



August 2015

Connecticut Enacts Health Care Legislation in June Special Session

On June 29 and 30, 2015, the Connecticut General Assembly conducted a special legislative session following the close of the 2015 regular session. Among other things, the General Assembly passed a bill to implement the state budget for the biennial period ending June 30, 2017. Governor Dannel P. Malloy signed this bill into law on June 30, 2015. The budget implementer bill, now known as [June Special Session Public Act 15-5](#), contains a number of health care-related provisions. Below are highlights of the health care provisions in the budget implementer bill. This new legislation has not been interpreted by the courts, and you may wish to consult with an attorney to determine how the legislation may affect your particular situation.

THE FOLLOWING SECTIONS BECAME EFFECTIVE ON JULY 1, 2015

Taxation of Real and Personal Property Acquired by Certain Health Systems on or after October 1, 2015

This legislation implements a new provision that permits municipalities to tax real property acquired on or after October 1, 2015, by a health system that had net patient revenue in 2013 of \$1.5 billion or more from Connecticut facilities. This legislation also allows municipalities to tax any personal property incident to the rendering of health care services located on such real property. These new taxation provisions do not apply to any real or personal property located on a hospital's campus, which is defined to include the physical area immediately adjacent to a hospital's main buildings and other areas and structures not strictly contiguous to the main buildings but located within 250 yards of the main buildings. Taxes assessed under this provision are liabilities of, and must be paid by, the health system, not a hospital or other affiliate of the health system.

Comprehensive Newborn Screening Program Fees

The Department of Public Health (DPH) oversees a comprehensive newborn screening program that includes testing, tracking, and treating newborn infants for certain conditions and diseases, including HIV, phenylketonuria, and other metabolic diseases, hypothyroidism, and sickle cell disease. In connection with this program, DPH currently charges each institution providing care for newborn infants a minimum fee of \$56 to cover the expenses of the screening program. This legislation increases the minimum fee to

\$98.

Possible Rate Adjustment for Homemaker-Home Health Aid Medication Administration

In 2012, Connecticut enacted a law allowing registered nurses (RNs) to delegate the administration of medication, other than medication administered by injection, to homemaker-home health aides certified to administer medication. This legislation requires the Department of Social Services (DSS) to study the Medicaid home health savings achieved as a result of the 2012 RN delegation law. It permits DSS to reduce medication administration reimbursement rates if it finds, by January 1, 2016, that the savings are insufficient to meet the savings assumed in the 2015–2017 Connecticut state budget. DSS may reduce the rates as necessary to achieve the savings projected in the budget. In the event that DSS determines that a reduction in reimbursement rates is necessary, this legislation requires DSS to consider whether a supplemental Medicaid rate or a pay-for-performance program should be established for providers that have implemented successful nurse delegation programs, as determined by DSS.

Nursing Home Bed Certificate of Need Moratorium

Current law places a moratorium on DSS approving requests for certificates of need (CONs) for additional nursing home beds except in certain limited circumstances. This legislation extends DSS's moratorium indefinitely and modifies the current exemptions. The moratorium exemption currently allows Medicaid beds to be relocated from a licensed nursing facility to a new facility to meet a priority need identified in the state's long-term care Medicaid strategic plan. This legislation removes this exemption and replaces it with an exemption allowing DSS to approve a CON for additional Medicaid nursing home beds that are relocated from a licensed facility to a new licensed facility, as long as certain requirements are met. First, at least one currently licensed facility must be closed as part of the transaction. Second, the new facility's bed total must be at least 10 percent lower than the total number of relocated beds. Last, the relocation and closure must meet a need in the state's long-term care Medicaid strategic plan.

