Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): DSS_1 Comprehensive DSS Revisions

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Social Services
Liaison: Heather Rossi Phone: 860-424-5646 E-mail: heather.rossi@ct.gov
Lead agency division requesting this proposal: Division of Integrated Services
Agency Analyst/Drafter of Proposal: Marc Shok, Vanessa Soares Bowden and Joseph Smiga

Title of Proposal **Clarification of Aid and Attendance in Public Act 12-208**
Statutory Reference 17b-104, 17b-191, 17b-256f,17b-261, 17b-261n, 17b-342, 17b-342a, 17b-492 and 17b-801,
Proposal Summary To clarify the language in Public Act 12-208, which requires the exclusion of only the Aid and Attendance portion of a veteran's pension when calculating eligibility for several programs.
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

This proposal is to clarify the language in Public Act 12-208, which requires the exclusion of only the Aid and Attendance portion of a veteran's pension when calculating eligibility for several programs. Several attorneys and clients are misinterpreting the current language and asserting that the *entire* VA pension should be excluded. This was never the intent of Public Act 12-208. This proposal seeks to make it clear that it is only the Aid and Attendance portion of the basic monthly pension is excluded as income.

- **Origin of Proposal** **_X_ New Proposal** **___ Resubmission**

This language originated from Public Act 12-208, An Act Expanding Access By Veterans To Public Assistance Programs.

This new proposal serves only to clarify the interpretation of Aid and Attendance in PA 12-208 as referenced in the above statutes.

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: N/A Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal: N/A
State: N/A
Federal: N/A
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

N/A

17b-191, 17b-261, 17b-261n, 17b-342, 17b-342a, and 17b-801:

In determining eligibility, the commissioner shall not consider as income the Aid and Attendance [pension] benefit[s] that may be added to the United States Department of Veterans Affairs basic monthly pension [granted to] of a veteran, as defined in section 27-103, or the surviving spouse of such veteran, when the veteran or surviving spouse of such veteran qualifies for Aid and Attendance.

17b-104

In determining eligibility, the commissioner shall [disregard from] not consider as income the Aid and Attendance [pension] benefit[s] that may be added to the United States Department of Veterans Affairs basic monthly pension [granted to] of a veteran, as defined in section 27-103, or the surviving spouse of such veteran, when the veteran or surviving spouse of such veteran qualifies for Aid and Attendance.

17b-256f and 17b-492

The commissioner shall not consider as income the Aid and Attendance [pension] benefit[s] that may be added to the United States Department of Veterans Affairs basic monthly pension [granted to] of a veteran, as defined in section 27-103, or the surviving spouse of such veteran, when the veteran or surviving spouse of such veteran qualifies for Aid and Attendance.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): DSS_1 Comprehensive DSS Revisions

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Social Services
Liaison: Heather Rossi Phone: 860-424-5646 E-mail: heather.rossi@ct.gov
Lead agency division requesting this proposal: Medical Care Administration
Agency Analyst/Drafter of Proposal: Barbara Fletcher/Rob Zavoski

Title of Proposal **Comprehensive DSS Revisions**
Statutory Reference 17b-239(f)
Proposal Summary 1. Amend the date that the department must the annual LIHEAP allocation plan from August 1 to October 1. 2. Allow department to implement policies and procedures related to the Money Follows the Program while adopting regulations. 3. Amend section 89 of public act 13-247 of the 2013 session – LCO/OLR identified technical correction 4. Repeal Sec. 17b-239(f) of the CGS
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

1. Amending the date to reflect current timeframes in which the allocation plan are developed based on federal release of information and legislative hearings.
2. Language was inadvertently omitted from previous amendments to this section.
3. Technical implementer correction
4. This section directs the Department to pay hospitals for administratively necessary days (ANDs) when the client no longer needs acute hospital level of care but the hospital is unable to find an appropriate placement. This provision is problematic for two reasons:
    a. The intent of this section is inconsistent with our efforts to restructure payments to inpatient hospitals under a DRG methodology.
    b. There are no HIPAA-compliant codes for these services;

Payments made under this section are made on an interim basis and must be cost settled at the end of the year. The interim payment has no effect on the ultimate payment for the clients' care.

- **Origin of Proposal** **__X_ New Proposal** **___ Resubmission**

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) none
State none
Federal none
Additional notes on fiscal impact In CY 2012 the Department paid for 3 units of the AND codes for a total payment of $1,409. In CY 2011, the Department paid $8078 for a total

of 19 units.

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 1. Section 16a-41a of the general statutes is repealed and the following is inserted in lieu thereof:

(a) The Commissioner of Social Services shall submit to the joint standing committees of the General Assembly having cognizance of energy planning and activities, appropriations, and human services the following on the implementation of the block grant program authorized under the Low-Income Home Energy Assistance Act of 1981, as amended:

(1) Not later than [August] October first, annually, a Connecticut energy assistance program annual plan which establishes guidelines for the use of funds authorized under the Low-Income Home Energy Assistance Act of 1981, as amended, and includes the following:

Sec. 2. Section 17b-369 of the general statutes is repealed and the following is inserted in lieu thereof:

(a) The Commissioner of Social Services, pursuant to Section 6071 of the Deficit Reduction Act of 2005, shall submit an application to the Secretary of Health and Human Services to establish a Money Follows the Person demonstration project. Such project shall serve not more than five thousand persons and shall be designed to achieve the objectives set forth in Section 6071(a) of the Deficit Reduction Act of 2005. Services available under the demonstration project shall include, but not be limited to, personal care assistance services. The commissioner may apply for a Medicaid research and demonstration waiver under Section 1115 of the Social Security Act, if such waiver is necessary to implement the demonstration project. The commissioner may, if necessary, modify any existing Medicaid home or community-based waiver if such modification is required to implement the demonstration project.

(b) (1) The Commissioner of Social Services shall submit, in accordance with this subdivision, a copy of any report on the Money Follows the Person demonstration project that the commissioner is required to submit to the Secretary of Health and Human Services and that pertains to (A) the status of the implementation of the Money Follows the Person demonstration project, (B) the anticipated date that the first eligible person or persons will be transitioned into the community, or (C) information concerning when and how the Department of Social Services will transition additional eligible persons into the community. The commissioner shall submit such copy to the joint standing committee of the General Assembly having cognizance of matters relating to human services and to the select committee of the General Assembly having cognizance of matters relating to aging, in accordance with the provisions of section 11-4a. Copies of reports prepared prior to October 1, 2009, shall be submitted by said date and copies of reports prepared thereafter shall be submitted semiannually.

(2) After October 1, 2009, if the commissioner has not prepared any new reports for submission to the Secretary of Health and Human Services for any six-month submission period under subdivision (1) of this subsection, the commissioner shall prepare and submit a written report in accordance with this subdivision to the joint standing committee of the General Assembly having cognizance of matters relating to human services and to the select committee of the General Assembly having cognizance of matters relating to aging, in accordance with the provisions of section 11-4a. Such report shall include (A) the status of the implementation of the Money Follows the Person demonstration project, (B) the anticipated date that the first eligible person or persons will be transitioned into the community, and (C) information concerning when and how the Department of Social Services will transition additional eligible persons into the community.

(c) The Commissioner of Social Services shall develop a strategic plan, consistent with the long-term care plan established pursuant to section 17b-337, to rebalance Medicaid long-term care supports and services, including, but not limited to, those supports and services provided in home, community-based settings and institutional settings. The commissioner shall include home, community-based and institutional providers in the development of the strategic plan. In developing the strategic plan the commissioner shall consider topics that include, but are not limited to: (1) Regional trends concerning the state's aging population; (2) trends in the demand for home, community-based and institutional services; (3) gaps in the provision of home and community-based services which prevent community placements; (4) gaps in the provision of institutional care; (5) the quality of care provided by home, community-based and institutional providers; (6) the condition of institutional buildings; (7) the state's regional supply of institutional beds; (8) the current rate structure applicable to home, community-based and institutional services; (9) the methods of implementing adjustments to the bed capacity of individual nursing facilities; and (10) a review of the provisions of subsection (a) of section 17b-354.

(d) The Commissioner of Social Services may contract with nursing facilities, as defined in section 17b-357, and home and community-based providers for the purpose of carrying out the strategic plan. In addition, the commissioner may revise a rate paid to a nursing facility pursuant to section 17b-340 in order to effectuate the strategic plan. The commissioner may fund strategic plan initiatives with federal grant-in-aid resources available to the state pursuant to the Money Follows the Person demonstration project pursuant to Section 6071 of the Deficit Reduction Act, P.L. 109-171, and the State Balancing Incentive Payments Program under the Patient Protection and Affordable Care Act, P.L. 111-148.

(e) The Commissioner of Public Health, or the commissioner's designee, may waive the requirements of sections 19-13-D8t, 19-13-D6 and 19-13-D105 of the regulations of Connecticut state agencies, if a provider requires such a waiver for purposes of effectuating the strategic

plan developed pursuant to subsection (c) of this section and the commissioner, or the commissioner's designee, determines that such waiver will not endanger the health and safety of the provider's residents or clients. The commissioner, or the commissioner's designee, may impose conditions on the granting of any waiver which are necessary to ensure the health and safety of the provider's residents or clients. The commissioner, or the commissioner's designee, may revoke any waiver granted pursuant to this subsection upon a finding that the health or safety of a resident or client of a provider has been jeopardized.

(f) The commissioner, pursuant to section 17b-10, may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec.4. Subdivision (1) of subsection (h) of section 17b-340 of the general statutes, as amended by section 89 of public act 13-247 of the 2013 session, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(h) (1) For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate in excess of one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate that is less than one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to sixty-five per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred thirty per cent of the median of operating cost components in effect January 1, 1992. Beginning with the fiscal year ending June 30, 1993, for the purpose of determining allowable fair rent, a residential care home with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Beginning with the fiscal year ending June 30, 1997, a residential care home with allowable fair rent less than three dollars and ten cents per day shall be reimbursed as having allowable fair rent equal to three dollars and ten cents per day. Property additions placed in service during the cost year ending September 30, 1996, or any succeeding cost year shall receive a fair rent allowance for such additions as an addition to three dollars and ten cents per day if the fair rent for the facility for property placed in service prior to September 30, 1995, is less than or equal to three dollars and ten cents per day. For the fiscal year ending June 30,

1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. Beginning with the fiscal year ending June 30, 1997, minimum allowable patient days for rate computation purposes for a residential care home with twenty-five beds or less shall be eighty-five per cent of licensed capacity. Beginning with the fiscal year ending June 30, 2002, for the purposes of determining the allowable salary of an administrator of a residential care home with sixty beds or less the department shall revise the allowable base salary to thirty-seven thousand dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies. The rates for the fiscal year ending June 30, 2002, shall be based upon the increased allowable salary of an administrator, regardless of whether such amount was expended in the 2000 cost report period upon which the rates are based. Beginning with the fiscal year ending June 30, 2000, and until the fiscal year ending June 30, 2009, inclusive, the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall be increased by two per cent, and beginning with the fiscal year ending June 30, 2002, the inflation adjustment for rates made in accordance with subsection (c) of said section shall be increased by one per cent. Beginning with the fiscal year ending June 30, 1999, for the purpose of determining the allowable salary of a related party, the department shall revise the maximum salary to twenty-seven thousand eight hundred fifty-six dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies and beginning with the fiscal year ending June 30, 2001, such allowable salary shall be computed on an hourly basis and the maximum number of hours allowed for a related party other than the proprietor shall be increased from forty hours to forty-eight hours per work week. For the fiscal year ending June 30, 2005, each facility shall receive a rate that is two and one-quarter per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is determined in accordance with applicable law and subject to appropriations, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (A) The federal financial participation matching funds associated with the rate increase are no longer available; or (B) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30,

2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than four per cent greater than the rate in effect for the facility on September 30, 2006, except for any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate, except (i) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (ii) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except that (I) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (II) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2013, the Commissioner of Social Services may, within available appropriations, provide a rate increase to a residential care home. Any facility that would have been issued a lower rate for the fiscal year ending June 30, 2013, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, the Commissioner of Social Services may provide fair rent increases to any facility that has undergone a material change in circumstances related to fair rent and has an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. For the fiscal years ending June 30, 2014, and June 30, 2015, for those facilities that have a calculated rate greater than the rate in effect for the fiscal year ending June 30, 2013, the commissioner may increase facility rates based upon available appropriations up to a stop gain as determined by the commissioner. No facility shall be issued a rate that is lower than the rate in effect on June 30, 2013**[.]**, except that **[**Any**]** any facility that would have been issued a lower rate for the fiscal year ending June 30, 2014, or the fiscal year ending June 30, 2015, due to interim rate status or agreement with the commissioner, shall be issued such lower rate.

Sec. 4. Section 17b-239(f) of CGS is repealed


STATE OF CONNECTICUT
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Agency Legislative Proposal - 2014 Session

Document Name DSS_1 Comprehensive DSS Revisions

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Department of social services

Liaison: Heather Rossi
Phone: 860-424-5646
E-mail: heather.rossi@ct.gov

Lead agency division requesting this proposal: Alternate Care Unit

Agency Analyst/Drafter of Proposal: Kathy Bruni

Title of Proposal

Statutory Reference 17b-342(a)(4)

Proposal Summary: This change proposes to eliminate the 60% cap on the waiver services outlined in the statute. The total cap for waiver and state plan services cannot exceed 100% of the net cost of nursing home and there is no reason to cap the subset of waiver services. It is in fact an impediment to keeping some clients in the community as some waiver services such as Adult Family Living would not be able to be provided seven days per week and stay under the 60% cap despite being thousands of dollars below the 100% cap. The federal match on all services is 50% so there is no financial impact on making this change. No other Medicaid waiver programs have this limiting structure.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

- **Origin of Proposal** **__X_ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Department of Social Services
Agency Contact (name, title, phone): Kathy Bruni, Program Manager 860-424-5177
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

State

Federal

Additional notes on fiscal impact; This is entirely cost neutral

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Sec. 17b-342. (Formerly Sec. 17-314b). Connecticut home-care program for the elderly. (a) The Commissioner of Social Services shall administer the Connecticut home-care program for the elderly state-wide in order to prevent the institutionalization of elderly persons (1) who are recipients of medical assistance, (2) who are eligible for such assistance, (3) who would be eligible for medical assistance if residing in a nursing facility, or (4) who meet the criteria for the state-funded portion of the program under subsection (i) of this section. For purposes of this section, a long-term care facility is a facility which has been federally certified as a skilled nursing facility or intermediate care facility. The commissioner shall make any revisions in the state Medicaid plan required by Title XIX of the Social Security Act prior to implementing the program. [The annualized cost of the community-based services provided to such persons under the program shall not exceed sixty per cent of the weighted average cost of care in skilled nursing facilities and intermediate care facilities.] The program shall be structured so that the net cost to the state for long-term facility care in combination with the [community-based] services under the program shall not exceed the net cost the state would have incurred without the program.

Agency Legislative Proposal - 2014 Session

Document NameDSS_1 Comprehensive DSS Revisions

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Department of Social Services

Liaison: Heather Rossi
Phone: 860-424-5646
E-mail: Heather.Rossi@ct.gov

Lead agency division requesting this proposal:
CON & Rate Setting

Agency Analyst/Drafter of Proposal:
Melanie Dillon & Rich Wysocki

Title of Proposal
Certificate of Need

Statutory Reference
17b-352, 17b-353, 17b-354, 17b-354a, 17b-354b, 17b-354c and 17b-355

Proposal Summary

The proposed legislation deletes obsolete provisions and makes technical changes. The revised statutes are arranged in a more logical and cohesive format. The proposal also removes the requirement for a CON for transfers of ownership and acquisition of imaging equipment.

The proposed Section 17b-352 delineates all of the activities that require Certificate of Need (CON) approval, maintains the moratorium on additional nursing home beds through June 30, 2016, provides correct statutory references, and removes outdated references to the Office of Health Care Access (OHCA). The moratorium language was moved from 17b-354 to the proposed section 17b-352. The former subsections in 17b-354 with respect to continuing care facilities has been deleted as continuing care facilities are addressed in Chapter 319hh. Rather than addressing a "continuing care facility which guarantees life care for its residents" the proposed moratorium language references continuing care facilities that are registered as continuing facilities pursuant to Chapter 319hh.

The guidelines utilized in evaluating a CON proposal were moved from section 17b-355 to the proposed section 17b-353 and has been revised to remove irrelevant criteria. Requirements with respect to the application and hearing process have been consolidated into the proposed section 17b-354. The proposed section 17b-354 changes some of the requirements for a hearing and allows for expedited review in certain types of CON applications.

The proposed section 17b-354a establishes the time period for which a CON is valid, the process for requesting an extension of a CON, requirements for demonstrating that construction has begun and the department's ability to withdraw, revoke or rescind the CON.

The proposed changes to 17b-354b and 17b-354c are primarily technical in nature and remove obsolete provisions. Judicial enforcement language has been moved from section 17b-354a to section 17b-355.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

The Office of Health Care Access division of the Department of Public Health (OHCA) revised its CON statutes in 2010 and the CON regulations in 2013. Subsection (g) of the existing section 17b-352, subsection (e) of the existing section 17b-353 and subsection (j) of the existing section 17b-354 allows the Department to implement OHCA's regulations until the department adopts regulations. Given the significant changes to the CON process within OHCA's statutes and regulations, however, the department should not rely upon OHCA's regulations. There are other references to OHCA that have also been removed as those sections are now obsolete.

