

# 2014 Legislation Session: Health Care Reform

## Enhancing Access and Quality of Care

*Implementing the Governor's Mental Health Initiative.* Both the proposed Governor's budget and the adopted budget include funding of \$2.2 million to fund 110 dedicated units of scattered site supportive housing for persons with mental illness; \$250,000 for an anti-stigma campaign; and \$1.75 million for residential and transitional services for high risk populations, including young adults. In addition, specialized crisis intervention training will be required for all new law enforcement candidates and for all active state and local law enforcement personnel during their re-certification process. Funding of \$50,000 is provided in the budget to support this training.

*Improving Access to Primary Care.* With thousands of new entrants into Connecticut's insurance marketplace, developing workforce capacity that can enhance early access to preventative screening and quality care is critical. The Governor proposed and ensured passage of legislation to eliminate barriers that keep APRNs from diagnosing and treating to the full extent of their training and capitalize on our state's existing clinical expertise. Public Act 14-12 allows Advanced Practice Registered Nurses (APRNs) to practice independently after engaging in collaborative practice with a physician for not less than three years and two thousand hours.

*Expanding the State-Funded Home Care Program for Adults with Disabilities.* This program allows up to 50 individuals in the community who are not Medicaid eligible, but who meet nursing facility level of care standards and have a degenerative, neurological condition such as multiple sclerosis or Parkinson's disease, to receive services within their home. The Governor's budget provided funding to double the number of people who can receive services, increasing the total number of clients served to 100. This provision was included in the final budget.

*Expanding the Katie Beckett Waiver.* The Katie Beckett Waiver enables children with severe disabilities who otherwise would have to be institutionalized to live at home with needed medical supports. Both the Governor's budget and the adopted budget include \$750,000 to provide services for an additional 100 children under the waiver.

*Reducing the Waiting List for the Acquired Brain Injury (ABI) Waiver.* The adopted budget provides \$650,000 in funding to reduce the ABI waiver wait list from 30 to 15. This waiver allows adults who have an ABI to remain in the community, instead of having to be placed in an institutional setting. In addition, Public Act 14-150 ensures that services under the existing ABI waiver will not be phased out, nor will individuals have to be institutionalized in order to meet federal cost neutrality requirements.

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*Connecting the Public to Behavioral Health Services.* Public Act 14-115 requires the Office of the Healthcare Advocate (OHA) to establish an information and referral service to help residents and providers receive behavioral health care information, timely referrals, and access to behavioral health care providers. The adopted budget funds two new positions in OHA in order perform these duties. In addition, Public Act 14-211 allows the Department of Public Health to include certain off-site locations under an outpatient clinic's existing license to allow for the provision of psychiatric and substance abuse services in additional settings. This change in licensing will allow adults to receive these services at alternate locations, expand the co-location of behavioral health services in primary care offices, and improve integrated care for individuals with co-occurring physical and behavioral health conditions.

### **Increasing Transparency and Promoting Affordability in Our Health Care System**

*Ensuring Competitive Health Care Markets.* While hospital mergers are highly publicized, most acquisitions of medical groups, clinics, and ambulatory surgery centers are not. The recent trend of increased consolidations and mergers reportedly to achieve greater efficiencies for the practices involved may result in anticompetitive consequences for patients. To avoid such consequences and protect consumers, the Governor proposed legislation (PA 14-168) to give the Attorney General formal notification and basic information regarding material changes to the business or corporate structure of a physician group practice. The legislation also requires a certificate of need for transfers of ownership of certain group practices to any entity other than physicians or physician groups. In addition, all hospitals and hospital systems and physician groups comprised of greater than thirty physicians will now be required to annually file a report detailing the group practices they own or with which they are affiliated. As a result of these changes, the AG will be more able to determine whether a particular transaction has anticompetitive implications or violates the state's antitrust laws. Additional provisions of the bill include:

- A broadening of the guidelines and principles of the certificate of need process by including consideration of the community, provider diversity, and patient choice, as well as adverse effects on health care costs or accessibility to care;
- A change in the laws permitting for-profit hospitals to establish foundations, including restrictions on who may serve on such foundations and who can organize a medical foundation; and
- A requirement that hospitals make reasonable efforts to notify a patient's primary care physician of their admittance to the hospital, if the patient so desires.

