \$100 application fee and a \$100 evaluation fee. It establishes a \$500 fee for the 15-session program; the 10-session fee remains \$350. All fees must be credited to the pretrial account. The bill makes people ordered into substance abuse treatment responsible for paying program costs. As under current law, (1) indigent people cannot be excluded from any program and (2) program fees are not refundable if a person is later found ineligible to participate or fails to complete a program.

The bill extends to all components of the drug education program the current prohibition against participation for anyone who previously participated in it or the community service labor program. It requires people placed in the drug education program to receive appropriate intervention or treatment services as recommended in their evaluation. Placement cannot exceed one year. Treatment services must be provided only at a state-licensed facility that is compliance with all state standards governing its operations. Program participants must agree to: (1) complete whichever option the court orders, (2) begin participating within 90 days after the order is entered, and (3) accept placement in a treatment program after completing the education program if a DMHAS provider recommends this. The bill increases the time people participating in the drug education program must also participate in the community service labor program. Current law requires them to participate for four days. The bill requires those in the 10-session intervention program or the treatment program participate in community service labor for at least five days, while those in the 15-session program must participate for at least 10

days. The bill creates the same reinstatement procedures and fees for the substance abuse education program as it does for the alcohol education program (see above).

Section 56 requires DMHAS and DSS to enter into a memorandum of understanding under which DMHAS will continue to manage the SAGA behavioral health program. Effective from passage.

Section 58 The bill specifies that materials or information produced for peer review purposes, in any format or media, are not subject to disclosure under the Freedom of Information Act (FOIA). By law, “peer review” means the procedure for evaluation by health care professionals of the quality and effectiveness of services ordered or performed by other health care professionals. This includes practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, and claims review.

The bill specifies that it does not preclude DPH from accessing peer review materials and information in connection with any department review or investigation of a provider's license. But DPH may not disclose the information to any person outside of the agency, except as necessary to take disciplinary action against the provider, and the information cannot be disclosed under FOIA. The bill also specifies that it does not limit other protections on peer review provided by law. Effective from passage.

Accessing Information via the Connecticut General Assembly Web Page:

If you wish to read the text of these bills, log onto the Connecticut General Assembly web page at:

<http://www.cga.ct.gov>

Type the bill number in the box (at the top of the page) – just the actual number, you do not need S.B. or H.B. – and click on “GO”. The page which will come up shows the bill history, summary, etc. for that bill. If you wish to read the bill text, scroll down the page, and click on the bill text, and the bill will come up on the screen.