There are several references to dates that are over 20 years ago and no longer necessary. For example, the moratorium refers to the addition of beds between September 1991 and June 2013. There are also references to OHCA decisions prior to 1993 that are deemed to be a decision of the Commissioner of Social Services. The projects authorized under those CONs were completed long ago and thus, there is no need to continue to reference those decisions. Section 17b-354b, which has not been revised since 1998, references four bed rooms licensed prior to July 1, 1992. Section 17b-354c referenced applications filed on or before May 1, 2001.

The majority of the changes are technical in nature; however, there are a few substantive changes. The department proposes to remove the CON requirement for acquisition of imaging equipment because the OHCA has authority over the acquisition of imaging equipment by any person, provider or facility. There is no reason to require DSS to also evaluate the acquisition of imaging equipment particularly when OHCA has the requisite expertise to evaluate such acquisitions. Moreover, OHCA may choose to exempt nursing facilities, residential care homes and rest homes from CON requirements pursuant to section 19a-638 (b) (4). The department also proposes to remove CON requirements for transfers of ownership prior to licensure because the approved CON pertains to the physical location.

The department also proposes an expedited review process for the closure or reduction of beds in a residential care home as this is not a medical facility, the average licensed beds is approximately 15 – 20 beds, and often, a resident is eligible for community based programs that may be available in the area.

The department further proposes to remove the requirement for a public hearing when the closure is attributable to occupancy of less than 80% because once census has decrease below this level, it becomes difficult for the facility to remain financially viable and may lead to health and safety concerns impacting residents. Also, a rapid decline in census indicates there are beds available for the residents in the service area.

- **Origin of Proposal** **__X_ New Proposal** **___ Resubmission**

If this is a resubmission, please share: *(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* *(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* *(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* *(4) What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Sec. 1. Section 17b-352 of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) For the purposes of this section [and *section 17b-353*], "facility" means a residential facility for persons with intellectual disability licensed pursuant to section 17a-277 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities, a nursing home, rest home or residential care home, as defined in section 19a-490[, as amended by this act].

[(b) Any facility which intends to (1) transfer all or part of its ownership or control prior to being initially licensed; (2) introduce any additional function or service into its program of care or expand an existing function or service; or (3) terminate a service or decrease substantially its total bed capacity, shall submit a complete request for permission to implement such transfer, addition, expansion, increase, termination or decrease with such information as the department requires to the Department of Social Services, provided no permission or request for permission to close a facility is required when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545. The Office of the Long-Term Care Ombudsman pursuant to section 17b-400 shall be notified by the facility of any proposed actions pursuant to this subsection at the same time the request for permission is submitted to the department and when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545.

(c) An applicant, prior to submitting a certificate of need application, shall request, in writing, application forms and instructions from the department. The request shall include: (1) The name of the applicant or applicants; (2) a statement indicating whether the application is for (A) a new, additional, expanded or replacement facility, service or function, (B) a termination or reduction in a presently authorized service or bed capacity or (C) any new, additional or terminated beds and their type; (3) the estimated capital cost; (4) the town where the project is or will be located; and (5) a brief description of the proposed project. Such request shall be deemed a letter of intent. No certificate of need application shall be considered submitted to the department unless a current letter of intent, specific to the proposal and in accordance with the provisions of this subsection, has been on file with the department for not less than ten business days. For purposes of this subsection, "a current letter of intent" means a letter of intent on file with the department for not more than one hundred eighty days. A certificate of need application shall be deemed withdrawn by the department, if a department completeness letter is not responded to

within one hundred eighty days. The Office of the Long-Term Care Ombudsman shall be notified by the facility at the same time as the letter of intent is submitted to the department.

(d) Any facility acting pursuant to subdivision (3) of subsection (b) of this section shall provide written notice, at the same time it submits its letter of intent, to all patients, guardians or conservators, if any, or legally liable relatives or other responsible parties, if known, and shall post such notice in a conspicuous location at the facility. The notice shall state the following: (A) The projected date the facility will be submitting its certificate of need application, (B) that only the department has the authority to either grant, modify or deny the application, (C) that the department has up to ninety days to grant, modify or deny the certificate of need application, (D) a brief description of the reason or reasons for submitting a request for permission, (E) that no patient shall be involuntarily transferred or discharged within or from a facility pursuant to state and federal law because of the filing of the certificate of need application, (F) that all patients have a right to appeal any proposed transfer or discharge, and (G) the name, mailing address and telephone number of the Office of the Long-Term Care Ombudsman and local legal aid office.

(e) The department shall review a request made pursuant to subsection (b) of this section to the extent it deems necessary, including, but not limited to, in the case of a proposed transfer of ownership or control prior to initial licensure, the financial responsibility and business interests of the transferee and the ability of the facility to continue to provide needed services, or in the case of the addition or expansion of a function or service, ascertaining the availability of the function or service at other facilities within the area to be served, the need for the service or function within the area and any other factors the department deems relevant to a determination of whether the facility is justified in adding or expanding the function or service. The commissioner shall grant, modify or deny the request within ninety days of receipt thereof, except as otherwise provided in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the department has requested additional information subsequent to the commencement of the commissioner's review period. The director of the office of certificate of need and rate setting may extend the review period for a maximum of thirty days if the applicant has not filed in a timely manner information deemed necessary by the department. The applicant may request and shall receive a hearing in accordance with section 4-177 if aggrieved by a decision of the commissioner.]

(b) A certificate of need issued by the Department of Social Services shall be required for:

(1) Establishment of a new facility;

(2) termination of a service or services;

(3) closure of a facility, unless a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545;

(4) an increase or decrease in the licensed bed capacity of a facility; and

(5) capital expenditures in excess of two million dollars.

The facility shall notify the Office of the Long-Term Care Ombudsman of any proposed actions to be taken pursuant to this subsection at the same time the request for permission is submitted to the department and when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545.

Notwithstanding any other provisions in statute, the commissioner of social services may not require a facility to seek certificate of need approval in accordance with this section if the facility can demonstrate the request is associated with an approved long term care rebalancing project or nursing facility diversification project. The commissioner of social services may establish a pilot program to seek competitive procurement of up to thirty five beds at licensed nursing facilities provided there is clear public need in accordance with Section 17b-353 (c).

(c) The Department of Social Services shall not accept or approve any requests for additional nursing home beds or to modify the capital cost of any prior approval, through June 30, 2016, except if the beds requested (1) are restricted to use by patients with acquired immune deficiency syndrome or traumatic brain injury; (2) are associated with a continuing care facility that does not participate in the Medicaid program and is registered as a continuing care facility pursuant to Chapter 319hh; (3) are Medicaid - certified beds to be relocated from one licensed nursing facility to another licensed nursing facility, to a new facility to meet a priority need identified in the strategic plan developed pursuant to subsection (c) of section 17b-369, or to a small house nursing home, as defined in section 17b-372, provided (A) the availability of beds in an area of need will not be adversely affected; (B) no such relocation shall result in an increase in state expenditures; and (C) the relocation results in a reduction in the number of nursing facility beds in the state; (4) the facility is operated exclusively by and for a religious order which is committed to the care and well-being of its members for the duration of their lives and whose members are bound thereto by the profession of permanent vows; (5) are twenty or fewer beds associated with a free standing facility dedicated to providing hospice care services for terminally ill persons operated by an organization previously authorized by the Department of Public Health to provide hospice services in accordance with section 19a-122b.

(d) The Commissioner of Social Services may waive or modify any requirement of this section, except subdivision (2) of subsection (c) which prohibits participation in the Medicaid program, to enable an established continuing care facility to add nursing home beds.

[(f)] (h)The Commissioner of Social Services shall not approve any requests for beds in residential facilities for persons with intellectual disability which are licensed pursuant to section 17a-227 and are certified to participate in the Title XIX Medicaid Program as intermediate care facilities for individuals with intellectual disabilities, except those beds necessary to implement the residential placement goals of the Department of Developmental Services which are within available appropriations.

[(g)] (i) The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this section. [The commissioner shall implement the standards and procedures of the Office of Health Care Access division of the Department of Public Health concerning certificates of need established pursuant to section 19a-643, as appropriate for the purposes of this section, until the time final regulations are adopted in accordance with said chapter 54.]

Sec. 2. Section 17b-353 of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

[(a) Any facility, as defined in subsection (a) of section 17b-352, which proposes (1) a capital expenditure exceeding one million dollars, which increases facility square footage by more than five thousand square feet or five per cent of the existing square footage, whichever is greater, (2) a capital expenditure exceeding two million dollars, or (3) the acquisition of major medical equipment requiring a capital expenditure in excess of four hundred thousand dollars, including the leasing of equipment or space, shall submit a request for approval of such expenditure, with such information as the department requires, to the Department of Social Services. Any such facility which proposes to acquire imaging equipment requiring a capital expenditure in excess of four hundred thousand dollars, including the leasing of such equipment, shall obtain the approval of the Office of Health Care Access division of the Department of Public Health in accordance with the provisions of chapter 368z, subsequent to obtaining the approval of the Commissioner of Social Services. Prior to the facility's obtaining the imaging equipment, the Commissioner of Public Health, after consultation with the Commissioner of Social Services, may elect to perform a joint or simultaneous review with the Department of Social Services.

(b) An applicant, prior to submitting a certificate of need application, shall request, in writing, application forms and instructions from the department. The request shall include: (1) The name of the applicant or applicants; (2) a statement indicating whether the application is for (A) a new, additional, expanded or replacement facility, service or function, (B) a termination or reduction in a presently authorized service or bed capacity, or (C) any new, additional or terminated beds and their type; (3) the estimated capital cost; (4) the town where the project is or will be located; and (5) a brief description of the proposed project. Such request shall be deemed a letter of intent. No certificate of need application shall be considered submitted to the department unless a current letter of intent, specific to the proposal and in accordance with the provisions of this subsection, has been on file with the department for not less than ten business days. For purposes of this subsection, "a current letter of intent" means a letter of intent on file with the department for not more than one hundred eighty days. A certificate of need application shall be deemed withdrawn by the department if a department completeness letter is not responded to within one hundred eighty days.

(c) In conducting its activities pursuant to this section, section 17b-352 or both, except as provided for in subsection (d) of this section, the Commissioner of Social Services or said commissioner's designee may hold a public hearing on an application or on more than one application, if such applications are of a similar nature with respect to the request. At least two weeks' notice of the hearing shall be given to the facility by certified mail and to the public by publication in a newspaper having a substantial circulation

in the area served by the facility. Such hearing shall be held at the discretion of the commissioner in Hartford or in the area so served. The commissioner or the commissioner's designee shall consider such request in relation to the community or regional need for such capital program or purchase of land, the possible effect on the operating costs of the facility and such other relevant factors as the commissioner or the commissioner's designee deems necessary. In approving or modifying such request, the commissioner or the commissioner's designee may not prescribe any condition, such as, but not limited to, any condition or limitation on the indebtedness of the facility in connection with a bond issued, the principal amount of any bond issued or any other details or particulars related to the financing of such capital expenditure, not directly related to the scope of such capital program and within the control of the facility. If the hearing is conducted by a designee of the commissioner, the designee shall submit any findings and recommendations to the commissioner. The commissioner shall grant, modify or deny such request within ninety days, except as provided for in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the commissioner or the commissioner's designee has requested additional information subsequent to the commencement of the review period. The commissioner or the commissioner's designee may extend the review period for a maximum of thirty days if the applicant has not filed in a timely manner information deemed necessary by the commissioner or the commissioner's designee.

(d) No facility shall be allowed to close or decrease substantially its total bed capacity until such time as a public hearing has been held in accordance with the provisions of this subsection and the Commissioner of Social Services has approved the facility's request unless such decrease is associated with a census reduction. The commissioner may impose a civil penalty of not more than five thousand dollars on any facility that fails to comply with the provisions of this subsection. Penalty payments received by the commissioner pursuant to this subsection shall be deposited in the special fund established by the department pursuant to subsection (c) of *section 17b-357* and used for the purposes specified in said subsection (c). The commissioner or the commissioner's designee shall hold a public hearing upon the earliest occurrence of: (1) Receipt of any letter of intent submitted by a facility to the department, or (2) receipt of any certificate of need application. Such hearing shall be held at the facility for which the letter of intent or certificate of need application was submitted not later than thirty days after the date on which such letter or application was received by the commissioner. The commissioner or the commissioner's designee shall provide both the facility and the public with notice of the date of the hearing not less than fourteen days in advance of such date. Notice to the facility shall be by certified mail and notice to the public shall be by publication in a newspaper having a substantial circulation in the area served by the facility.]

(a) In any deliberation involving a certificate of need application filed pursuant to section 17b-352 of the Connecticut General Statutes, the department shall consider the following guidelines and principles:

(1) the financial feasibility of the request and its impact on the applicant's rates and financial condition;

(2) the contribution of the request to the quality, accessibility and cost-effectiveness of health care delivery in the region;

(3) whether there is clear public need for the request;

(4) the relationship of any proposed change to the applicant's current utilization statistics;

(5) the business interests of all owners, partners, associates, incorporators, directors, sponsors, stockholders and operators and the personal background of such persons, and any other factor which the department deems relevant.

(b) In considering whether there is clear public need for any request for additional nursing home beds associated with a continuing care facility submitted pursuant to section 17b-352, the commissioner may consider the need for beds for current and prospective residents of the continuing care facility.

(c) In considering whether there is clear public need for any request for the relocation of beds, the commissioner shall consider whether there is a demonstrated bed need in the towns within a fifteen-mile radius of the town in which the beds are proposed to be located. Bed need may be based on the recent occupancy percentage of area nursing facilities and the projected bed need for no more than five years into the future at ninety-seven and one-half per cent occupancy using the latest official population projections by town and age as published by the Office of Policy and Management or the latest available state-wide nursing facility utilization statistics by age cohort from the Department of Public Health. The commissioner may also consider area specific utilization and reductions in utilization rates to account for the increased use of less institutional alternatives.

[(e)] (d) The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this section. [The commissioner shall implement the standards and procedures of the Office of Health Care Access division of the Department of Public Health concerning certificates of need established pursuant to section 19a-643, as appropriate for the purposes of this section, until the time final regulations are adopted in accordance with said chapter 54.]

Sec. 3. Section 17b-354 of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

[(a) Except for applications deemed complete as of August 9, 1991, the Department of Social Services shall not accept or approve any requests for additional nursing home beds or modify the capital cost of any prior approval for the period from September 4, 1991, through June 30, 2016, except (1) beds restricted to use by patients with acquired immune deficiency syndrome or traumatic brain injury; (2) beds associated with a continuing care facility which guarantees life care for its residents; (3) Medicaid certified beds to be relocated from one licensed nursing facility to another licensed nursing facility, to a new facility to meet a priority need identified in the strategic plan developed pursuant to subsection (c) of section 17b-369, or to a small house nursing home, as defined in section 17b-372, provided (A) the availability of beds in an area of need will not be adversely affected; (B) no such relocation shall result in

an increase in state expenditures; and (C) the relocation results in a reduction in the number of nursing facility beds in the state; (4) a request for no more than twenty beds submitted by a licensed nursing facility that participates in neither the Medicaid program nor the Medicare program, admits residents and provides health care to such residents without regard to their income or assets and demonstrates its financial ability to provide lifetime nursing home services to such residents without participating in the Medicaid program to the satisfaction of the department, provided the department does not accept or approve more than one request pursuant to this subdivision; (5) a request for no more than twenty beds associated with a free standing facility dedicated to providing hospice care services for terminally ill persons operated by an organization previously authorized by the Department of Public Health to provide hospice services in accordance with section 19a-122b; and (6) new or existing Medicaid certified beds to be relocated from a licensed nursing facility in a municipality with a 2004 estimated population of one hundred twenty-five thousand to a location within the same municipality, provided such Medicaid certified beds do not exceed sixty beds. Notwithstanding the provisions of this subsection, any provision of the general statutes or any decision of the Office of Health Care Access, (i) the date by which construction shall begin for each nursing home certificate of need in effect August 1, 1991, shall be December 31, 1992, (ii) the date by which a nursing home shall be licensed under each such certificate of need shall be October 1, 1995, and (iii) the imposition of such dates shall not require action by the Commissioner of Social Services. Except as provided in subsection (c) of this section, a nursing home certificate of need in effect August 1, 1991, shall expire if construction has not begun or licensure has not been obtained in compliance with the dates set forth in subparagraphs (i) and (ii) of this subsection.