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*Expanding Connecticut's False Claims Act (FCA).* The FCA authorizes the Office of the Attorney General (OAG) to initiate investigations and prosecute false claims submitted under a medical assistance program administered by DSS. In addition, the FCA provides for a private party to initiate a FCA case and gives the OAG the ability to intervene in that action and take primary responsibility for the conduct of the litigation. If a case is initiated by a private party under the FCA and there is a court award or an out-of-court settlement, the court can award the private party between 15% to 30% of the state's recovery, as well as reasonable expenses and attorney's fees and costs against the defendant which the court finds have been necessarily incurred. The FCA also provides protection and remedies to whistleblowers from workplace retaliation. Consistent with the Governors' proposal, Public Act 14-217 extends the application of Connecticut's FCA to all health and human services agencies and programs, as well as state payments made for state employee and retiree health and state paid Workers' Compensation medical claims. This expansion will help to ensure that laws are in place to combat fraud directed against state programs and maximize savings and recovery targets as required under the biennial budget, which assumes a \$39 million increase in recoveries in FY 15 (from \$65 million to \$104 million) as a result of enhanced efforts to reduce fraud, waste and abuse. More importantly, it will help to ensure that the state's limited resources are available for the purposes for which they were intended.

*Informing Consumers About Facility Fees Charged at Hospitals.* Facility fees are fees that hospitals and other health systems can charge on top of the cost of any procedures performed. The charging of these additional facility fees (over and above the fee for professional services rendered) has become an increasingly widespread practice as previously independent physician groups and clinicians are acquired by hospitals. Public Act 14-145, originally proposed by the Attorney General, would require hospitals and health systems that charge this additional fee to provide written disclosure to patients and prominently display signs in locations visible by patients regarding the fee.

*Reducing State Employee Health Care Costs.* Public Act 14-217 requires the Comptroller to analyze the effect of facility fees on the state employee health insurance plans and determine the feasibility of removing fees that the Comptroller deems are inappropriate or unreasonable.

*Disclosing Observation Status to Patients.* Hospital stays for patients that are in "observation status" are classified as hospital outpatient stays, not inpatient stays, despite the fact that the patients may stay many days and nights in hospital beds and receive virtually identical care to those considered inpatient. Because it is not easily discernible that the patient is receiving "outpatient care," patients may be surprised to

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find that they are responsible for more of their cost of care than anticipated. Public Act 14-180 requires that hospitals provide verbal and written notice to each patient placed in observation status (unless the patient leaves within a 24-hour period) to disclose that being in that particular status may affect the patient's coverage under Medicare, Medicaid, or private insurance.

### Supporting the State's Medical and Home Care Providers

*Investing in Primary Care Providers.* The Affordable Care Act required states to increase Medicaid reimbursement for primary care providers to Medicare levels for calendar years 2013 and 2014. The Governor's proposed budget included \$15.1 million to maintain these higher reimbursement levels. The adopted budget includes \$10 million to support higher reimbursement for primary care providers, but at a somewhat reduced level.

*Funding a COLA for Home Care Providers.* The adopted budget includes \$1.6 million to provide a 1% cost of living adjustment for home and community-based providers who serve individuals on Medicaid and through the Connecticut Home Care Program for Elders, effective January 1, 2015.

*Increasing Medicaid Rates for Mental Health Providers.* The adopted budget includes \$4.15 million to provide rate increases under Medicaid for mental health clinic and outpatient services. This increase will incentivize more providers to serve the Medicaid population, which will in turn increase this population's access to behavioral health services.

*Changing Reimbursement for Emergency Department Physicians.* Public Act 14-160 allows emergency department physicians to enroll separately as Medicaid providers and qualify for direct reimbursement services at the Medicaid rate. This change is to be implemented concurrently with the implementation of the diagnosis-related group methodology of payment to hospitals.

*Improving the Medicaid Provider Audit Process.* Public Act 14-162 make several changes to the Department of Social Services' (DSS) processes for auditing Medicaid providers. When conducting audits, DSS only reviews a sample of claims and, for those providers who have more than \$150,000 of aggregate claims annually, projects the results of the audit to the entire universe of the providers' claims. The new legislation increases this minimum limit to \$200,000; providers that fall under that threshold will no longer be subject to increased recoveries due to extrapolation. In addition, DSS is required to

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establish and publish audit protocols to assist providers and provide free training on how to avoid clerical errors.