Existing law exempts from the moratorium additional beds used only to treat patients with acquired immune deficiency syndrome (AIDS) or traumatic brain injury. This legislation revises that exemption to apply it to additional beds used solely by patients who need neurological rehabilitation. It also eliminates exemptions formerly available in the following circumstances: (1) the relocation of Medicaid-certified beds from a licensed nursing facility to a small house nursing home; (2) a request for 20 or fewer beds from a licensed nursing facility that does not participate in Medicaid or Medicare, provides care to residents regardless of financial considerations, and shows that it is financially able to provide lifetime nursing home services to its residents; (3) a request for 20 or fewer beds from a freestanding facility that provides hospice care services to terminally ill patients and is operated by an organization that DPH authorized to provide hospice services; and (4) a request for 60 or fewer new or existing Medicaid-certified beds to be relocated within a city that as of 2004 had an estimated population of 125,000.

Medicaid Payments to Hospitals

Under current law, Medicaid reimbursement rates for acute care hospitals, including children's hospitals, are based on diagnosis-related groups (DRGs) established by DSS. To arrive at a payment amount, the DRG relative weights are multiplied by a hospital-specific base rate derived from the hospital's reasonable costs. Current law requires DSS to set these rates annually. This legislation requires DSS to set DRG payments on an annual basis within available appropriations and to transition the hospital-specific rates to statewide rates by "peer group" over a period of four years beginning on January 1, 2016, within available appropriations and at DSS's discretion. This legislation defines "peer group" as a group composed of (1) privately operated acute care hospitals, (2) publicly operated acute care hospitals, or (3) acute care children's hospitals licensed by DPH. DSS may further subdivide the peer group of privately operated acute care hospitals in its discretion.

Currently, DSS must pay hospitals prospectively established reasonable rates for outpatient clinic and emergency room visits. Current law also requires that on or after July 1, 2013, DSS pay hospitals for outpatient and emergency room care in accordance with the Medicare Ambulatory Payment

Classification (MAPC) system, subject to a state conversion factor; however, DSS has not yet implemented the MAPC. Under this legislation, prior to MAPC implementation, DSS must base each hospital's charges on the charge master in effect as of June 1, 2015. Annual increases in each hospital's charge master can be no more than the annual Medicare economic index increase. After MAPC implementation, a covered outpatient hospital service that lacks an MAPC code will be paid pursuant to a fee schedule or alternative payment methodology established by DSS. This legislation requires DSS to establish its rates for outpatient and emergency room episodes of care, both before and after implementation of MAPC, within available appropriations.

Under existing law, DSS must also modify MAPC to cover certain services that it generally does not cover, including pediatric, obstetric, neonatal, and perinatal services. This legislation removes the requirement for MAPC to cover those services and replaces it with a requirement to cover mammograms, durable medical equipment, and physical, occupational, and speech therapy.

Finally, this legislation revises DSS's rate setting for the cost of special services, adjustments based on fluctuations in costs, and rates to freestanding chronic diseases hospitals to state that all such rates and adjustments must be made within available appropriations. The legislation further specifies that DSS is not required to increase rates paid to hospitals based on inflation.

Medicaid Provider Audits

This legislation makes a number of revisions to the processes by which DSS audits certain Medicaid service providers, including hospitals, physicians, federally qualified health centers, home health agencies, and certain long-term care facilities that receive Medicaid or other state payments.

Under existing law, DSS may use extrapolation to find that a provider received an overpayment or underpayment only if (1) the provider has a sustained or high level of payment errors, (2) the provider did not correct its errors after education, or (3) the annual aggregate value of the claims is more than \$200,000. Under this legislation, DSS may only use extrapolation when the total extrapolated overpayment, as calculated using a "statistically valid sampling and extrapolation methodology" (SVEM), is more than 1.75 percent of the total claims paid to the provider during the audit period. The legislation defines SVEM as a methodology that (1) is validated by a statistician who has performed graduate-level work in statistics and has substantial experience developing statistically valid samples and extrapolating the results for government entities, (2) excludes claims that are not representative of the sample, (3) has at least a 95 percent confidence level, and (4) includes stratified sampling when applicable. Stratified sampling is a sampling methodology that divides a population into groups based on similar characteristics. Under this legislation, DSS is prohibited from using extrapolation if the provider has credible evidence that DSS or one of its contractors caused the overpayment. In such circumstances, DSS may still recover the amount of the original overpayment.