(b) For the purposes of subsection (a) of this section, "a continuing care facility which guarantees life care for its residents" means: (1) A facility which does not participate in the Medicaid program; (2) a facility which establishes its financial stability by submitting to the commissioner documentation which (A) demonstrates in financial statements compiled by certified public accountants that the facility and its direct or indirect owners have (i) on the date of the certificate of need application and for five years preceding such date, net assets or reserves equal to or greater than the projected operating revenues for the facility in its first two years of operation or (ii) assets or other indications of financial stability determined by the commissioner to be sufficient to provide for the financial stability of the facility based on its proposed financial structure and operations, (B) demonstrates in financial statements compiled by certified public accountants that the facility, on the date of the certificate of need application, has a projected debt coverage ratio at ninety-five per cent occupancy of at least one and twenty-five one-hundredths, (C) details the financial operation and projected cash flow of the facility on the date of the certificate of need application, to be updated every five years thereafter, and demonstrates that fees payable by residents and the assets, income and insurance coverage of residents, in combination with other sources of facility funding, are sufficient to provide for the expenses of life care services for the life of the residents to be made available within a continuum of care which shall include the provision of health services in the independent living units, and (D) provides that any transfer of ownership of the facility to take place within a five-year period from the date of approval of its certificate of need shall be subject to the approval of the Commissioner of Social Services in accordance with the provisions of section 17b-355; (3) a facility which establishes to the satisfaction of the commissioner that it can provide

for the expenses of the continuum of care to be made available to residents by complying with the provisions of chapter 319f and demonstrating sufficient assets, income, financial reserves or long-term care insurance to provide for such expenses and maintain financially viable operation of the facility for a thirty-year period based on generally accepted accounting practices and actuarial principles, which demonstration (A) may include making available to prospective residents long-term care insurance policies which are substantially equivalent in value and coverage to policies precertified pursuant to section 38a-475, (B) shall include establishing eligibility criteria and screening each resident prior to admission and annually thereafter to ensure that his assets, income and insurance coverage are sufficient in combination with other sources of facility funding to cover such expenses, (C) shall include entering into contracts with residents concerning monthly or other periodic fees payable by residents for services provided, and (D) allowing residents whose expenses are not covered by insurance to pledge or transfer income, assets or proceeds from the sale of assets in amounts sufficient to cover such expenses; (4) a facility which demonstrates it will establish a contingency fund, prior to becoming operational, in an initial amount of five hundred thousand dollars which shall be increased in equal annual increments to at least one million dollars by the start of the facility's sixth year of operation and which shall be replenished within twelve months of any expenditure, provided the amount to be replenished shall not exceed two hundred fifty thousand dollars annually until one million dollars is reached, to provide for the expenses of the continuum of care to be made available to residents which may not be covered by residents' assets, income or insurance, provided the commissioner may approve the establishment of a contingency fund in a lesser amount upon the application of a facility for which a lesser amount is appropriate based on the size of the facility; and (5) a facility which is operated by management with demonstrated experience and ability in the operation of similar facilities. Notwithstanding the provisions of this subsection, a facility may be deemed a continuing care facility which guarantees life care for its residents if (A) the facility meets the criteria set forth in subdivisions (2) to (5), inclusive, of this subsection, was Medicaid certified prior to October 1, 1993, and has been deemed qualified to enter into a continuing care contract under chapter 319hh for at least two consecutive years prior to filing its certificate of need application under this section, provided (i) no additional bed approved pursuant to this section shall be Medicaid certified; (ii) no patient in such a bed shall be involuntarily transferred to another bed due to his eligibility for Medicaid and (iii) the facility shall pay the cost of care for a patient in such a bed who is Medicaid eligible and does not wish to be transferred to another bed or (B) the facility is operated exclusively by and for a religious order which is committed to the care and well-being of its members for the duration of their lives and whose members are bound thereto by the profession of permanent vows. On and after July 1, 1997, the Department of Social Services shall give priority to a request for modification of a certificate of need from a continuing care facility which guarantees life care for its residents pursuant to the provisions of this subsection.

(c) For the purposes of this section and sections 17b-352 and 17b-353, construction shall be deemed to have begun if the following have occurred and the department has been so notified in writing within the thirty days prior to the date by which construction is to begin: (1) All necessary town, state and federal approvals required to begin construction have been obtained, including all zoning and wetlands approvals; (2) all necessary town and state permits required to begin construction or site work have been obtained;

(3) financing approval, as defined in subsection (d) of this section, has been obtained; and (4) construction of a structure approved in the certificate of need has begun. For the purposes of this subsection, commencement of construction of a structure shall include, at a minimum, completion of a foundation. Notwithstanding the provisions of this subsection, upon receipt of an application filed at least thirty days prior to the date by which construction is to begin, the commissioner may deem construction to have begun if: (A) An owner of a certificate of need has fully complied with the provisions of subdivisions (1), (2) and (3) of this subsection; (B) such owner submits clear and convincing evidence that he has complied with the provisions of this subsection sufficiently to demonstrate a high probability that construction shall be completed in time to obtain licensure by the Department of Public Health on or before the date required pursuant to subsection (a) of this section; (C) construction of a structure cannot begin due to unforeseeable circumstances beyond the control of the owner; and (D) at least ten per cent of the approved total capital expenditure or two hundred fifty thousand dollars, whichever is greater, has been expended.

(d) For the purposes of subsection (c) of this section, subject to the provisions of subsection (e) of this section, financing shall be deemed to have been obtained if the owner of the certificate of need receives a commitment letter from a lender indicating an affirmative interest in financing the project subject to reasonable and customary conditions, including a final commitment from the lender's loan committee or other entity responsible for approving loans. If a lender which has issued a commitment letter subsequently refuses to finance the project, the owner shall notify the department in writing within five business days of the receipt of the refusal. The owner shall, if so requested by the department, provide the commissioner with copies of all communications between the owner and the lender concerning the request for financing. The owner shall have one further opportunity to obtain financing which shall be demonstrated by submitting another commitment letter from a lender to the department within thirty days of the owner's receipt of the refusal from the first lender.

(e) On and after March 1, 1993, financing shall be deemed to have been obtained for the purposes of this section and sections 17b-352 and 17b-353 if the owner of the certificate of need has (1) received a final commitment for financing in writing from a lender or (2) provided evidence to the department that the owner has sufficient funds available to construct the project without financing.

(f) Any decision of the Office of Health Care Access issued prior to July 1, 1993, as to whether construction has begun or financing has been obtained for nursing home beds approved by the office prior to said date shall be deemed to be a decision of the Commissioner of Social Services for the purposes of this section and sections 17b-352 and 17b-353.

(g) (1) A continuing care facility which guarantees life care for its residents, as defined in subsection (b) of this section, (A) shall arrange for a medical assessment to be conducted by an independent physician or an access agency approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined by regulations adopted pursuant to subsection (e) of section 17b-342, prior to the admission of any resident to the nursing facility and shall document such assessment in the resident's medical file and (B) may transfer or discharge a resident who

has intentionally transferred assets in a sum which will render the resident unable to pay the cost of nursing facility care in accordance with the contract between the resident and the facility.

(2) A continuing care facility which guarantees life care for its residents, as defined in subsection (b) of this section, may, for the seven-year period immediately subsequent to becoming operational, accept nonresidents directly as nursing facility patients on a contractual basis provided any such contract shall include, but not be limited to, requiring the facility (A) to document that placement of the patient in such facility is medically appropriate; (B) to apply to a potential nonresident patient the financial eligibility criteria applied to a potential resident of the facility pursuant to said subsection (b); and (C) to at least annually screen each nonresident patient to ensure the maintenance of assets, income and insurance sufficient to cover the cost of at least forty-two months of nursing facility care. A facility may transfer or discharge a nonresident patient upon the patient exhausting assets sufficient to pay the costs of his care or upon the facility determining the patient has intentionally transferred assets in a sum which will render the patient unable to pay the costs of a total of forty-two months of nursing facility care from the date of initial admission to the nursing facility. Any such transfer or discharge shall be conducted in accordance with section 19a-535. The commissioner may grant one or more three-year extensions of the period during which a facility may accept nonresident patients, provided the facility is in compliance with the provisions of this section.

(h) Notwithstanding the provisions of subsection (a) of this section, if an owner of an approved certificate of need for additional nursing home beds has notified the Office of Health Care Access or the Department of Social Services on or before September 30, 1993, of his intention to utilize such beds for a continuing care facility which guarantees life care for its residents in accordance with subsection (b) of this section and has filed documentation with the Department of Social Services on or before September 30, 1994, demonstrating the requirements of said subsection (b) have been met, the certificate of need shall not expire.

(i) The Commissioner of Social Services may waive or modify any requirement of this section, except subdivision (1) of subsection (b) which prohibits participation in the Medicaid program, to enable an established continuing care facility registered pursuant to chapter 319hh prior to September 1, 1991, to add nursing home beds provided the continuing care facility agrees to no longer admit nonresidents into any of the facility's nursing home beds except for spouses of residents of such facility and provided the addition of nursing home beds will not have an adverse impact on the facility's financial stability, as defined in subsection (b) of this section, and are located within a structure constructed and licensed prior to July 1, 1992.]

(a) An applicant, prior to submitting a certificate of need application, shall request, in writing, application forms and instructions from the department. The request shall include: (1) The name of the applicant or applicants; (2) a statement indicating whether the application is for (A) a new, additional, expanded or replacement facility or service, (B) a termination or reduction in a presently authorized service or bed capacity, or (C) any new, additional or terminated beds and their type; (3) the estimated capital cost; (4) the town where the project is or will be located; and (5) a brief description of the

proposed project. Such request shall be deemed a letter of intent. No certificate of need application shall be considered submitted to the department unless a current letter of intent, specific to the proposal and in accordance with the provisions of this subsection, has been on file with the department for not less than ten business days. For purposes of this subsection, "a current letter of intent" means a letter of intent on file with the department for not more than one hundred eighty days. A certificate of need application shall be deemed withdrawn by the department if a department completeness letter is not responded to within one hundred eighty days. The Office of the Long-Term Care Ombudsman shall be notified by the facility at the same time as the letter of intent is submitted to the department.

(b) Any facility acting pursuant to subdivision (3) of subsection (b) of section 17b-352 shall provide written notice, at the same time it submits its letter of intent, to all patients, guardians or conservators, if any, or legally liable relatives or other responsible parties, if known, and shall post such notice in a conspicuous location at the facility. The notice shall state the following: (A) The projected date the facility will be submitting its certificate of need application, (B) that only the department has the authority to either grant, modify or deny the application, (C) that the department has up to ninety days to grant, modify or deny the certificate of need application, (D) a brief description of the reason or reasons for submitting a request for permission, (E) that no patient shall be involuntarily transferred or discharged within or from a facility pursuant to state and federal law because of the filing of the certificate of need application, (F) that all patients have a right to appeal any proposed transfer or discharge, and (G) the name, mailing address and telephone number of the Office of the Long-Term Care Ombudsman and local legal aid office.

(c) The commissioner shall grant, modify or deny a certificate of need application within ninety days of receipt thereof, except as otherwise provided in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the department has requested additional information subsequent to the commencement of the commissioner's review period. The director of the office of certificate of need and rate setting may extend the review period for a maximum of thirty days if the applicant has not filed in a timely manner information deemed necessary by the department. The applicant may request and shall receive a hearing in accordance with section 4-177 if aggrieved by a decision of the commissioner.

(d) In conducting its activities pursuant to section 17b-352, except as provided for in subsection (e) of this section, the Commissioner of Social Services or said commissioner's designee may hold a public hearing on an application or on more than one application, if such applications are of a similar nature with respect to the request. At least two weeks' notice of the hearing shall be given to the facility by certified mail and to the public by publication in a newspaper having a substantial circulation in the area served by the facility. Such hearing shall be held at the discretion of the commissioner in Hartford or in the area so served. If the hearing is conducted by a designee of the commissioner, the designee shall submit any findings and recommendations to the commissioner. The commissioner shall grant, modify or deny such request within ninety days, except as provided for in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the commissioner or the

commissioner's designee has requested additional information subsequent to the commencement of the review period. The commissioner or the commissioner's designee may extend the review period for a maximum of thirty days if the applicant has not filed in a timely manner information deemed necessary by the commissioner or the commissioner's designee.

(e) The Commissioner of Social Services or the commissioner's designee shall hold a public hearing for the closure of a nursing facility unless the occupancy is less than eighty percent of licensed bed capacity or the facility is a residential care home or a residential facility for persons with intellectual disability licensed pursuant to section 17a-277 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities. The commissioner may impose a civil penalty of not more than five thousand dollars on any facility that fails to comply with the provisions of this subsection. Penalty payments received by the commissioner pursuant to this subsection shall be deposited in the special fund established by the department pursuant to subsection (c) of *section 17b-357* and used for the purposes specified in said subsection (c). The commissioner or the commissioner's designee shall hold a public hearing upon the earliest occurrence of: (1) Receipt of any letter of intent submitted by a facility to the department, or (2) receipt of any certificate of need application. Such hearing shall be held at the facility for which the letter of intent or certificate of need application was submitted not later than thirty days after the date on which such letter or application was received by the commissioner. The commissioner or the commissioner's designee shall provide both the facility and the public with notice of the date of the hearing not less than fourteen days in advance of such date. Notice to the facility shall be by certified mail and notice to the public shall be by publication in a newspaper having a substantial circulation in the area served by the facility.

(f) The Commissioner of Social Services may conduct an expedited review of a certificate of need application for the closure of or a reduction in the licensed bed capacity of a residential care home or a residential facility for persons with intellectual disability licensed pursuant to section 17a-277 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities.

(g) The Commissioner may grant a nursing facility's certificate of need request to close the facility without holding a public hearing if occupancy at the nursing facility is sixty percent or less of the facility's licensed bed capacity, provided there are sufficient nursing facility beds in towns within a fifteen mile radius to accommodate residents.

[(j)] (h) The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this section. [The commissioner shall implement the standards and procedures of the Office of Health Care Access division of the Department of Public Health concerning certificates of need established pursuant to section 19a-643, as appropriate for the purposes of this section, until the time final regulations are adopted in accordance with said chapter 54.]

Sec. 4. Section 17b-354a of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

[The Superior Court on application of the Commissioner of Social Services or the Attorney General, may enforce, by appropriate decree or process any provision of *section* 17b-352, 17b-353 or 17b-354, respectively, or any act or any order of the commissioner rendered in pursuance of any such provision.]

(a) A certificate of need shall be valid only for the project described in the application. A certificate of need shall be valid for two years from the date of issuance by the department except a certificate of need for capital improvements, which shall be valid for five years from the date of issuance by the department. During the period of time that such certificate is valid and the thirty-day period following the expiration of the certificate, the holder of the certificate shall provide the office with such information as the department may request on the development of the project covered by the certificate.

(b) Upon request from a certificate holder, the department may extend the duration of a certificate of need for such additional period of time as the department determines is reasonably necessary to expeditiously complete the project.

(c) In the event that the department determines that: (1) Commencement, construction or other preparation has not been substantially undertaken during a valid certificate of need period; or (2) the certificate holder has not made a good-faith effort to complete the project as approved, the department may withdraw, revoke or rescind the certificate of need.

(d) For the purposes of this section, construction shall be deemed to have begun if the following have occurred: (1) All necessary town, state and federal approvals required to begin construction have been obtained, including all zoning and wetlands approvals; and (2) all necessary town and state permits required to begin construction or site work have been obtained.

(e) Financing shall be deemed to have been obtained for the purposes of this section if the owner of the certificate of need: (1) receives a commitment letter from a lender indicating an affirmative interest in financing the project subject to reasonable and customary conditions, including a final commitment from the lender's loan committee or other entity responsible for approving loans or (2) received a final commitment for financing in writing from a lender or (3) provided evidence to the department that the owner has sufficient funds available to construct the project without financing.

(f) A certificate of need shall not be transferable or assignable nor shall a project be transferred from a certificate holder to another person.

Sec. 5. Section 17b-354b of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

The Commissioner of Social Services may approve the relocation of Medicaid certified nursing home beds from a licensed nursing home to a continuing care facility registered with the Department of Social Services in accordance with the provisions of sections 17b-520 to 17b-535, inclusive, and may approve Medicaid participation for any such nursing home beds transferred to a continuing care facility as part of the approval of any such relocation, provided the relocation of beds complies with the requirements of

subdivision (3) of subsection (a) of section 17b-352 and provided further that: [(1) Beds are transferred and eliminated from existing four-bed rooms licensed prior to July 1, 1992; (2)] (1) the Medicaid per diem rate does not exceed the rate in place at the facility that is transferring beds, and increases in such rate are limited annually thereafter to any rate increase limits under section 17b-340; and [(3)] (2) any such nursing home bed transfer is to a continuing care facility under the same ownership or a subsidiary of the nursing home transferring such bed.

Sec. 6. Section 17b-354c of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) **[**Except for applications filed on or before May 1, 2001, which shall not be subject to the restrictions set forth in this section, for the period from July 1, 2001, to June 30, 2007, rest] Rest homes with nursing supervision beds under common ownership with chronic and convalescent nursing home beds in the same or an immediately adjacent building may be converted to chronic and convalescent nursing home beds in accordance with the provisions of section 17b-352, provided that such conversion shall not result in an increase in cost to the state of more than twelve per cent of the amount previously paid to the facility annually for both levels of care. This limitation shall apply only to conversion of rest homes with nursing supervision beds under common ownership with chronic and convalescent nursing home beds or in the same or an immediately adjacent building. Rest homes with nursing supervision beds in freestanding facilities [and rest homes with nursing supervision beds transferred to another licensed and Medicaid-certified nursing home may] be converted to chronic and convalescent nursing home beds pursuant to section 17b-352[and subsection (a) of section 17b-354 as applicable].

