

Detail by section number of Public Act 14-217
An Act Implementing Provisions of the State Budget for the Fiscal Year Ending June 30, 2015

EMERGENCY CERTIFIED [H.B. No. 5597 Public Act 14-217](#) AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE FISCAL YEAR ENDING JUNE 30, 2015 This act implements the state budget for FY 2015.

Below is a description of some of the provisions of [Public Act 14-217](#) that have potential to impact, or might be of interest to, DDS consumers and their families or guardians, DDS employees or DDS providers.

Sections 1 through 18 and 257 of [Public Act 14-217](#) repeal the current Connecticut False Claims Act (CFCA), which prohibits anyone from knowingly filing false or fraudulent claims for payment or approval under any Department of Social Services (DSS) medical assistance program, and replace it with substantially similar provisions, with certain changes. Under the act, “state-administered health or human services programs” include programs administered by the: 1. Department of Developmental Services (DDS); and 2. state employee, retiree, and other health programs administered by the state comptroller’s office (OSC).

The act expands provisions of the current CFCA that ban the following actions to all state-administered health or human services programs, rather than just DSS medical assistance programs: 1. knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval; 2. knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim; 3. being authorized to make or deliver a document certifying receipt of property used, or to be used, by the state relative to these programs and, with intent to defraud the state, make or deliver the document without completely knowing that the information on it is true; 4. knowingly buying, or receiving as a pledge of an obligation or debt, public property from a state employee or officer who may not legally sell or pledge the property; 5. 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; 6. knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the state; and 7. conspiring to commit the above actions.

Current law also prohibits anyone with possession, custody, or control of property or money used, or to be used, by the state for DSS medical assistance programs, and, with intent to defraud the state or willfully conceal the property, from (1) delivering or causing to be delivered less property than the amount for which the person receives a receipt or certificate or (2) conspiring to do so. The act: 1. similarly expands this prohibition to all state-administered health or human services programs and 2. lowers the threshold by which someone is guilty of violating this provision by removing the need to act with the intent to defraud the state or willfully conceal the property and instead requiring the act to be committed knowingly. EFFECTIVE DATE: Upon passage

Sections 19 through 22 of [Public Act 14-217](#) make several changes concerning emergency medical services (EMS) and primary service area responders (PSARs). By law, a “primary service area” is a specific geographic area to which the Department of Public Health (DPH) assigns a designated EMS provider for each category of emergency medical response services. These providers are termed “primary service area responders.”

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Sections 19 and 20 of [Public Act 14-217](#) require each municipality to update its local EMS plan as it determines necessary. In updating its plan, a municipality must consult with its PSAR. Upon request, DPH must assist municipalities with the updating process by (1) providing technical assistance and (2) helping to resolve disagreements between the municipality and PSAR concerning the plan. The act also requires DPH, at least every five years, to review local EMS plans and PSARs' provision of services under them. If DPH rates a PSAR as failing, the commissioner may require it to comply with a department-developed performance improvement plan. PSARs rated as failing may also be subject to (1) later performance reviews or (2) removal as the town's PSAR for failing to improve their performance. The act allows DPH to initiate a hearing on its own and remove the PSAR if DPH rated it as failing to comply with performance standards and the responder subsequently fails to improve its performance. The town may also petition for removal of the PSAR. The act defines the term "performance crisis" for which a town could petition for the removal of the PSAR and sets forth conditions for a DPH investigation.

Section 21 of [Public Act 14-217](#) requires that before a PSAR sells or transfers more than half of its ownership interest or assets, it must give at least 60 days' notice to (1) DPH and (2) the chief elected official or chief executive officer of the municipality where the PSAR is assigned. The intended buyer or transferee must apply to DPH for approval. In deciding whether to approve the transaction, DPH must consider the applicant's (1) performance history in Connecticut or other states and (2) financial ability to perform PSAR responsibilities under the local EMS plan.