Current law allows providers to submit to the auditor documentation related to any discrepancy that the auditor identifies during an audit. This legislation specifies that the documentation may include evidence that payment or billing errors were the result of the provider's transition to a new payment or billing service system or a new accounting system.

Under existing law, providers may contest a decision in the final audit report by requesting a review of the contested decision(s) within 30 days after receiving the final audit report. This legislation provides that the review will be in the form of a hearing conducted pursuant to Connecticut's Uniform Administrative Procedure Act (UAPA). As with the current process, the official presiding over the hearing must be an impartial DSS designee who is not an employee of DSS's Office of Quality Assurance or of an entity that contracts with DSS to conduct audits. This legislation permits a provider to argue that the negative finding resulted from the provider's compliance with a federal or state law or regulation. A final decision must be issued within 90 days of close of evidence or the date on which final briefs are filed, whichever is later. Furthermore, when a provider requests a hearing to contest an overpayment based on extrapolation, DSS is not permitted to recoup the overpayment until the final decision on the hearing is issued.

Currently, DSS must notify a provider at least 30 days prior to commencing an audit. Under this legislation, as part of the 30 days' notice, DSS must also furnish the provider with the SVEM to be used. Once the audit begins, DSS must provide the auditor's name and contact information to the provider, as well as the location of the audit and how requested information must be submitted. This legislation also limits the claims subject to audit to those paid within 36 months before the date claims are selected for audit.

Currently, DSS is required to establish audit protocols for specific categories of providers and services. This legislation requires DSS to establish audit protocols for homemaker companion services no later than January 1, 2016.

Funding for Federally Qualified Health Centers

Existing law requires that DSS distribute funding, within available appropriations, to federally qualified health centers (FQHCs) based on the FQHCs' cost reports until the General Assembly's Human Services and Appropriations committees approve an alternate payment methodology. This legislation permits DSS to develop the alternate payment methodology, which must then be approved by the Human Services and Appropriations committees. Until a new methodology is implemented, DSS must distribute supplemental funding, within available appropriations, to FQHCs based on cost, volume, and quality measures.

Financial Assistance to Community Health Centers

This legislation repeals the DPH program that provides financial assistance to community health centers, which are public or nonprofit private medical care facilities that have been designated by the U.S. Department of Health and Human Services as FQHCs or FQHC look-alikes. State funding is still available to community health centers through grants and bond issuances.

THE FOLLOWING SECTIONS ARE EFFECTIVE OCTOBER 1, 2015

Tax on Ambulatory Surgical Centers

Connecticut's 2015–2017 budget, as revised by this legislation, implements a new 6 percent tax on the gross receipts of ambulatory surgical centers (ASCs) that will be assessed quarterly. This tax does not apply to the first million dollars of gross receipts of the ASC during the applicable fiscal year nor does it apply to any gross receipts that qualify as net patient revenue of a hospital subject to the state's hospital tax. An ASC is defined to include any facility designated as such under federal regulations and licensed by DPH as an outpatient surgical facility and any other Medicare-certified ASC. Each ASC must electronically report to the Department of Revenue Services the name, location, and gross receipts of such ASC during the preceding quarter by January 31, 2016, and thereafter by the last day of January, April, July, and October of each year. The tax must be paid via electronic funds transfer at the time such report is filed. Unpaid taxes are subject to a penalty of 10 percent of the unpaid amount or \$50, whichever is greater, and will incur interest at a rate of 1 percent per month or a fraction thereof from the tax due date until paid in full. ASCs are not, however, prohibited from seeking remuneration for amounts due as a result of this new tax.

Electronic Prescription Drug Monitoring Program

This legislation revises current law concerning the state's electronic prescription drug monitoring program. Currently, pharmacies and providers who dispense controlled substances are required to submit weekly reports to the Department of Consumer Protection regarding the prescription and dispensation of controlled substances. They have the option of submitting such reports electronically or in an alternate format if they do not maintain electronic records. This legislation institutes mandatory

electronic reporting for all pharmacies and dispensers subject to the prescription drug monitoring program as of July 1, 2016. Such reports must now be made immediately, and in no event more than 24 hours, after dispensing a prescription.