(b) **[** No later than December 31, 2001, the commissioner shall publish proposed regulations pursuant to subsections (a) to (e), inclusive, of section 4-168 implementing this section] The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this section.

Sec. 7. Section 17b-355 of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

[In determining whether a request submitted pursuant to sections 17b-352 to 17b-354, inclusive, will be granted, modified or denied, the Commissioner of Social Services shall consider the following: The relationship of the request to the state health plan, the financial feasibility of the request and its impact on the applicant's rates and financial condition, the contribution of the request to the quality, accessibility and cost-effectiveness of health care delivery in the region, whether there is clear public need for the request, the relationship of any proposed change to the applicant's current utilization statistics, the business interests of all owners, partners, associates, incorporators, directors, sponsors, stockholders and operators and the personal background of such persons, and any other factor which the department deems relevant. Whenever the granting, modification or denial of a request is inconsistent with the state health plan, a written explanation of the reasons for the inconsistency shall be included in the decision. In considering whether there is clear public need for any request for additional nursing home beds associated with a

continuing care facility submitted pursuant to section 17b-354, the commissioner shall only consider the need for beds for current and prospective residents of the continuing care facility. In considering whether there is clear public need for any request for the relocation of beds, the commissioner shall consider whether there is a demonstrated bed need in the towns within a fifteen-mile radius of the town in which the beds are proposed to be located. Bed need shall be based on the recent occupancy percentage of area nursing facilities and the projected bed need for no more than five years into the future at ninety-seven and one-half per cent occupancy using the latest official population projections by town and age as published by the Office of Policy and Management and the latest available state-wide nursing facility utilization statistics by age cohort from the Department of Public Health. The commissioner may also consider area specific utilization and reductions in utilization rates to account for the increased use of less institutional alternatives.]

The Superior Court on application of the Commissioner of Social Services or the Attorney General, may enforce, by appropriate decree or process any provision of sections 17b-352, 17b-353, 17b-354 or 17b-354a respectively, or any act or any order of the commissioner rendered in pursuance of any such provision.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
DSS

Liaison: Heather Rossi
Phone: 860-424-5646
E-mail: heather.rossi@ct.gov

Lead agency division requesting this proposal: OLCRAH

Agency Analyst/Drafter of Proposal: Brenda Parrella

Title of Proposal
AAC HEARINGS CONDUCTED BY THE DEPARTMENT OF SOCIAL SERVICES

Statutory Reference 17B-60, 17B-61, 17B-238

Proposal Summary

Section 1 expands the ways that client hearings may be requested to include by mail, phone or other electronic means as required under the ACA; specifies who may request a hearing on behalf of a client; increases the number of days within which DSS must schedule a hearing from 30 to 45; limits to 3 the number of continuances that may be granted; provides that a client need not be present if represented by legal counsel and not needed to testify; and allows testimony by phone in the hearing officer's discretion.

Section 2 makes clarifications that are not substantive changes to practice.

Section 3 specifies that the decisions that may be contested under the section are those that involve the issuance of a payment rate to a provider and addresses some obsolete language.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) *Have there been changes in federal/state/local laws and regulations that make this legislation necessary?* In part
(2) *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?*
(3) *Have certain constituencies called for this action?* no
(4) *What would happen if this was not enacted in law this session?*
We would continue with outdated inefficient practices except where superseded by federal law.

This proposal updates DSS hearings procedures for clarity, efficiency and consistency with federal law.

- **Origin of Proposal** **_x__ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

State

Federal

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Insert fully drafted bill here

DSS Hearings Revisions

Section 1. Section 17b-60 is amended as follows:

Sec. 17b-60. **(a)** An aggrieved person **or any other person authorized by law to request [a fair] an administrative hearing** [on] **concerning** a decision of the [Commissioner] **Department** of Social Services [or the conservator of any such person on his behalf] may [make application for] **request** such hearing **by mail, by telephone or by electronic means determined acceptable to the Department**.[in writing over his signature to the commissioner and shall state in such application in simple language] **A person authorized by law to request an administrative hearing shall include (1) any person with legal authority to act on behalf of the aggrieved person, including a conservator of estate, a legal guardian, a person with power of attorney, if permitted under the terms of the designation of power of attorney, or, for a deceased person, an executor or administrator of estate; and (2) an authorized representative who meets the requirements set forth in state and federal law.**

(b)The request for a hearing shall include the reasons why [he]**the person** claims to be aggrieved **and shall be made** [. Such application shall be mailed] to the [commissioner] **Department of Social Services** within sixty days after the [rendition of such] decision **is issued by the Department, unless otherwise prescribed by federal law** . The [commissioner] **Department** shall [thereupon] hold [a fair] **an administrative** hearing within [thirty] **forty-five** days from receipt **of the request for a hearing** [thereof] and shall, at least ten days prior to the date of such hearing, [mail a] **provide** notice, giving the time and place thereof, to [such]**the** aggrieved person **and the person who**

requested the hearing on such person's behalf, or if the [application]**request** concerns a denial of or failure to provide **a special need benefit for** emergency housing **pursuant to section 17b-808**, the [commissioner] **Department** shall hold a [fair] hearing within four business days from receipt [thereof]**of the request for a hearing**, and shall make all reasonable efforts to provide notice of the time and place of the [fair] hearing to [such] **the** aggrieved person **and the person who requested the hearing on such person's behalf**, at least one business day prior to said hearing. A reasonable period of continuance **of a hearing scheduled pursuant to this section** may be granted for good cause**, provided no more than three continuances shall be granted**.

(c) The aggrieved person **or that person's legal representative or authorized representative** shall appear [personally] at the hearing, **except that, if the aggrieved person is represented by legal counsel who is present at the hearing, and the hearing officer determines that testimony of the aggrieved person or the legal representative or authorized representative is not required in order to properly adjudicate the hearing, no such appearance shall be required. At the hearing officer's discretion, testimony by the aggrieved person, such person's legal representative or authorized representative or by other witness by telephone may be accepted in lieu of personal appearance.[**unless his physical or mental condition precludes appearing in person, and may be represented by an attorney or other authorized representative.]

(d) A [stenographic or mechanical record] **recording** shall be made of each hearing, but need not be transcribed except (1) in the event of an appeal from the decision of the hearing officer or (2) if a copy is requested by the aggrieved person, in either of which cases it shall be furnished by the [Commissioner] **Department** of Social Services without charge.

(e) The Commissioner of Social Services and any person authorized by [him] **the Commissioner** to conduct any hearing under the provisions of this section shall have **the** power to administer oaths and take testimony under oath relative to the matter of the hearing and may subpoena witnesses and require the production of records, papers and documents pertinent to such hearing. No witness under subpoena authorized to be issued by the provisions of this section shall be excused from testifying

or from producing records, papers or documents on the ground that such testimony or the production of such records or other documentary evidence would tend to incriminate him, but such evidence or the records or papers so produced shall not be used in any criminal proceeding against him. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to him by the commissioner or his authorized agent or to produce any records and papers pursuant thereto, the commissioner or his agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person resides, or to any judge of said court if the same is not in session, setting forth such disobedience to process or refusal to answer, and said court or such judge shall cite such person to appear before said court or such judge to answer such question or to produce such records and papers and, upon his refusal to do so, shall commit such person to a community correctional center until he testifies, but not for a longer period than sixty days. Notwithstanding the serving of the term of such commitment by any person, the commissioner or his agent may proceed with such inquiry and examination as if the witness had not previously been called upon to testify. Officers who serve subpoenas issued by the commissioner or under his authority and witnesses attending hearings conducted by [him] **the Commissioner or his agent** hereunder shall receive like fees and compensation as officers and witnesses in the courts of this state to be paid on vouchers of the commissioner on order of the Comptroller.

Section 2. Section 17b-61 is amended as follows:

Sec. 17b-61. (a) Not later than sixty days after **the record closes in a** [such] hearing, or three business days if the hearing concerns a denial of or failure to provide **a special need benefit for** emergency housing **pursuant to section 17b-808**, the commissioner or his designated hearing officer shall [render] **issue** a final decision based upon all the evidence introduced before him **or her** and [applying] all pertinent provisions of law, regulations and departmental policy**.**[, and such] **The** final decision shall **be issued within ninety days after the hearing request was made, pursuant to section 17b-60, and** shall supersede the decision made without a hearing**.[**, provided final definitive administrative action shall be taken by the commissioner or his designee within ninety days after the request of such hearing pursuant to section 17b-60.] Notice of

such final decision shall be given to the aggrieved person **and the person who requested the hearing on such person's behalf**, by mailing him a copy [thereof] **of the decision** within one business day of [its rendition] **the date it is issued**. Such decision after hearing shall be final except as provided in subsections (b) and (c) of this section.

(b) The [applicant for such hearing, if] aggrieved **person [** ,] may appeal therefrom in accordance with section 4-183. Appeals from decisions of [said commissioner] **the Department of Social Services** shall be privileged cases to be heard by the court as soon after the return day as shall be practicable.

(c) The commissioner may, for good cause shown by an aggrieved person, extend the time for filing an appeal to Superior Court beyond the time limitations of section 4-183, as set forth below:

(1) Any aggrieved person who is authorized to appeal a decision of the [commissioner] **Department**, pursuant to subsection (b) of this section, but who fails to serve or file a timely appeal to the Superior Court pursuant to section 4-183, may, as provided in this subsection, petition that the commissioner, for good cause shown, extend the time for filing any such appeal. Such a petition must be filed with the commissioner in writing and contain a complete and detailed explanation of the reasons that precluded the petitioner from serving or filing an appeal within the statutory time period. Such petition must also be accompanied by all available documentary evidence that supports or corroborates the reasons advanced for the extension request. In no event shall a petition for extension be considered or approved if filed later than ninety days after the rendition of the final decision. The decision as to whether to grant an extension shall be made consistent with the provisions of subdivision (2) of this subsection and shall be final and not subject to judicial review.

(2) In determining whether to grant a good cause extension, as provided for in this subsection, the commissioner, or his authorized designee, shall, without the necessity of further hearing, review and, as necessary, verify the reasons advanced by the petition in justification of the extension request. A determination that good cause prevented the filing of a timely

appeal shall be issued in writing and shall enable the petitioner to serve and file an appeal within the time provisions of section 4-183, from the date of the decision granting an extension. The circumstances that precluded the petitioner from filing a timely appeal, and which may be deemed good cause for purposes of granting an extension petition, include, but are not limited to: (A) Serious illness or incapacity of the petitioner which has been documented as materially affecting the conduct of personal affairs; (B) a death or serious illness in the petitioner's immediate family that has been documented as precluding the petitioner from perfecting a timely appeal; (C) incorrect or misleading information given to the petitioner by the agency, relating to the appeal time period, and shown to have been materially relied on by the petitioner as the basis for failure to file a timely appeal; (D) evidence that the petitioner did not receive notice of the agency decision; and (E) other unforeseen and unavoidable circumstances of an exceptional nature which prevented the filing of a timely appeal.

Section 3. Subsection (b) of section 17b-238 is amended as follows:

(b) Any institution or agency to which payments are to be made under sections 17b-239 to 17b-246, inclusive, and sections 17b-340 and 17b-343 which is aggrieved by [any decision of said]**a payment rate issued by the** commissioner may, within ten days after written notice thereof from the commissioner, obtain, by written request to the commissioner, a [rehearing] **hearing** on all items of aggrievement. [On and after July 1, 1996, a rehearing] **A hearing** shall be held by the commissioner or his designee, provided a detailed written description of all such items is filed within ninety days of written notice of the commissioner's decision. The [rehearing] **hearing** shall be held within thirty days of the filing of the detailed written description of each specific item of aggrievement. The commissioner shall issue a final decision within sixty days of the close of evidence or the date on which final briefs are filed, whichever occurs later. Any designee of the commissioner

who presides over such [rehearing] **hearing** shall be impartial and shall not be employed within the Department of Social Services office of certificate of need and rate setting. Any such items not resolved at such [rehearing] **hearing** to the satisfaction of either such institution or agency or said commissioner shall be submitted to binding arbitration to an arbitration board consisting of one member appointed by the institution or agency, one member appointed by the commissioner and one member appointed by the Chief Court Administrator from among the retired judges of the Superior Court, which retired judge shall be compensated for his services on such board in the same manner as a state referee is compensated for his services under section 52-434. The proceedings of the arbitration board and any decisions rendered by such board shall be conducted in accordance with the provisions of the Social Security Act, 49 Stat. 620 (1935), 42 USC 1396, as amended from time to time, and chapter 54.

Agency Legislative Proposal - 2014 Session

Document Name: DSS_1 Comprehensive DSS Revisions

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Department of Social Services

Liaison: Heather Rossi
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Lead agency division requesting this proposal:
Division of Health Services

Agency Analyst/Drafter of Proposal:
Kristin Dowty, Patricia McCooey, and Melanie Dillon

Title of Proposal
HUSKY Programs

Statutory References
§§ 17b-261i,17b-261m, 17b-289, 17b-290, 17b-291, 17b-292, 17b-292a, 17b-294a, 17b-295, 17b-297, 17b-299, 17b-300, 17b-303, 17b-304, 17b-306, Public Act 13-234, Secs. 79, 102.

Proposal Summary

Eliminate outdated and inapplicable provisions in the HUSKY Statute and in other provisions related to medical assistance programs.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

This proposal would eliminate a number of outdated provisions in the HUSKY Act (Conn. Gen. Stat. Section 17b-289 et seq.) and other eligibility sections of Ch. 319v, Medical Assistance. The proposed changes are necessary to conform all aspects of the eligibility and services sections to the Administrative Services Organization model of providing care to HUSKY and CHIP clients, using a fee-for-service rather than a managed care delivery model. A number of other provisions are no longer applicable or describe initiatives that are no longer applicable as they were supplanted by other legislation.

For example, Conn. Gen. Stat. Sec. 17b-261i refers to a specific ASO for aged, blind and disabled clients. DSS has implemented a single ASO for all eligibility groups.

There are also a number of provisions in the HUSKY B statute that are no longer in effect. Examples of

areas that need revision include:

- The HUSKY Act refers to "HUSKY Plan, Part A" and "HUSKY Plan, Part B." This terminology and the concept of a HUSKY plan marketed to and serving children is no longer valid or in effect. Under the ASO model, all clients are served by the HUSKY Health Program.
- A number of the definitions in 17b-290 are no longer accurate. The legislative proposal will add new definitions for consistency with the Affordable Care Act and current program operations.
- The role of the "single point of entry servicer" is no longer accurate. The Xerox role in our eligibility processes is evolving. The role they are currently playing is not required by federal law, so we may wish to describe their role as a contractor in the most general terms possible.

Other Eligibility provisions

Finally, the eligibility statutes for Medicaid and CHIP should be amended to conform to the federal mandates for a conversion to eligibility rules based upon Modified Adjusted Gross Income. This would include, but not be limited to, Conn. Gen. Stat. Section 17b-261(a)

The Federal Poverty Limits used in the HUSKY Act and elsewhere in statute are no longer accurate as DSS was required to convert those limits under the federal ACA Modified Adjusted Gross Income (MAGI) eligibility rules that go into effect on January 1, 2014 for Medicaid and CHIP.

- **Origin of Proposal** **__X_ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

DSS HUSKY Revisions

Sec. 1. Section 17b-261 of the General Statutes is repealed and the following is substituted in lieu thereof (*effective upon passage*):

(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (e) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate region of residence and if such person is an institutionalized individual as defined in Section 1917(c) of the Social Security Act, 42 USC 1396p(c), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such disposition shall be treated in accordance with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of property made on behalf of an applicant or recipient or the spouse of an applicant or recipient by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility. The commissioner shall establish the standards for eligibility for medical assistance at one hundred forty-three per cent of the benefit amount paid to a family unit of equal size with no income under the temporary family assistance program in the appropriate region of residence. In determining eligibility, the commissioner shall not consider as

income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran. Except as provided in section 17b-277 **and section 17b-292**, the medical assistance program shall provide coverage to persons under the age of nineteen with family income up to one hundred **ninety-six** [eighty-five] per cent of the federal poverty level without an asset limit and to persons under the age of nineteen and their parents and needy caretaker relatives, who qualify for coverage under Section 1931 of the Social Security Act, with family income up to one hundred **ninety-six** [eighty-five] per cent of the federal poverty level without an asset limit. Such levels shall be based on the regional differences in such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall be applied as may be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of (1) the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance, (2) the effect that having income that exceeds the limits prescribed in this subsection will have with respect to program eligibility, and (3) the availability of, and eligibility for, services provided by the Nurturing Families Network established pursuant to section 17b-751b. **For coverage dates on or after January 1, 2014, the Department will use the modified adjusted gross income financial eligibility rules set forth in section 1904(e)(14) of the Social Security Act and the implementing regulations to determine eligibility for HUSKY A, HUSKY B and HUSKY D applicants, as defined in section 17b-290.** Persons who are determined ineligible for assistance pursuant to this section shall be provided a written statement notifying such persons of their ineligibility and advising such persons of **their eligibility for one of the other insurance affordability programs as defined in 42 CFR 435.4.**[the availability of HUSKY Plan, Part B health insurance benefits.]