Section 22 of [Public Act 14-217](#) requires municipalities seeking a change in their PSARs, under certain circumstances, to submit to DPH alternative local EMS plans. The municipalities' alternative plan must include the name of a recommended PSAR for each category of emergency medical response services. Each new recommended PSAR who agrees to be considered for the PSA designation must apply to DPH. If DPH receives such an alternative plan, including for the proposed removal of a PSAR and designation of a new PSAR, DPH must hold a hearing. The current PSAR must have an opportunity to be heard and can submit information for consideration. In deciding whether to approve the plan, DPH must consider relevant factors, including: 1. the plan's impact on (a) patient care, (b) EMS system design, including system sustainability, and (c) the local, regional, and statewide EMS system; 2. the recommendation of the sponsor hospital's medical oversight staff; and 3. the financial impact to the municipality without compromising the quality of patient care. If DPH approves the alternative plan and the application of the recommended PSAR, DPH must issue a written decision to reassign the PSA in accordance with the alternative plan with the effective date for the reassignment. The act also requires a current PSAR to deliver services in accordance with the local EMS plan until the effective date of the reassignment. EFFECTIVE DATE: October 1, 2014, except the provisions on PSAR sales and buyer approval are effective upon passage.

Sections 23 through 26 of [Public Act 14-217](#) authorize official checkers at polling places to use a secretary of the state-approved electronic device to check in electors at the polls. By law, official checkers are responsible for verifying electors' identification and checking their names off the official registry list before they are permitted to vote. The act also eliminates a provision under which the two electors next in line to vote may be admitted into the polling area to receive a ballot. EFFECTIVE DATE: Upon passage

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Section 46 of [Public Act 14-217](#) requires police basic training programs conducted by the State Police, Police Officer Standards and Training Council, or municipal police departments to include a course on handling incidents involving people affected with a serious mental illness. It also requires review training conducted by them to make provisions for such a course. EFFECTIVE DATE: October 1, 2014

Sections 48 through 54 and section 258 of [Public Act 14-217](#) restore the state's rental rebate program to its status prior to the implementation of Public Act 13-234 that had, among other things, (1) transferred administration of the state's rental rebate program for the elderly and people with total and permanent disabilities from the OPM to the Department of Housing (DOH) and (2) limited eligibility to individuals that received a rebate in calendar year 2011. The act: (1) returns administration of the rental rebate program to OPM, (2) eliminates the requirement that eligible rebate applicants must have received a rebate in calendar year 2011, and (3) makes numerous conforming changes. However, the act retains provisions in PA 13-234 (1) extending the period, from 90 to 120 days, for approving payments to municipalities and forwarding them to the comptroller and (2) requiring DSS to disclose information to DOH (now OPM) for purposes of administering the rental rebate program. EFFECTIVE DATE: Upon passage, and applicable to rebate applications made on or after April 1, 2014

Section 73 of [Public Act 14-217](#) increases, from 50 to 100, the number of persons who may receive services through CHCPD. CHCPD, a state-funded pilot program administered by DSS, provides home- and community-based services to certain people with disabilities as an alternative to nursing home care. EFFECTIVE DATE: July 1, 2014

Section 74 of [Public Act 14-217](#) expands the list of over-the-counter drugs that DSS may pay for through its medical assistance programs to include those that must be covered as essential health benefits under the federal Affordable Care Act (ACA), including drugs rated "A" or "B" in the current U.S. Preventive Services Task Force (USPSTF) recommendations for people with specific diagnoses. Such drugs include (1) aspirin for men age 45 to 79 and women age 55 to 79 to prevent cardiovascular disease and (2) folic acid for women who are pregnant or capable of pregnancy. The law generally bans DSS from paying for over-the-counter drugs, with the following exceptions: 1. over-the-counter drug coverage through the Connecticut AIDS Drug Assistance Program (CADAP), 2. insulin or insulin syringes, 3. nutritional supplements for people who (a) must be tube fed or (b) cannot safely get nutrition in any other form, and 4. smoking cessation drugs. EFFECTIVE DATE: Upon passage