Licensure of Genetic Counselors

This legislation recognizes a new licensure category for genetic counselors. Under this legislation, individuals licensed as genetic counselors are permitted to furnish counseling services that address the physical and psychological issues associated with the occurrence of, or the risk of occurrence of, a genetic disorder, birth defect, or genetically influenced condition or disease in an individual or a family. As of October 1, 2015, DPH is directed to grant one-year genetic counselor licenses to individuals certified as genetic counselors by the American Board of Genetic Counseling or the American Board of Medical Genetics and Genomics. In lieu of certification, an applicant may receive a genetic counselor license upon demonstration that, prior to October 1, 2015, the individual has earned a master's or doctorate in genetics or a related field, has eight years of practical experience in genetic counseling, and attended a continuing education program approved by the National Society of Genetic Counselors within the previous five years. This provision also allows individuals similarly certified as genetic counselors in other states to be licensed by endorsement, provided that the licensure or certification requirements in the jurisdiction where they were licensed are similar to or more stringent than Connecticut's licensing standards and that such individuals do not have any pending disciplinary actions or unresolved complaints against them in any jurisdiction. DPH is also authorized to issue a temporary permit to a licensure applicant who holds a master's degree or higher in genetic counseling or a related field that allows the holder to practice genetic counseling under the general supervision of a licensed genetic counselor or a licensed physician. A temporary permit may be valid for up to one year and may not be granted to any applicant subject to pending professional disciplinary action or unresolved complaints.

This legislation permits DPH to adopt regulations governing the licensure and discipline of genetic counselors. It authorizes DPH to take disciplinary action against genetic counselors for (1) failure to conform to professional standards; (2) felony conviction; (3) fraud or deceit in obtaining or renewing a license or in providing genetic counseling services; (4) negligent, incompetent, or wrongful conduct; (5) physical, mental, or emotional illness or a disorder creating an inability to conform to professional standards; (6) alcohol or substance abuse; or (7) willful falsification of entries in any record pertaining to genetic counseling. The above genetic counselor licensure requirements do not apply to licensed physicians, advanced practice registered nurses, nurse-midwives, federally employed genetic counselors, or individuals acting within the scope of practice of a license and training who do not hold themselves out as genetic counselors. The licensure requirements also do not apply to students enrolled in a genetic counseling or accredited medical genetic program, or a graduate nursing or medical education program in genetics, provided that genetic counseling is an integral part of the student's curriculum and the student is acting under the direct supervision of a physician or licensed genetic counselor.

Reporting Impaired Health Care Professionals

Under current law, physicians, physician assistants, and hospitals must file a petition with DPH within 30 days of receiving information that a physician or physician assistant is or may be unable to practice with reasonable skill or safety due to a variety of reasons, including physical or mental impairment and chemical dependency. This legislation expands the reporting requirement to require all "health care professionals" to file a petition with DPH within 30 days of receiving any information that a health care professional is unable to practice with reasonable skill or safety. The term "health care professional" is broadly defined and includes nurses, podiatrists, dentists, psychologists, and physical and occupational therapists. In the event that the information relates to a health care professional's inability to practice due to chemical dependency, emotional or behavioral disorder, or physical or mental illness, the reporting obligation can be satisfied by referring the affected health care professional to the assistance program for health care professionals, known as the Health Assistance InterVention Education Network (HAVEN).

The legislation requires that all health care professionals notify DPH within 30 days after (1) an arrest for alleged possession, use, prescription for use, or distribution of a controlled substance, legend drug, or

alcohol or (2) a diagnosis of mental illness or behavioral or emotional disorder. The health care professional may satisfy the obligation by seeking assistance with HAVEN. In addition, health care professionals must report any disciplinary action taken against the individual in another jurisdiction within 30 days. The legislation also establishes the process by which DPH must investigate any petitions received pursuant to the legislation, which is identical to the current process applicable to physicians and physician assistants.

If you have any questions, please contact a member of Robinson+Cole's [Health Law Group](#):

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