Sec. 2. Section 17b-261h of the General Statutes is repealed and the following is substituted in lieu thereof (*effective upon passage*):

(a) The Commissioner of Social Services shall, if required, seek a waiver from federal law for the purpose of enhancing the enrollment of HUSKY [Plan, Part] A recipients, **as defined in section 17b-290(16)**, in available employer-sponsored private health insurance. Such a waiver shall include, but shall not be limited to, provisions that: (1) Require the enrollment of HUSKY [Plan, Part] A parents, needy caretaker relatives and dependents in any available employer-sponsored health insurance to the maximum extent of available coverage as a condition of eligibility when determined to be cost effective by the Department of Social Services; (2) require a subsidy to be paid directly to the HUSKY [Plan, Part] A caretaker relative in an amount equal to the premium payment requirements of any available employer-sponsored health insurance paid by way of payroll deduction; and (3) assure HUSKY [Plan, Part] A coverage requirements for medical assistance not covered by any available employer-sponsored health insurance.

(b) Notwithstanding any provision of the general statutes or any provision established in a contract between an employer and a health insurance carrier, no HUSKY [Plan, Part] A recipient, required to enroll in available employer-sponsored health insurance under this section, shall be prohibited from enrollment in employer-sponsored health insurance due to limitations on enrollment of employees in employer-sponsored health insurance to open enrollment periods.

(c) The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures

implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 3. Section 17b-261m of the General Statutes, as amended by section 79 of public act 13-234, is repealed and the following is substituted in lieu thereof (e*ffective upon passage*):

(a) The Commissioner of Social Services may contract with one or more administrative services organizations to provide care coordination, utilization management, disease management, customer service and review of **appeals** [grievances] for recipients of assistance under **the HUSKY Health Program, as defined in Section 17b-290(16)** [Medicaid, HUSKY Plan, Parts A and B [and the Charter Oak Health Plan]. Such organization may also provide network management, credentialing of providers, monitoring of copayments and premiums and other services as required by the commissioner. [Subject to approval by applicable federal authority, the Department of Social Services shall utilize the contracted organization's provider network and billing systems in the administration of the program.] In order to implement the provisions of this section, the commissioner may establish rates of payment to providers of medical services under this section if the establishment of such rates is required to ensure that any contract entered into with an administrative services organization pursuant to this section is cost neutral to such providers in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality.

(b) Any contract entered into with an administrative services organization, pursuant to subsection (a) of this section, shall include a provision to reduce inappropriate use of hospital emergency department services. Such provision may include intensive case management services and a cost-sharing requirement.

Sec. 4. Section 17b-290 of the General Statutes is repealed and the following is substituted in lieu thereof:

As used in sections 17b-289 to 17b-303, inclusive [,and section 16 of public act 97-1 of the October 29 special session *]:

(1) "Applicant" means an individual over the age of eighteen years who is a natural or adoptive parent or a legal guardian; a caretaker relative, foster parent or stepparent with whom the child resides; [or a noncustodial parent under order of a court or family support magistrate to provide health insurance, who applies for coverage under the HUSKY Plan, Part B on behalf of a child] and shall include a child who is eighteen years of age or emancipated in accordance with the provisions of sections 46b-150 to 46b-150e, inclusive, and who is applying on his own behalf or on behalf of a minor dependent for coverage under such plan;

(2) "Child" means an individual under nineteen years of age;

(3) "Coinsurance" means the sharing of health care expenses by the insured and an insurer in a specified ratio;

(4) "Commissioner" means the Commissioner of Social Services;

(5) "Copayment" means a payment made on behalf of [an enrollee] **a member** for a specified service under [the] HUSKY [Plan, Part] B;

(6) "Cost sharing" means arrangements made on behalf of [an enrollee] **a member** whereby an applicant pays a portion of the cost of health services, sharing costs with the state and includes copayments, premiums, deductibles and coinsurance;

(7) "Deductible" means the amount of out-of-pocket expenses that would be paid for health services on behalf of [an enrollee] **a member** before becoming payable by the insurer;

(8) "Department" means the Department of Social Services;

[(9) "Durable medical equipment" **or "DME"** means [durable medical equipment, as defined in Section 1395x(n) of the Social Security Act]] **equipment that meets all of the following requirements:**

(A) can withstand repeated use;

(B) is primarily and customarily used to serve a medical purpose;

(C) generally is not useful to a person in the absence of an illness or injury; and

(D) is nondisposable;

(9)[(10)] "Eligible beneficiary" means a child who meets the requirements [specified] in section 17b-292, **and the requirements specified in section 2110(b)(2)(B) of the Social Security Act as amended by 10203(b)(2)(D) of the Affordable Care Act** [except a child excluded under the provisions of Subtitle J of Public Law 105-33 or a child of any municipal employee eligible for employer-sponsored insurance on or after October 30, 1997, provided a child of such a municipal employee may be eligible for coverage under the HUSKY Plan, Part B if dependent coverage was terminated due to an extreme economic hardship on the part of the employee, as determined by the commissioner];

[(11) "Enrollee" means an eligible beneficiary who receives services under the HUSKY Plan, Part B;]

[(12)] "Family" means any combination of the following: (A) An individual; (B) the individual's spouse; (C) any child of the individual or such spouse; or (D) the legal guardian of any such child if the guardian resides with the child;]

(10) "Household" has the same meaning as provided in 42 CFR 435.603;

(11) "Household income" has the same meaning as provided in 42 CFR 435.603;

[(13)]**(12)** "HUSKY [Plan, Part] A" means Medicaid provided to children, caretaker relatives, and pregnant **and post-partum** women pursuant to section 17b-261 or 17b-277;

[(14)]**(13)** "HUSKY [Plan, Part] B" means the health insurance plan for children established pursuant to the provisions of sections 17b-289 to 17b-303, inclusive[, and section 16 of public act 97-1 of the October 29 special session *];

(14) "HUSKY C" means Medicaid provided to individuals who are sixty-five years of age or older or who are blind or have a disability;

(15) "HUSKY D" or Medicaid Coverage for the Lowest Income Populations program, means Medicaid provided to non-pregnant low-income adults who are age eighteen to sixty-four, as authorized by Section 102 of Public Act 13-234;

(16)"HUSKY Health" means the combined HUSKY A, HUSKY B, HUSKY C and HUSKY D programs, which provide Medicaid coverage to eligible children, parents, relative caregivers, elders, individuals with disabilities, low-income adults, and pregnant women ;

[(15)]**(17)** "HUSKY Plus [programs]" means [two] **the** supplemental health [insurance programs] **program** established pursuant to section 17b-294a for medically eligible [enrollees] **members** of [the] HUSKY [Plan, Part] B whose medical needs cannot be accommodated within the basic benefit package offered to [enrollees] **members**. [One program] **Husky Plus** shall supplement coverage for those medically eligible [enrollees] **members** with intensive physical health needs [and the other program shall supplement coverage for those medically eligible enrollees with intensive behavioral health needs];

[(16) "Income" means income as calculated in the same manner as under the Medicaid program pursuant to section 17b-261;]

(18) “MAGI-based income” has the same meaning as provided in 42 CFR 435.603;

(19) “Member” means an eligible beneficiary who receives services under Husky A, B or D;

[(17)] **(20)** "Parent" means a natural parent, stepparent, adoptive parent, guardian or custodian of a child;

[(18)] **(21)** "Premium" means any required payment made by an individual to offset or pay in full the cost under [the] HUSKY [Plan, Part] B;

[(19)] **(22)** "Preventive care and services" means: (A) Child preventive care, including periodic and interperiodic well-child visits, routine immunizations, health screenings and routine laboratory tests; (B) prenatal care, including care of all complications of pregnancy; (C) care of newborn infants, including attendance at high-risk deliveries and normal newborn care; (D) WIC evaluations; (E) child abuse assessment required under sections 17a-106a and 46b-129a; (F) preventive dental care for children; and (G) periodicity schedules and reporting based on the standards specified by the American Academy of Pediatrics;

[(20)] **(23)** "Primary and preventive health care services" means the services of licensed physicians, optometrists, nurses, nurse practitioners, midwives and other related health care professionals which are provided on an outpatient basis, including routine well-child visits, diagnosis and treatment of illness and injury, laboratory tests, diagnostic x-rays, prescription drugs, radiation therapy, chemotherapy, hemodialysis, emergency room services, and outpatient alcohol and substance abuse services, as defined by the commissioner;

[(21)] **(24)** “Qualified entity” means any entity: (A) Eligible for payments under a state plan approved under Medicaid and which provides medical services under [the] HUSKY [Plan, Part] A[,] or [B] that is a qualified entity, as defined in 42

USC 1396r-1a, as amended by Section 708 of Public Law 106-554, and that is determined by the commissioner to be capable of making the determination of eligibility. The commissioner shall provide qualified entities with such forms **or information on filing an application electronically** as **is[**are] necessary for an application to be made on behalf of a child under [the] HUSKY [Plan, Part] A and information on how to assist parents, guardians and other persons in completing and filing such forms **or electronic application**;

(25) "Tax dependent" has the same meaning as the term "dependent" under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year;

[(22)] **(26)** "WIC" means the federal Special Supplemental Food Program for Women, Infants and Children administered by the Department of Public Health pursuant to *section 19a-59c*.

Sec. 5. Section 17b-292 of the General Statutes is repealed and the following is substituted in lieu thereof:

[(a)]**(a)** A child who resides in a household with a [family] **household** income which exceeds one hundred **ninety-six** [eighty-five] per cent of the federal poverty level and does not exceed three hundred **eighteen** per cent of the federal poverty level may be eligible for subsidized benefits under [the] HUSKY [Plan, Part] B.

[(b)]**(b)** A child who resides in a household with a [family] **household** income over three hundred **eighteen** per cent of the federal poverty level may be eligible for unsubsidized benefits under [the] HUSKY [Plan, Part] B.

[(c) Whenever a court or family support magistrate orders a noncustodial parent to provide health insurance for a child, such parent may provide for coverage under the HUSKY Plan, Part B.]

(c) [To the extent] **If a HUSKY B member has limited benefit coverage for services that are also covered under HUSKY B** [allowed under federal law,] the commissioner **shall require such other coverage to pay for the goods or services prior to any payment by the HUSKY B program.** [shall not pay for services or durable medical equipment under the HUSKY Plan, Part B if the enrollee has other insurance coverage for the services or such equipment.]

(d) A newborn child who otherwise meets the eligibility criteria for the HUSKY [Plan, Part] B shall be eligible for benefits retroactive to his or her date of birth, provided an application is filed on behalf of the child not later than thirty days after such date. Any uninsured child born in a hospital in this state or in a border state hospital shall be enrolled on an expedited basis in [the] HUSKY [Plan, Part] B, provided (1) the parent or caretaker relative of such child resides in this state, and (2) the parent or caretaker relative of such child authorizes enrollment in the program. The commissioner shall pay any premium cost such family would otherwise incur for the first four months of coverage.

(e) The commissioner shall implement presumptive eligibility for children applying for Medicaid and may, if cost effective, implement presumptive eligibility for children in families with income under three hundred per cent of the federal poverty level applying for [the] HUSKY [Plan, Part] B. Such presumptive eligibility determinations shall be in accordance with applicable federal law and regulations. The commissioner shall adopt regulations, in accordance with chapter 54, to establish standards and procedures for the designation of organizations as qualified entities to grant presumptive eligibility. Qualified entities shall [ensure that,] at the time a presumptive eligibility determination is made, **provide assistance to applicants with the [**a] complet[ed]**ion and submission of an** application [for benefits is submitted to the department] for a full eligibility determination. In establishing such standards and procedures, the commissioner shall ensure the representation

of state-wide and local organizations that provide services to children of all ages in each region of the state.

(f) In accordance with 42 CFR 435.1110, the commissioner shall provide Medicaid during a presumptive eligibility period to individuals who are determined presumptively eligible by a qualified hospital. A hospital making such a presumptive eligibility determination shall provide assistance to individuals in completing and submitting an application for full benefits and with understanding any requirements for verification or other documentation. The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

[(g) The commissioner shall provide for a single point of entry servicer for applicants and enrollees under the HUSKY Plan, Part A and Part B. The commissioner, in consultation with the servicer, shall establish a centralized unit to be responsible for processing all applications for assistance under the HUSKY Plan, Part A and Part B. The department, through its servicer, shall ensure that a child who is determined to be eligible for benefits under the HUSKY Plan, Part A, or the HUSKY Plan, Part B has uninterrupted health insurance coverage for as long as the parent or guardian elects to enroll or re-enroll such child in the HUSKY Plan, Part A or Part B. The commissioner, in consultation with the servicer, and in accordance with the provisions of *section 17b-297*, shall jointly market both Part A and Part B together as the HUSKY Plan and shall develop and implement public information and outreach activities with community programs. Such servicer shall electronically transmit data with respect to enrollment and

disenrollment in the HUSKY Plan, Part A and Part B to the commissioner.

(h) Upon the expiration of any contractual provisions entered into pursuant to subsection (g) of this section, the commissioner shall develop a new contract for single point of entry services. The commissioner may enter into one or more contractual arrangements for such services for a contract period not to exceed seven years. Such contracts shall include performance measures, including, but not limited to, specified time limits for the processing of applications, parameters setting forth the requirements for a completed and reviewable application and the percentage of applications forwarded to the department in a complete and timely fashion. Such contracts shall also include a process for identifying and correcting noncompliance with established performance measures, including sanctions applicable for instances of continued noncompliance with performance measures.

(i) The single point of entry servicer shall send all applications and supporting documents to the commissioner for determination of eligibility. The servicer shall enroll eligible beneficiaries in the applicant's choice of an administrative services organization. If there is more than one administrative services organization, upon enrollment in an administrative services organization, an eligible HUSKY Plan, Part A or Part B beneficiary shall remain enrolled in such organization for twelve months from the date of such enrollment unless (1) an eligible beneficiary demonstrates good cause to the satisfaction of the commissioner of the need to enroll in a different organization, or (2) the beneficiary no longer meets program eligibility requirements.

(j) Not later than ten months after the determination of eligibility for benefits under the HUSKY Plan, Part A and Part B and annually thereafter, the commissioner or the servicer, as the case may be, shall, within existing budgetary resources, mail or, upon request of a participant, electronically transmit an application form to each participant in the plan for the

purposes of obtaining information to make a determination on continued eligibility beyond the twelve months of initial eligibility. To the extent permitted by federal law, in determining eligibility for benefits under the HUSKY Plan, Part A or Part B with respect to family income, the commissioner or the servicer shall rely upon information provided in such form by the participant unless the commissioner or the servicer has reason to believe that such information is inaccurate or incomplete. The Department of Social Services shall annually review a random sample of cases to confirm that, based on the statistical sample, relying on such information is not resulting in ineligible clients receiving benefits under the HUSKY Plan, Part A or Part B. The determination of eligibility shall be coordinated with health plan open enrollment periods.]

[(k)] **(g)** The commissioner shall implement [the] HUSKY [Plan, Part] B while in the process of adopting necessary policies and procedures in regulation form in accordance with the provisions of section 17b-10.

[(l) The commissioner shall adopt regulations, in accordance with chapter 54, to establish residency requirements and income eligibility for participation in HUSKY B and procedures for a simplified mail-in application. Notwithstanding the provisions of section 17b-257b, such regulations shall provide that any child adopted from another country by an individual who is a citizen of the United States and a resident of this state shall be eligible for benefits under the HUSKY Plan, Part B upon arrival in this state.]

Sec. 6. Section 17b-294a of the General Statutes is repealed and the following is substituted in lieu thereof:

(a) The commissioner shall, within available appropriations, establish [two] **a** supplemental health [insurance programs] **program**, to be known as HUSKY Plus [programs], for [enrollees] **members** of the subsidized portions of the HUSKY [Plan, Part] B [with family incomes which do not exceed three hundred **eighteen** per cent of the federal poverty level,] whose medical needs

cannot be accommodated within the basic benefit package offered [enrollees] **to members**. [One program] **HUSKY Plus** shall supplement coverage for those medically eligible [enrollees] **members** with intensive physical health needs [and one shall supplement coverage for those medically eligible enrollees with intensive behavioral health needs].

(b) Within available appropriations, the commissioner shall contract with entities to administer and operate the HUSKY Plus program for [medically eligible enrollees] **members** with intensive physical health needs. Such entities shall be the same entities that the Department of Public Health contracts with to administer and operate the program under Title V of the Social Security Act. The advisory committee established by the Department of Public Health for Title V of the Social Security Act shall be the steering committee for such program, except that such committee shall include representatives of the Departments of Social Services and Children and Families.

[(c) Within available appropriations, the commissioner shall contract with one or more entities to operate the HUSKY Plus program for medically eligible enrollees with intensive behavioral health needs. The steering committee for such program shall be established by the commissioner, in consultation with the Commissioner of Children and Families. The steering committee shall include representatives of the Departments of Social Services and Children and Families.]

[(d)] (c) The acuity standards or diagnostic eligibility criteria, or both, the service benefits package and the provider network for the HUSKY Plus program for intensive physical health needs shall be consistent with that of Title V of the Social Security Act. Such service benefit package shall include powered wheelchairs.

[(e) The steering committee for intensive behavioral health needs shall submit recommendations to the commissioner for acuity standards or diagnostic eligibility criteria, or both, for admission to the program for intensive behavioral health

needs as well as a service benefits package. The criteria shall reflect the severity of psychiatric or substance abuse symptoms, the level of functional impairment secondary to symptoms and the intensity of service needs. The network of community-based providers in the program shall include the services generally provided by child guidance clinics, family service agencies, youth service bureaus and other community-based organizations.]