Section 77 of [Public Act 14-217](#) requires the comptroller to study and report on how facility fees and the total fees hospitals or health systems charge or bill for outpatient hospital service impact the state employee health insurance plans. It defines a "facility fee" as any hospital or health system fee charged for outpatient services provided in a facility that it owns or operates that is (1) separate and distinct from the fee charged for providing professional medical services and (2) intended to compensate the hospital or health system for its operational expenses. The act requires the comptroller to analyze the fees' impact on the state employee plans. EFFECTIVE DATE: Upon passage

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Section 78 of [Public Act 14-217](#) requires DSS to analyze, by November 1, 2014, the cost of providing services under the (1) Connecticut home-care program for the elderly and (2) pilot program to provide home care services to persons with disabilities. DSS must (1) include a determination of necessary reimbursement rates for providers and (2) report a summary of the analysis to the Appropriations and Human Services committees. EFFECTIVE DATE: Upon passage

Section 131 of [Public Act 14-217](#) requires the Department of Consumer Protection (DCP), in consultation with the Connecticut Pharmacists Association and Connecticut Police Chiefs Association, to develop and implement a program to collect and dispose of unwanted pharmaceuticals (medication). The program must provide for (1) a secure locked box accessible to the public 24 hours a day to drop off unwanted medication anonymously at all local police stations and (2) transporting the medication to a biomedical waste treatment facility for incineration. The act requires DCP to organize a public awareness campaign to educate the public about the program and the dangers of unsafe medication disposal. EFFECTIVE DATE: October 1, 2014

Section 135 of [Public Act 14-217](#) requires DSS to report to the Human Services Committee on the impact of: 1. designating products and services in Healthcare Common Procedure Coding System (HCPCS) codes as CRT; 2. setting minimum standards for suppliers to be considered qualified CRT suppliers and eligible for Medicaid reimbursement; 3. preserving the option for CRT to be billed and paid for as a purchase, allowing for single payments for devices needed for at least one year, excluding crossover claims for clients enrolled in both Medicare and Medicaid; and 4. requiring an evaluation for Medicaid recipients receiving a CRT wheelchair or seating component by a (a) qualified health care professional and (b) qualified CRT professional to qualify for reimbursement. Under the act, CRT are products classified as durable medical equipment (DME) within the Medicare program that are individually configured and medically necessary to meet individuals' specific and unique medical, physical, and functional needs and capacities for basic and instrumental activities of daily living. EFFECTIVE DATE: Upon passage

Section 136 of [Public Act 14-217](#) requires DSS to submit to the federal Centers for Medicare and Medicaid Services a state plan amendment to increase the Medicaid rate for private psychiatric residential treatment facilities. Under the act, a “private psychiatric residential treatment facility” is a nonhospital facility with an agreement with a state Medicaid agency to provide inpatient services to people who are (1) Medicaid-eligible and (2) younger than age 21. EFFECTIVE DATE: Upon passage

Section 137 of [Public Act 14-217](#) requires the Finance, Revenue and Bonding Committee chairpersons to convene a panel of experts to study the state's overall state and local tax structure. The panel, which cannot include legislators, must include experts in tax law, tax accounting, tax policy, economics, and business finance. The panel must consider and evaluate options to modernize tax policy, structure, and administration regarding: 1. efficiency, 2. administrative costs, 3. equity, 4. reliability, 5. stability and volatility, 6. sufficiency, 7. simplicity, 8. incidence, 9. economic development and competitiveness, 10. employment, 11.

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affordability, and 12. overall public policy. In developing options, the panel must consider their impact and the extent to which tax policy affects business and consumer decision making.

The panel of experts also must evaluate the feasibility of the following options: 1. creating a tiered property tax payment system that includes any property owned by the (a) state; (b) an institution, facility, or hospital for which the state made a payment in lieu of taxes to the host municipality; or (c) nonprofit entity; 2. assessing a “community benefit fee” on any tax-exempt property; 3. taxing property owned by an institution, facility, or hospital for which the state made a payment in lieu of taxes; and 4. requiring institutions, facilities, or hospitals to report the value of their real and personal property.