[(f)] **(d)** The commissioner shall adopt regulations, in accordance with chapter 54, to establish a procedure for the appeal of a denial of coverage under [any of] the HUSKY Plus [programs] **program**. Such regulations shall provide that (1) an appeal of a denial of coverage for a medically eligible [enrollee] **member** with intensive physical health needs shall be taken to the steering committee for intensive physical health needs[, (2) an appeal of a denial of coverage for a medically eligible enrollee with intensive behavioral health needs shall be taken to the steering committee for intensive behavioral health needs, and (3)] **(2)** a medically eligible [enrollee] **member** with intensive physical [or behavioral] health needs may appeal the decision of any such steering committee to the commissioner.

[(g)] **(e)** The commissioner shall contract for an external quality review of the HUSKY Plus programs. [Not later than January 1, 1999, and annually thereafter, the commissioner shall submit a report to the Governor and the General Assembly on the HUSKY Plus programs which shall include an evaluation of the health outcomes and access to care for medically eligible enrollees in the HUSKY Plus programs.]

[(h)] **(f)** On and after the date on which any medically eligible [enrollee] **member** begins receiving benefits under the HUSKY Plus [programs] **program**, such [enrollee] **member** shall not be eligible for services under Title V of the Social Security Act.

[(i) Not later than December 1, 1997, or not less than fifteen days before submission of the state children's health

insurance plan to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, insurance and appropriations and the budgets of state agencies, whichever is sooner, the commissioner shall submit to said joint standing committees of the General Assembly any part of the state children's health insurance plan that refers to the HUSKY Plus programs. Such submission shall address acuity standards and diagnostic eligibility criteria, the service benefit package and coordination between the HUSKY Plan, Part B and the HUSKY Plus programs and coordination with other state agencies. Within fifteen days of receipt of such submission, said joint standing committees of the General Assembly may advise the commissioner of their approval, denial or modifications, if any, of the submission. If the joint standing committees do not concur, the committee chairmen shall appoint a committee on conference which shall be comprised of three members from each joint standing committee. At least one member appointed from each committee shall be a member of the minority party. The report of the committee on conference shall be made to each committee, which shall vote to accept or reject the report. The report of the committee on conference may not be amended. If a joint standing committee rejects the report of the committee on conference, the submission shall be deemed approved. If the joint standing committees accept the report, the committee having cognizance of matters relating to appropriations and the budgets of state agencies shall advise the commissioner of their approval or modifications, if any, of the submission, provided if the committees do not act within fifteen days, the submission shall be deemed approved.]

[(j)] **(g)** The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to establish criteria and specify services for the HUSKY Plus [programs] **program**. Such regulations shall state that the HUSKY Plus [programs]**program** shall give priority [in such programs] to [enrollees] **members** with family incomes at or below two hundred [thirty-five] **forty-nine** per cent of the federal poverty level.

[(k)] (h) As used in this section, "medically eligible [enrollee] **member**" means any [enrollee] **member** with [special needs related to either physical or behavioral health] **intensive physical health needs** who meets the acuity standards or diagnostic eligibility criteria adopted by the commissioner regarding the acuity, diagnosis, functional impairment and intensive service needs of the [enrollee] **member**.

Sec. 7. Section 17b-295 of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) The commissioner shall impose cost-sharing requirements, including the payment of a premium or copayment, in connection with services provided under [the] HUSKY [Plan, Part] B, to the extent permitted by federal law. Copayments under [the] HUSKY [Plan, Part] B, shall be the same as those in effect for active state employees enrolled in a point-of-enrollment health care plan, provided the [family's] **household's** annual combined premiums and copayments do not exceed the maximum annual aggregate cost-sharing requirement. The cost-sharing requirements imposed by the commissioner shall be in accordance with the following limitations:

(1) The commissioner may increase the maximum annual aggregate cost-sharing requirements, provided such cost-sharing requirements shall not exceed five per cent of the [family's] **household's** gross annual income.

(2) In accordance with federal law, the commissioner may impose a premium requirement on families whose income exceeds two hundred [thirty-five] **forty-nine** per cent of the federal poverty level as a component of the family's cost-sharing responsibility and, for the fiscal years ending June 30, 2012, to June 30, 2016, inclusive, may annually increase the premium requirement based on the percentage increase in the Consumer Price Index for medical care services; and

(3) The commissioner shall monitor copayments and premiums under the provisions of subdivision (1) of this subsection.

(b) (1) Except as provided in subdivision (2) of this subsection, the commissioner may impose limitations on the amount, duration and scope of benefits under [the] HUSKY [Plan, Part] B.

(2) The limitations adopted by the commissioner pursuant to subdivision (1) of this subsection shall not preclude coverage of any item of durable medical equipment or service that is medically necessary.

Sec. 8. Section 17b-300 of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

The applicant for [an enrollee] **a HUSKY B member** shall notify the Department of Social Services of any change in circumstance that could affect the enrollee's continued eligibility for coverage under [the] HUSKY [Plan, Part] B within thirty days of such change. An [enrollee] **member** shall be disenrolled if the commissioner determines the [enrollee] **member** is no longer eligible for participation in such plan for reasons including, but not limited to, those specified in section 17b-301 and the nonpayment of premiums.

Sec. 9. Section 17b-303 of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) For purposes of determining eligibility for the HUSKY [Plan, Part] B and to the extent permitted by federal law and to the extent federal financial participation is available, the commissioner may disregard [family] **household** income. Such disregard of [family] **household** income shall allow subsidized coverage for an eligible beneficiary who resides in a household

with a [family] **household** income of not more than three hundred **eighteen** per cent of the federal poverty level. No such income disregard shall have the effect of granting eligibility for a child under the HUSKY [Plan, Part] A.

(b) The commissioner may submit an application for a waiver under Section 1115 of the Social Security Act (1) to authorize the use of funds received under Title XXI of the Social Security Act to establish a non-Medicaid health insurance program for eligible beneficiaries who reside in a household with a [family] **household** income of more than two hundred [thirty-five] **forty-nine** per cent of the federal poverty level but less than three hundred **eighteen** per cent of the federal poverty level, and (2) to allow families under Section 2105(c)(3) of Title XXI of the Social Security Act to purchase health insurance under the HUSKY [Plan, Part] B with a sliding fee scale for [families] **households** with an income up to three hundred **eighteen** per cent of the federal poverty level and at full premium for those uninsured [families] **households** with an income of over three hundred **eighteen** per cent of the federal poverty level. The commissioner may submit an application for a waiver of allowable expenditures in excess of ten per cent under the provisions of Section 2105(c)(2) of Subtitle J of Public Law 105-33.

(c) The commissioner shall submit any application for a federal waiver or proposed modification of any such waiver in connection with [the] HUSKY [Plan, Part] A and [Part] B, except the initial waivers specified under subsection (b) of this section, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, insurance and appropriations and the budgets of state agencies prior to the submission of such application or proposed modification to the federal government in accordance with the provisions of section 17b-8.

(d) If the waiver specified in subdivision (1) of subsection (b) of this section is denied and the income disregard under subsection (a) of this section is not available, uninsured children who reside in a household with a [family] **household**

income of more than two hundred [thirty-five] **forty-nine** per cent of the federal poverty level but less than three hundred **eighteen** per cent of the federal poverty level shall be eligible for unsubsidized benefits under the provisions of subsection (b) of section 17b-292.

Sec. 10. Section 17b-306 of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) The Commissioner of Social Services, in consultation with the Commissioner of Public Health, shall develop and within available appropriations implement a plan for a system of preventive health services for children under [the] HUSKY [Plan, Part] A and [Part] B. The goal of the system shall be to improve health outcomes for all children enrolled in [the] HUSKY **Health** [Plan] and to reduce racial and ethnic health disparities among children. Such system shall ensure that services under the federal Early and Periodic Screening, Diagnosis and Treatment Program are provided to children enrolled in [the] HUSKY [Plan, Part] A.

(b) The plan shall:

(1) Establish a coordinated system for preventive health services for HUSKY [Plan, Part] A and [Part] B beneficiaries including, but not limited to, services under the federal Early and Periodic Screening, Diagnosis and Treatment Program, ophthalmologic and optometric services, oral health care, care coordination, chronic disease management and periodicity schedules based on standards specified by the American Academy of Pediatrics;

(2) Require the Department of Social Services to track the utilization of services in the system of preventive health services by HUSKY [Plan, Part] A and [Part] B beneficiaries to ensure that such beneficiaries receive all the services available under the system and to track the health outcomes of children; and

(3) Include payment methodologies to create financial incentives and rewards for health care providers who participate and provide services in the system, such as case management fees, pay for performance, and payment for technical support and data entry associated with patient registries.

[(c) The Commissioner of Social Services shall develop the plan for a system of preventive health services not later than January 1, 2008, and implement the plan not later than July 1, 2008.

(d) Not later than July 1, 2009, the Commissioner of Social Services shall report, in accordance with the provisions of *section 11-4a*, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, insurance and public health on the plan for a system of preventive health services. The report shall include information on health outcomes, quality of care and methodologies utilized in the plan to improve the quality of care and health outcomes for children.]

Sec. 12. Sec. 17b-304. Regulations.

The commissioner shall implement the policies and procedures necessary to carry out the provisions of sections 17b-294 to 17b-303, inclusive, 17b-257b, **and** 17b-261 [and section 16 of public act 97-1 of the October 29 special session*] while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal within twenty days after implementation. Such policies and procedures shall be valid until the time final regulations are effective.

Sec. 14. Section 17b-261i of the general statutes is repealed.

Section 15. Section 17b-289 of the general statutes is repealed.

Sec. 16. Section 17b-291 of the general statutes is repealed.

Sec. 15. Section 17b-292a of the general statutes is repealed.

Sec. 17. Section 17b-297 of the general statutes is repealed.

Sec. 18. Section 17b-299 of the general statutes is repealed.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): DSS_1 OTC Changes Required for Medicaid Expansion

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Social Services
Liaison: Heather Rossi Phone: (860) 424-5646 E-mail: heather.rossi@ct.gov
Lead agency division requesting this proposal: Division of Health Services
Agency Analyst/Drafter of Proposal: Joel Norwood, Staff Attorney, DSS Office of Legal Counsel, Regulations and Administrative Hearings

Title of Proposal Amending Medicaid Over-the-Counter Drug Coverage Exclusion to Comply with Medicaid Expansion Requirements
Statutory Reference Conn. Gen. Stat. § 17b-280a
Proposal Summary This proposal, while adding very modest additional Medicaid over-the-counter drug coverage, is necessary to comply with federal requirements for the Medicaid expansion, which is projected to bring over $1 billion in federal reimbursement annually. This proposal amends Conn. Gen. Stat. § 17b-280a to add a new exception to the Medicaid coverage exclusion for over-the-counter drugs. This change is necessary to allow coverage of over-the-counter drugs that are required to be included in the benefits package for the Medicaid expansion to non-disabled, non-elderly adults without dependent children (Medicaid for the Lowest Income Populations or "Medicaid expansion") earning up to 138% of the Federal Poverty Level. This amendment authorizes DSS to provide this coverage for any medical assistance program (including the existing Medicaid coverage groups) because DSS, as described in its Medicaid expansion plan submitted pursuant to Section 102 of Public Act 13-234, intends to align the Medicaid expansion benefit package with the Medicaid State Plan benefit package provided to all other Medicaid beneficiaries. At this time, the only additional over-the-counter drugs that would be required to be covered by this change are those listed on the U.S. Preventive Services Task Force A and B Recommendations. Specifically, those drugs include only: (1) low-dose aspirin to prevent cardiovascular disease for men ages 45 to 79 years of age and women ages 55 to 79 years of age when the potential benefit outweighs the potential harm and (2) folic acid for women who are planning or are capable of becoming pregnant (folic acid is already covered for women who are pregnant). See Proposal Background below for additional detail.
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

The Medicaid expansion is governed by federal law added by section 2001 of the Patient Protection and Affordable Care Act. Beginning January 1, 2014, federal law requires the benefit package provided to individuals in the Medicaid expansion to offer ten Essential Health Benefits. 42 U.S.C. §§ 1396a(k)(1) and 1396u-7(b)(5). These requirements apply both to newly eligible individuals under the Medicaid expansion and also to individuals previously included in Connecticut's partial expansion of Medicaid to low-income adults beginning in April 2010 pursuant to 42 U.S.C. § 1396a(k)(2).

Among these 10 Essential Health Benefits ("EHBs"), the ninth benefit listed in the federal statute is "Preventive and wellness services and chronic disease management." 42 U.S.C. § 18022(b)(1)(I), referenced in 42 U.S.C. § 1396u-7(b)(5). In order to implement that requirement, the final federal rule (regulations) adopted by the U.S. Centers for Medicare & Medicaid Services ("CMS") on July 15, 2013, codified all 10 EHBs into federal regulations at 42 C.F.R. § 440.347(a). In the preamble to the final rule, CMS explained that the "Preventive Services" EHB requires states to cover a broad range of preventive services for their Medicaid expansion, including: "[1] 'A' or 'B' services recommended by the United States Preventive Services Task Force; [2] Advisory Committee for Immunization Practices recommended vaccines; [3] preventive care and screening of infants, children and adults recommend by HRSA's Bright Futures program, and [4] additional preventive services for women recommended by the Institute of Medicine." CMS Preamble to Final Rule, 78 Fed. Reg. 42160, 42224 (numbering added for clarity) (Jul. 15, 2013). In response to a public comment on the regulation, CMS declined to codify that list of services in the regulation text of 42 C.F.R. § 440.347, explaining that it was already based on the federal statute in section 2713 of the Public Health Services Act, codified at 42 U.S.C. § 300gg-13 and implementing regulations at 45 C.F.R. § 147.130.

Connecticut's Medicaid program already covers the vast majority of the preventive services included in those guidelines. The only items not currently covered are the over-the-counter medications recommended for individuals with certain diagnoses in the U.S. Preventive Services Task Force ("USPSTF") recommendations. Those over-the-counter drugs are not currently covered because Conn. Gen. Stat. § 17b-280a, which was adopted in 2010, prohibits such coverage except in limited circumstances not applicable to the preventive services requirements. The only preventive services required as part of the EHB that are not covered by Medicaid are the over-the-counter drugs listed in the following three USPSTF recommendations (listed in full at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm):

Topic	Description	Grade	Release Date of Current Recommendation
Aspirin to prevent cardiovascular disease: men	The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A	March 2009
Aspirin to prevent cardiovascular	The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in	A	March 2009

disease: women	gastrointestinal hemorrhage.		
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	May 2009

In working with CMS to prepare the detailed Alternative Benefit Plan that will describe the benefit package to be provided to individuals under the Medicaid expansion, CMS has confirmed that all of these requirements must be met for full compliance with the Medicaid expansion requirements (and associated federal reimbursement). The CMS Medicaid State Plan Amendment template for the Alternative Benefit Plan also confirms this requirement and mandates DSS to describe this coverage, which must, at a minimum, include all of the preventive services required for this EHB.

DSS is working with CMS to establish a compliance plan and timetable so that CMS will deem the plan to be in substantial compliance with federal requirements pending the adoption of this statutory change. Because full compliance with federal requirements (subject to the small flexibility allowed by CMS to enable this statutory change to be adopted) is necessary for reimbursement for the Medicaid expansion, it is essential that this statute is passed during this legislative session.

Because this is a very minor coverage expansion, it will not have a substantial impact on the Medicaid program. All affected constituencies are likely to favor this change because it enables greater access to preventive services for Medicaid beneficiaries.

- **Origin of Proposal** **_X_ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) None.
State As noted above, this coverage is necessary for compliance with federal requirements for the Medicaid expansion. Total federal reimbursement for the Medicaid expansion is estimated to be approximately $770 million in Federal Fiscal Year 2014 and $1.22 billion in Federal Fiscal Year 2015. For the specific coverage enabled to be added by this proposal, only modest increased costs are anticipated because these medications (folic acid and aspirin) are inexpensive and are only required to be covered for individuals with certain diagnoses (described above).
Federal Because the specific coverage enable to be added by this proposal is very inexpensive, the federal budget impact is also modest, based on 100% Federal Financial Participation (*i.e.*, federal match) for the Medicaid expansion population and 50% FFP for the remainder of the Medicaid population.
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The policy and programmatic changes are minor. If this proposal is approved, DSS would need change payment systems to enable reimbursement for aspirin and folic acid for individuals with the specified diagnoses.