Sections 140 through 157 of [Public Act 14-217](#) establish a legal framework and specify rules and procedures for establishing and dissolving a for-profit corporation that both pursues social benefits and increases value for its shareholders (benefit corporation or b-corp). B-corps formed under the provisions of this act operate under the same laws as traditional business corporations and seek to increase shareholder value. But their corporate purpose also includes doing things that generally benefit society and the environment or create specific public benefits. The act’s governance structure and accountability requirements align with the b-corp’s public benefit purpose. The act requires a b-corp’s directors and officers to consider certain interests and constituencies besides the shareholders’ financial interests when making decisions. It also requires b-corps to report annually on their overall social and environmental performance. EFFECTIVE DATE: October 1, 2014.

Section 158 of [Public Act 14-217](#) eliminates the “within available appropriations” restriction on the Department of Public Health (DPH) with regard to collecting information to create individual profiles for physicians and APRNs for dissemination to the public. The act also adds to the profile information (1) whether or not the practitioner provides primary care services and (2) for an APRN, whether he or she is practicing independently or in collaboration with a physician to the list of collected information. Collected information includes, among other things, the practitioner’s specialty, primary practice location, and any hospitals at which he or she has admitting privileges. Unchanged by this act, DPH must also collect such information on dentists, chiropractors, optometrists, podiatrists, naturopaths, dental hygienists, and physical therapists within available appropriations. EFFECTIVE DATE: October 1, 2014

Section 159 of [Public Act 14-217](#) gives General Assembly approval of provisions in the contracts between (1) the Office of Early Childhood and the Connecticut State Employees Association (CSEA-SEIU, Local 2001) (“childcare workers”) and (2) the Personal Care Attendant Workforce Council and the New England Health Care Employees Union (District 1199, SEIU) (PCAs) that would supersede certain Connecticut laws or regulations. EFFECTIVE DATE: Upon passage

Section 162 of [Public Act 14-217](#) designates each state-owned campus that has an acute care hospital on the premises (i.e., John Dempsey Hospital on the UConn Health Center (UCHC) campus) as the primary service area (PSA) responder for that campus. The act would allow the UCHC fire department to treat and transport such a patient. EFFECTIVE DATE: October 1, 2014

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Sections 179 and 260 of [Public Act 14-217](#) make permanent certain court filing fee increases and fees that took effect July 1, 2012 and are set to expire on July 1, 2015. It also raises, from 70% to 95%, the portion of revenue received from these fee increases that the chief court administrator must transfer to the organization administering the interest on lawyers' trust accounts (IOLTA) program to fund legal services for the poor. EFFECTIVE DATE: July 1, 2014, for the changes in the allocation of the fee increases; October 1, 2014 for the extension of those increases.

Section 193 of [Public Act 14-217](#) requires DSS to accept electronic transmission of prescriptions for reimbursement under the medical assistance program for durable medical equipment, including wheelchairs, walkers, and canes. The prescriptions must be electronically signed by a licensed health care provider with prescriptive authority. EFFECTIVE DATE: Upon passage

Section 220 of [Public Act 14-217](#) requires DSS, by October 1, 2014, to amend the Medicaid state plan to include services provided to Medicaid recipients age 21 or older by the following licensed behavioral health clinicians: (1) psychologists, (2) clinical social workers, (3) alcohol and drug counselors, (4) professional counselors, and (5) marriage and family therapists. Under the bill, the commissioner must (1) include the clinicians' services as optional services under the Medicaid plan and (2) provide direct reimbursement to clinicians who (a) are enrolled as Medicaid providers and (b) treat Medicaid recipients in independent practice settings. EFFECTIVE DATE: July 1, 2014

Section 227 of [Public Act 14-217](#) removes the restriction that limits the deduction of a personal care attendant's (PCA) union dues and fees to payments from the waiver program in which a PCA's consumer is participating and instead allows the dues and fees to be deducted from any program covered by their collective bargaining agreement. EFFECTIVE DATE: Upon passage

For a complete description of all the provisions of **EMERGENCY CERTIFIED [H.B. No. 5597](#)** **[Public Act 14-217](#)** **AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE FISCAL YEAR ENDING JUNE 30, 2015** please read the Office of Legislative Research's Bill Analysis for [H.B. No. 5597](#) at <http://www.cga.ct.gov/2014/BA/2014HB-05597-R00-BA.htm>.