Insert fully drafted bill here

Section 17b-280a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Notwithstanding any provision of the general statutes, no payment shall be made under a medical assistance program administered by the Department of Social Services, except for the medical assistance program established pursuant to section 17b-256, for an over-the-counter drug, except for (1) insulin and insulin syringes, (2) nutritional supplements for individuals who are required to be tube fed or who cannot safely ingest nutrition in any other form, and as may be required by

federal law, **[**and**]** (3) effective January 1, 2012, smoking cessation drugs as provided in section 17b-278a and (4) any over-the-counter drugs that are required to be covered pursuant to 42 CFR 440.347, including drugs for individuals with specified diagnoses that are evidence-based items or services with a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force, provided that the Department of Social Services may also pay for such drugs under a medical assistance program or portion thereof that is not subject to 42 CFR 440.347. On or before August 1, 2011, the Commissioner of Social Services shall provide notice to pharmacists who provide services to beneficiaries of a medical assistance program administered by the department that such pharmacists may bill the department for supplies utilized in the treatment of diabetes using the durable medical equipment, medical surgical supply fee schedule. The commissioner shall provide a copy of such notice to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): DSS_1 Comprehensive DSS Revisions

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Social Services

Liaison: Heather Rossi
Phone: 860-5646
E-mail: heather.rossi@ct.gov

Lead agency division requesting this proposal:

Agency Analyst/Drafter of Proposal: Sharon Kopycinski/Marc Shok/Peter Hadler

Title of Proposal

An Act Concerning Payments to Residential Care Homes

Statutory Reference 17b-83, 17b-601, 17b-340

Proposal Summary

This bill is intended to improve the process by which DSS makes payments to licensed residential care homes (RCHs). This improvement is accomplished by permitting the Department to make state supplement benefit payments directly to RCHs instead of through residents. This aligns the payment process with the existing successful process for payments to nursing facilities. In addition to allowing the Department to make direct payments to RCHs, the bill requires RCHs to submit complete and accurate annual rate reports to the Department within 30 days of being notified that they failed to submit a complete and accurate report, or the RCHs will not receive retroactive rate increases. Finally, if a retroactive rate increase results in a current resident of an RCH becoming eligible for state supplement benefits, the Department will be able to provide the RCH a retroactive payment for the period that the eligible resident was in the RCH, up to a maximum of three months.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

The current payment process of state supplement benefits that are owed to a residential care home (RCH) requires that the benefits pass through the resident and then be paid to the RCH. This adds an unnecessary extra step in the payment process and frequently results in difficulties when the RCH is unable to obtain the owed payments from the residents. Making payments directly to the RCHs on a per diem or monthly basis will eliminate the need for payments to pass through residents and is expected to improve payment accuracy and timeliness. The Department currently successfully uses this payment model for payments to nursing facilities for Medicaid clients. RCHs have requested this operational change and the Department believes that it will improve payment accuracy and efficiency.

This bill also seeks to address an area of operational inefficiency involving retroactive rate increases. RCHs frequently fail to timely submit required annual cost reports, which often leads to no rate increase or a rate decrease. When an RCH ultimately submits the required report, the Department calculates a retroactive rate increase. Due to the increase, some residents of RCHs

who were previously ineligible for state supplement benefits become eligible because eligibility for state supplement benefits is linked to RCH payment rates. In order to calculate the amount owed to an RCH because of a retroactive increase, the Department imputes eligibility for state supplement benefits for admitted residents back to the effective date of the increase. This process is cumbersome, time-consuming and error-prone.

The Department proposes a two-pronged approach to improve this situation. In order to reduce the need to provide retroactive rate adjustments that date well back into the past, the Department proposes that the RCHs be required to timely submit their annual cost reports in order to obtain retroactive adjustments. The Department will provide a non-compliant RCH with a 30 day opportunity to submit a complete and accurate cost report. If the non-compliant RCH fails to produce the report in that period, then the RCH will not be eligible for a retroactive rate increase. In order to provide certainty to the RCH regarding the level of retroactive payment, the Department proposes that any resident who becomes eligible for benefits as a result of the increase will be determined to have applied for benefits as of the date of admission to the RCH or ninety days prior to application, whichever is more recent. The Department must limit eligibility retroactivity to ninety days due to Medicaid rules associated with state supplement benefits.

- **Origin of Proposal _X_ New Proposal ___ Resubmission**

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

State

Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Expected improvements in speed and accuracy of payments made to RCHs for care provided to residents receiving state supplement benefits. Expected improvements in DSS accounting of payments made to RCHs. Expected DSS efficiency gains from reduced need to calculate long and complicated payments due to retroactive rate increases.

Insert fully drafted bill here

Section 1. Section 17b-83 of the general statutes is repealed and the following is inserted in lieu thereof (*Effective upon passage*):

The aid granted under the state supplement program or the temporary family assistance program shall be in the form of money payments and shall be made by the commissioner within available Department of Social Services appropriations, directly to the applicant, a licensed residential care home, as defined in section 19a-490, or other person entitled to receive the same at such regular intervals as the Commissioner of Social Services determines, provided the payments of the costs of medical care and such other charges in connection with the care and maintenance of a beneficiary as the commissioner deems necessary and reasonable may be made to the applicant, a licensed residential care home or to those persons furnishing such services by the commissioner. Ninety per cent of clean claims for payments to persons furnishing such services shall be made no later than thirty days from receipt of the request for payment and ninety-nine per cent shall be made within ninety days of such receipt. For the purposes of this section "clean claim" means a claim which can be processed without obtaining additional substantiation from the person furnishing such services or other person entitled to receive payment. A claim submitted by any such person who is under investigation for fraud or abuse shall not be considered a clean claim.

Sec. 2. Section 17b-601 of the general statutes is repealed and the following in inserted in lieu thereof (*Effective upon passage*):

The Commissioner of Social Services shall adopt regulations in accordance with the provisions of chapter 54 establishing the method by which payments are made for recipients of the state supplement program who are residents of licensed residential care homes, as defined in section 19a-490. Such regulations shall provide for the safeguarding of residents' personal funds with respect to any homes that handle such funds. Regulations concerning payment **[**to**]** for residents shall provide for payment to the **[**recipient**]** licensed residential care home for the period during which the recipient makes the home his or her residence, without regard to periods during which the recipient is absent, provided the recipient can reasonably be expected to return to the home before the end of the month following the month in which the recipient leaves the home. If the Department determines that a resident of a home who applies for state supplement benefits is eligible for such benefits, then the Department shall pay the home at a per diem or monthly rate less any applied income due from the resident. Any retroactive adjustment to the rate of such a home by the commissioner that results in money due to such home shall be made to such home directly, and any such adjustment that results in an overpayment to the home shall be paid by the home to the department. If a retroactive adjustment to the rate of such home results in a current resident becoming eligible for state supplement benefits, and such resident applies for state supplement benefits, the department may determine the start date of eligibility for state supplement benefits to be the later of the resident's admission date or the date ninety days prior to the date the department receives the application. The commissioner shall continue to make payments to licensed residential care homes in accordance with reserved bed regulations until the effective date of the regulations adopted pursuant to this section.

Sec. 3. Subsection (a) of section 17b-340 of the general statutes is repealed and the following is inserted in lieu thereof (*Effective upon passage*):

(a) The rates to be paid by or for persons aided or cared for by the state or any town in this state to licensed chronic and convalescent nursing homes, to chronic disease hospitals associated with chronic and convalescent nursing homes, to rest homes with nursing supervision, to licensed residential care homes, as defined by section 19a-490, and to residential facilities for the mentally retarded which are licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as intermediate care facilities for the mentally retarded, for room, board and services specified in licensing regulations issued by the licensing agency shall be determined annually, except as otherwise provided in this subsection, after a public hearing, by the Commissioner of Social Services, to be effective July first of each year except as otherwise provided in this subsection. Such rates shall be determined on a basis of a reasonable payment for such necessary services, which basis shall take into account as a

factor the costs of such services. Cost of such services shall include reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons employed as managers or chief administrators or required to be licensed as nursing home administrators, and compensation for services rendered by proprietors at prevailing wage rates, as determined by application of principles of accounting as prescribed by said commissioner. Cost of such services shall not include amounts paid by the facilities to employees as salary, or to attorneys or consultants as fees, where the responsibility of the employees, attorneys, or consultants is to persuade or seek to persuade the other employees of the facility to support or oppose unionization. Nothing in this subsection shall prohibit inclusion of amounts paid for legal counsel related to the negotiation of collective bargaining agreements, the settlement of grievances or normal administration of labor relations. The commissioner may, in his discretion, allow the inclusion of extraordinary and unanticipated costs of providing services which were incurred to avoid an immediate negative impact on the health and safety of patients. The commissioner may, in his discretion, based upon review of a facility's costs, direct care staff to patient ratio and any other related information, revise a facility's rate for any increases or decreases to total licensed capacity of more than ten beds or changes to its number of licensed rest home with nursing supervision beds and chronic and convalescent nursing home beds. The commissioner may so revise a facility's rate established for the fiscal year ending June 30, 1993, and thereafter for any bed increases, decreases or changes in licensure effective after October 1, 1989. Effective July 1, 1991, in facilities which have both a chronic and convalescent nursing home and a rest home with nursing supervision, the rate for the rest home with nursing supervision shall not exceed such facility's rate for its chronic and convalescent nursing home. All such facilities for which rates are determined under this subsection shall report on a fiscal year basis ending on the thirtieth day of September. Such report shall be submitted to the commissioner by the thirty-first day of December. The commissioner may reduce the rate in effect for a facility which fails to submit a complete and accurate report on or before such date by an amount not to exceed ten per cent of such rate. If a licensed residential care home fails to submit a complete and accurate report, the department shall notify such home of the failure and the home shall have thirty days from the date the notice was issued to submit a complete and accurate report. If a licensed residential care home fails to submit a complete and accurate report within thirty days from the date of notice, such home shall not receive a retroactive rate increase. The commissioner shall annually, on or before the fifteenth day of February, report the data contained in the reports of such facilities to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations. For the cost reporting year commencing October 1, 1985, and for subsequent cost reporting years, facilities shall report the cost of using the

services of any nursing pool employee by separating said cost into two categories, the portion of the cost equal to the salary of the employee for whom the nursing pool employee is substituting shall be considered a nursing cost and any cost in excess of such salary shall be further divided so that seventy-five per cent of the excess cost shall be considered an administrative or general cost and twenty-five per cent of the excess cost shall be considered a nursing cost, provided if the total nursing pool costs of a facility for any cost year are equal to or exceed fifteen per cent of the total nursing expenditures of the facility for such cost year, no portion of nursing pool costs in excess of fifteen per cent shall be classified as administrative or general costs. The commissioner, in determining such rates, shall also take into account the classification of patients or boarders according to special care requirements or classification of the facility according to such factors as facilities and services and such other factors as he deems reasonable, including anticipated fluctuations in the cost of providing such services. The commissioner may establish a separate rate for a facility or a portion of a facility for traumatic brain injury patients who require extensive care but not acute general hospital care. Such separate rate shall reflect the special care requirements of such patients. If changes in federal or state laws, regulations or standards adopted subsequent to June 30, 1985, result in increased costs or expenditures in an amount exceeding one-half of one per cent of allowable costs for the most recent cost reporting year, the commissioner shall adjust rates and provide payment for any such increased reasonable costs or expenditures within a reasonable period of time retroactive to the date of enforcement. Nothing in this section shall be construed to require the Department of Social Services to adjust rates and provide payment for any increases in costs resulting from an inspection of a facility by the Department of Public Health. Such assistance as the commissioner requires from other state agencies or departments in determining rates shall be made available to him at his request. Payment of the rates established hereunder shall be conditioned on the establishment by such facilities of admissions procedures which conform with this section, section 19a-533 and all other applicable provisions of the law and the provision of equality of treatment to all persons in such facilities. The established rates shall be the maximum amount chargeable by such facilities for care of such beneficiaries, and the acceptance by or on behalf of any such facility of any additional compensation for care of any such beneficiary from any other person or source shall constitute the offense of aiding a beneficiary to obtain aid to which he is not entitled and shall be punishable in the same manner as is provided in subsection (b) of section 17b-97. For the fiscal year ending June 30, 1992, rates for licensed residential care homes and intermediate care facilities for the mentally retarded may receive an increase not to exceed the most recent annual increase in the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items. Rates for newly certified intermediate care facilities for the mentally retarded shall not exceed one hundred fifty per cent of the median rate of rates

in effect on January 31, 1991, for intermediate care facilities for the mentally retarded certified prior to February 1, 1991. Notwithstanding any provision of this section, the Commissioner of Social Services may, within available appropriations, provide an interim rate increase for a licensed chronic and convalescent nursing home or a rest home with nursing supervision for rate periods no earlier than April 1, 2004, only if the commissioner determines that the increase is necessary to avoid the filing of a petition for relief under Title 11 of the United States Code; imposition of receivership pursuant to sections 19a-541 to 19a-549, inclusive; or substantial deterioration of the facility's financial condition that may be expected to adversely affect resident care and the continued operation of the facility, and the commissioner determines that the continued operation of the facility is in the best interest of the state. The commissioner shall consider any requests for interim rate increases on file with the department from March 30, 2004, and those submitted subsequently for rate periods no earlier than April 1, 2004. When reviewing a rate increase request the commissioner shall, at a minimum, consider: (1) Existing chronic and convalescent nursing home or rest home with nursing supervision utilization in the area and projected bed need; (2) physical plant long-term viability and the ability of the owner or purchaser to implement any necessary property improvements; (3) licensure and certification compliance history; (4) reasonableness of actual and projected expenses; and (5) the ability of the facility to meet wage and benefit costs. No rate shall be increased pursuant to this subsection in excess of one hundred fifteen per cent of the median rate for the facility's peer grouping, established pursuant to subdivision (2) of subsection (f) of this section, unless recommended by the commissioner and approved by the Secretary of the Office of Policy and Management after consultation with the commissioner. Such median rates shall be published by the Department of Social Services not later than April first of each year. In the event that a facility granted an interim rate increase pursuant to this section is sold or otherwise conveyed for value to an unrelated entity less than five years after the effective date of such rate increase, the rate increase shall be deemed rescinded and the department shall recover an amount equal to the difference between payments made for all affected rate periods and payments that would have been made if the interim rate increase was not granted. The commissioner may seek recovery from payments made to any facility with common ownership. With the approval of the Secretary of the Office of Policy and Management, the commissioner may waive recovery and rescission of the interim rate for good cause shown that is not inconsistent with this section, including, but not limited to, transfers to family members that were made for no value. The commissioner shall provide written quarterly reports to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies and to the select committee of the General Assembly having cognizance of matters relating to aging, that identify each facility requesting an interim rate increase, the amount of the requested rate increase for each facility, the

action taken by the commissioner and the secretary pursuant to this subsection, and estimates of the additional cost to the state for each approved interim rate increase. Nothing in this subsection shall prohibit the commissioner from increasing the rate of a licensed chronic and convalescent nursing home or a rest home with nursing supervision for allowable costs associated with facility capital improvements or increasing the rate in case of a sale of a licensed chronic and convalescent nursing home or a rest home with nursing supervision, pursuant to subdivision (15) of subsection (f) of this section, if receivership has been imposed on such home.

Agency Legislative Proposal - 2014 Session

Document Name: DSS_1 Comprehensive DSS Revisions

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Department of Social Services

Liaison: Heather Rossi
Phone:
E-mail: Heather.Rossi@ct.gov

Lead agency division requesting this proposal:
Department of Social Service – Pharmacy Unit

Agency Analyst/Drafter of Proposal:
Melanie Dillon

Title of Proposal
Substitution of Generic Drugs

Statutory Reference
17b-274 (b) and 20-619 (c)

Proposal Summary

The Department of Social Services (DSS) proposes to revise the requirements for practitioners utilizing electronic prescriptions to prescribe a name brand drug product as "medically necessary." Sections 17b-274 (b) and 20-619 (c) currently require the prescribing practitioner to follow up with written certification that the brand name drug is medically necessary. As a result, the prescribing practitioner is required to send something in writing to the pharmacy even though the electronic prescription was meant to replace the need for a written prescription and allow for more efficiency in the provision of medical care to patients. As far as written and telephonic communications are concerned, the requirements remain the same.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

DSS proposes to change the requirements with respect to electronic prescriptions because the practitioner is unable to write on the electronic prescription. Instead, the practitioner logs into a secure electronic prescription system and selects a "dispense-as-written" or "DAW" code that alerts the pharmacist that a substitution of a generic drug for a brand name drug is not allowed by the prescribing practitioner. The electronic prescription system is a secure system and each physician has a unique log in and password. Electronic prescriptions allow a provider to send an accurate, error-free and understandable prescription directly to the pharmacy. During the process of sending a prescription electronically, the prescribing physician can verify eligibility and formulary data for a patient and view medication history for the patient. Electronic prescribing also helps the providers save time and money. Requiring follow up written notification within 10 days of sending the electronic prescription defeats the purpose of electronic prescriptions. It does not add to the process and creates unnecessary paperwork. Given the current requirements, many providers may opt to send a written prescription when prescribing brand name medication to avoid the two-step process associated with electronic prescribing.

- **Origin of Proposal** **_X_ New Proposal** **___ Resubmission**

If this is a resubmission, please share: *(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* *(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* *(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* *(4) What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Department of Consumer Protection Agency Contact (name, title, phone): John Gadea, Jr., Director, CP Drug Control Division Date Contacted: September 12, via telephone; September 16, shared proposed language via e-mail **We are working with DCP on the language to address their concerns. Language in the bill is a placeholder and will be replaced with compromise. Approve of Proposal _ _ YES ___NO __X_Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES _X_NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The proposed changes would eliminate redundant, unnecessary steps and encourage the use of electronic prescribing.

Subsection (b) of section 17b-274 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(b) A licensed medical practitioner may specify in writing or by a telephonic or electronic communication that there shall be no substitution for the specified brand name drug product in any prescription for a Medicaid recipient, provided (1) the practitioner specifies the basis on which the brand name drug product and dosage form is medically necessary in comparison to a chemically equivalent generic drug product substitution, [and] (2) for written and telephonic communications, the phrase "brand medically necessary" shall be in the practitioner's handwriting on the prescription form or, if the prohibition was communicated by telephonic communication, in the pharmacist's handwriting on such form, and shall not be preprinted or stamped or initialed on such form. If the practitioner specifies by telephonic communication that there shall be no substitution for the specified brand name drug product in any prescription for a Medicaid recipient, written certification in the practitioner's handwriting bearing the phrase "brand medically necessary" shall be sent to the dispensing pharmacy within ten days [.] , and (3) for electronic communications, the prescriber selects the dispense- as- written code indicating that a substitution is not allowed by the prescriber on the certified electronic prescription. A pharmacist shall dispense a generically equivalent drug product for any drug listed in accordance with the Code of Federal Regulations Title 42 Part 447.332 for a drug prescribed for a Medicaid [or state-administered general assistance] recipient unless the [phrase "brand medically necessary" is ordered] the prescribing practitioner has specified that there shall be no substitution for the specified brand name drug product in accordance with this subsection and such pharmacist has received approval to dispense the brand name drug product in accordance with subsection (c) of this section.

Section 20-619 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) For the purposes of *section 20-579* and this section:

(1) "Brand name" means the proprietary or trade name selected by the manufacturer and placed upon a drug product, its container, label or wrapping at the time of packaging;

(2) "Generic name" means the established name designated in the official United States Pharmacopoeia-National Formulary, official Homeopathic Pharmacopoeia of the United States, or official United States Adopted Names or any supplement to any of said publications;

(3) "Therapeutically equivalent" means drug products that are approved under the provisions of the federal Food, Drug and Cosmetic Act for interstate distribution and that will provide essentially the same efficacy and toxicity when administered to an individual in the same dosage regimen;

(4) "Dosage form" means the physical formulation or medium in which the product is intended, manufactured and made available for use, including, but not limited to, tablets, capsules, oral solutions, aerosol, inhalers, gels, lotions, creams, ointments, transdermals and suppositories, and the particular form of any physical formulation or medium that uses a specific technology or mechanism to control, enhance or direct the release, targeting, systemic absorption, or other delivery of a dosage regimen in the body;

(5) "Epilepsy" means a neurological condition characterized by recurrent seizures;

(6) "Seizures" means a disturbance in the electrical activity of the brain; [and]

(7) "Antiepileptic drug" means a drug prescribed for the treatment of epilepsy or a drug used to prevent seizures[.]; and

(8) "Dispense as written (DAW)" means the instruction to the pharmacist forbidding substitution of a generic drug or a therapeutically equivalent product for the specific drug product prescribed.

(b) Except as limited by subsections (c),(e) and (i) of this section, unless the purchaser instructs otherwise, the pharmacist may substitute a generic drug product with the same strength, quantity, dose and dosage form as the prescribed drug product which is, in the pharmacist's professional opinion, therapeutically equivalent. When the prescribing practitioner is not reasonably available for consultation and the prescribed drug does not use a unique delivery system technology, the pharmacist may substitute an oral tablet, capsule or liquid form of the prescribed drug as long as the form dispensed has the same strength, dose and dose schedule and is therapeutically equivalent to the drug prescribed. The pharmacist shall inform the patient or a representative of the patient, and the practitioner of the substitution at the earliest reasonable time.

(c) A prescribing practitioner may specify in writing or by a telephonic or other electronic communication that there shall be no substitution for the specified brand name drug product in any prescription, provided (1)[in any prescription for a Medicaid recipient, such] the practitioner specifies the basis on which the brand name drug product and dosage form is medically necessary in comparison to a chemically equivalent generic name drug product substitution, [and] (2) for written and telephonic communications, the phrase "brand medically necessary" shall be in the practitioner's handwriting on the

prescription form or, if the prohibition was communicated by telephonic communication, in the pharmacist's handwriting on such form, and shall not be preprinted or stamped or initialed on such form. [the phrase "BRAND MEDICALLY NECESSARY", shall be in the practitioner's handwriting on the prescription form or on an electronically produced copy of the prescription form or, if the prohibition was communicated by telephonic or other electronic communication that did not reproduce the practitioner's handwriting, a statement to that effect appears on the form. The phrase "BRAND MEDICALLY NECESSARY" shall not be preprinted or stamped or initialed on the form. If the practitioner specifies by telephonic or other electronic communication that did not reproduce the practitioner's handwriting that there shall be no substitution for the specified brand name drug product in any prescription for a Medicaid recipient, written certification in the practitioner's handwriting bearing the phrase "BRAND MEDICALLY NECESSARY" shall be sent to the dispensing pharmacy not later than ten days after the date of such communication.], and (3) for electronic communications, the prescriber selects the dispense-as-written code indicating that a substitution is not allowed by the prescriber on the certified electronic prescription.

(d) Each pharmacy shall post a sign in a location easily seen by patrons at the counter where prescriptions are dispensed stating that, "THIS PHARMACY MAY BE ABLE TO SUBSTITUTE A LESS EXPENSIVE DRUG PRODUCT WHICH IS THERAPEUTICALLY EQUIVALENT TO THE ONE PRESCRIBED BY YOUR DOCTOR UNLESS YOU DO NOT APPROVE." The printing on the sign shall be in block letters not less than one inch in height.

(e) A pharmacist may substitute a drug product under subsection (b) of this section only when there will be a savings in cost passed on to the purchaser. The pharmacist shall disclose the amount of the savings at the request of the patient.

(f) Except as provided in subsection (g) of this section, when a pharmacist dispenses a substitute drug product as authorized by subsection (b) of this section, the pharmacist shall label the prescription container with the name of the dispensed drug product. If the dispensed drug product does not have a brand name, the prescription label shall indicate the generic name of the drug product dispensed along with the name of the drug manufacturer or distributor.

(g) A prescription dispensed by a pharmacist shall bear upon the label the name of the drug in the container unless the prescribing practitioner writes "DO NOT LABEL", or words of similar import, on the prescription or so designates in an oral or electronic transmission of the prescription.

(h) Neither the failure to instruct by the purchaser as provided in subsection (b) of this section nor the fact that a sign has been posted as provided in subsection (d) of this section shall be a defense on the part of a pharmacist against a suit brought by any such purchaser.

(i) Upon the initial filling or renewal of a prescription that contains a statistical information code based upon the most recent edition of the International Classification of Diseases indicating the prescribed drug is used for the treatment of epilepsy or to prevent seizures, a pharmacist shall not fill the prescription by using a different drug manufacturer or distributor of the prescribed drug, unless the pharmacist (1)

provides prior notice of the use of a different drug manufacturer or distributor to the patient and the prescribing practitioner, and (2) obtains the written consent of the patient's prescribing practitioner. For purposes of obtaining the consent of the patient's prescribing practitioner required by this subsection, a pharmacist shall notify the prescribing practitioner via electronic mail or facsimile transmission. If the prescribing practitioner does not provide the necessary consent, the pharmacist shall fill the prescription without such substitution or use of a different drug manufacturer or distributor or return the prescription to the patient or to the patient's representative for filling at another pharmacy. If a pharmacist is unable to contact the patient's prescribing practitioner after making reasonable efforts to do so, such pharmacist may exercise professional judgment in refilling a prescription in accordance with the provisions of subsection (b) of *section 20-616*. For purposes of this subsection, "pharmacy" means a place of business where drugs and devices may be sold at retail and for which a pharmacy license was issued pursuant to *section 20-594*, including a hospital-based pharmacy when such pharmacy is filling prescriptions for employees and outpatient care, and a mail order pharmacy licensed by this state to distribute in this state. "Pharmacy" does not include a pharmacy serving patients in a long-term care facility, other institutional facility or a pharmacy that provides prescriptions for inpatient hospitals.

(j) The commissioner, with the advice and assistance of the commission, shall adopt regulations, in accordance with chapter 54, to carry out the provisions of this section.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): DSS_1 Comprehensive DSS Revisions

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Social Services

Liaison: Heather Rossi
Phone: 860-424-5646
E-mail: Heather.rossi@ct.gov

Lead agency division requesting this proposal: Office of Legal Counsel, Regulations and Administrative Hearings

Agency Analyst/Drafter of Proposal: Graham Shaffer

Title of Proposal: An Act Concerning the State-Administered General Assistance Program

Statutory Reference: General Statutes §§ 17b-104, 17b-191 and 17b-194 to 17b-196, inclusive

Proposal Summary

Sections 1, 2 and 3 – At one time, federal rules governing who may be included in a family assistance unit under the Temporary Assistance for Needy Families program (TANF) were fairly strict, and included narrow guidelines with respect to who was considered within the necessary degree of relationship to a child to be included in the child's family assistance unit. Thus, guardians, those applying for guardianship and certain caretaker relatives generally could not be included in the state's TANF-funded program, Temporary Family Assistance (TFA). Instead, these unusual families were captured by the entirely state-funded State-Administered General Assistance program (SAGA).

However, TANF rules subsequently underwent a liberalization whereby most caretaker relatives, regardless of the degree to which they were related to a child, could be included in the family assistance unit. Thereafter, the U.S. Department of Health and Human Services, through the Administration for Children and Families, released a guidance opinion explaining that, if a state's law provides that a guardian or other individual fulfilling parental responsibilities stands in loco parentis to children in their care, the state may include such guardian or other individual in the child's family assistance unit under TANF law. Because Connecticut law does recognize that guardians and certain other individuals stand in loco parentis to the children in their care, DSS utilized this opinion to transfer qualifying family assistance units from SAGA to federally-funded TFA.

The net result of all of these changes is that the state no longer has families with children on the SAGA ranks. Instead, these families have been transferred to TFA. In fact, because these families are now eligible for TFA, they are explicitly ineligible for continued assistance pursuant to SAGA. See General Statutes § 17b-191(a) ("No individual shall be eligible for cash assistance under [SAGA] if eligible for cash assistance under any other state or federal cash assistance program."). Accordingly, changes have been

made in sections 1 and 2 of this proposed bill that would eliminate outdated references to families in SAGA.

Next, changes in section 2 resolve ambiguity that results from using the qualifier "single" in subsection (b) of section 17b-191, which establishes standards of assistance under SAGA, when describing unemployable and transitional persons without also expressly discussing how married couples comprised of spouses who each qualify for SAGA should be treated. Presently, in the absence of express language concerning married couples without dependent children, the agency has calculates benefits for these married couples as it would for families that include dependent children; that is to say, the standard of assistance is based on a percentage of the TFA payment standard and varies depending on the region of the state in which the recipient lives. This has led to somewhat absurd results, however. For instance, a married couple without dependent children living in region A of the state (western Connecticut) would receive more than twice the amount of assistance that an unmarried unemployable person would receive in the same region. This is problematic because, as a general rule, DSS expects married couples to pool their resources and therefore typically affords a smaller assistance award per married recipient, not a greater award, as is the case in these instances in SAGA. Further, calculating benefits for married couples in this manner results in the spouses' transitional/unemployable status not being taken into consideration. Thus, a married couple will receive the same amount of benefits regardless of whether one or both of them is transitional and not required to pay for shelter, a status that would otherwise entitle an unmarried recipient to approximately $50 per month, as described in subdivision (3) of subsection (b) of section 17b-191.

The department is currently in the process of drafting new regulations that will correct these problems and treat each spouse as an individual recipient for purposes calculating benefits. DSS proposes eliminating the confusing "single" qualifier in this subsection to rectify the ambiguity described above. DSS also proposes including language that clarifies that the asset limit established in subsection (c) of this section—$250 per person—will be $500 dollars per married couple. This is a rule already followed by the department.

The remaining changes in these sections are technical and conforming changes. For instance, the department proposes eliminating outdated references to town-administered general assistance still contained in subsection (b) of section 17b-191, and including a sentence at the end of subsection (b) of section 17b-191 that cross-references 17b-104, which applies an annual cost of living adjustment to the standards of assistance set forth in 17b-191(b).

Section 4 - Changes to this section are merely intended to remove outdated provisions that were in place when towns continued to administer a general assistance program prior to the state takeover now known as SAGA.

Section 5 – The purpose of section 17b-196 is to ensure that families receiving assistance pursuant to TFA will continue to receive that assistance at the same level after a child who remains in high school is disqualified for continued assistance under federal rules due to attaining the age of 18. In other words, section 17b-196 is intended to pay benefits to a TFA family assistance unit, out of state SAGA funds, for the incremental difference between what the family was receiving when the child qualified as a member of the assistance unit and what the family now receives after the child's disqualification from TFA due to

age. However, it recently came to the department's attention that, as written, the provision could be read to justify assistance at the level an individual person would receive pursuant to TFA, and that the provision arguably conflicts with the standards of assistance set forth in section 17b-191. DSS is recommending minor clarifying changes that it believes will eliminate this ambiguity and more clearly reflect the intent of the provision.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

This proposal makes minor and technical changes to, resolves ambiguity in, and removes outdated provisions concerning statutes governing the state-administered general assistance program.

- **Origin of Proposal** **_X__ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

See proposal summary for a comprehensive summary.

Insert fully drafted bill here

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (c) of section 17b-104 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(c) On and after July 1, 1995, the payment standards for families receiving assistance under the temporary family assistance program **[**and the state-administered general assistance program**]** shall be equal to seventy-three per cent of the AFDC standards of need in effect June 30, 1995.

Sec. 2. Section 17b-191 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) Notwithstanding the provisions of sections 17b-190, 17b-195 and 17b-196, the Commissioner of Social Services shall operate a state-administered general assistance program in accordance with this section and sections 17b-131, 17b-193, 17b-194, 17b-197 and 17b-198. Notwithstanding any provision of the general statutes, on and after October 1, 2003, no town shall be reimbursed by the state for any general assistance medical benefits incurred after September 30, 2003, and on and after March 1, 2004, no town shall be reimbursed by the state for any general assistance cash benefits or general assistance program administrative costs incurred after February 29, 2004.

(b) No earlier than September 1, 2003, but not later than October 1, 2003, the state-administered general assistance program pursuant to this section **[**and any general assistance program operated by a town**]** shall provide cash assistance of (1) two hundred dollars per month **[**to a single**]** for an unemployable person upon determination of such person's unemployability; (2) two hundred dollars per month for a **[**single**]** transitional [individual**]** person who is required to pay for shelter; and (3) fifty dollars per month for a **[**single**]** transitional **[**individual**]** person who is not required to pay for shelter. **[**No earlier than September 1, 2003, but not later than October 1, 2003, eligible families shall receive cash assistance in an amount that is fifty dollars less than the standard of assistance such family would receive under the temporary family assistance program.**]** The standard of assistance paid for individuals residing in rated boarding facilities **[**,**]** shall remain at the level in effect on August 31, 2003. No **[**individual**]** person shall be eligible for cash assistance under the program if eligible for cash assistance under any other state or federal cash assistance program. The standards of assistance set forth in this subsection shall be subject to annual increases, as described in subsection (b) of section 17b-104 of the general statutes.

(c) To be eligible for cash assistance under the program, a person [shall**]** (1) shall be (A) eighteen years of age or older; (B) a minor found by a court to be emancipated pursuant to section 46b-150; **[**(C) under eighteen years of age and a member of a family eligible for cash or medical assistance under the program**]**; or **[**(D)**]** (C) under eighteen years of age and the commissioner determines good cause for such person's eligibility, and (2) shall not have assets exceeding two hundred fifty dollars or, if such person is married, such person and his or her spouse shall not have assets exceeding five hundred dollars. In determining eligibility, the commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran. No person who is a substance abuser

and refuses or fails to enter available, appropriate treatment shall be eligible for cash assistance under the program until such person enters treatment. No person whose benefits from the temporary family assistance program have terminated as a result of time-limited benefits or for **[**compliance**]** failure to comply with a program requirement shall be eligible for cash assistance under the program.

(d) Prior to or upon discontinuance of assistance, a person previously determined to be a transitional **[**individual**]** person may petition the commissioner to review the determination of his or her status. In such review, the commissioner shall consider factors, including, but not limited to: (1) Age; (2) education; (3) vocational training; (4) mental and physical health; and (5) employment history and shall make a determination of such person's ability to obtain gainful employment.

Sec. 3. Subsection (a) of section 17b-194 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) For the purposes of this section and sections 17b-131, 17b-191 to 17b-193, inclusive, 17b-195, 17b-197 and 17b-198, (1) an "employable person" means one (A) who is sixteen years of age or older but less than sixty-five years of age; and (B) who has no documented physical or mental impairment prohibiting such person from working or participating in an education, training or other work readiness program, or who has such an impairment which is expected to last less than two months, as determined by the commissioner; (2) an "unemployable person" means a person who (A) is under sixteen years of age or sixty-five years of age or older or fifty-five years of age or older with a history of chronic unemployment; (B) has a physical or mental impairment prohibiting such person from working or participating in an education, training or other work-readiness program, which is expected to last at least six months, as determined by the commissioner; (C) is pending receipt of supplemental security income, Social Security income or financial assistance through another program administered by the Department of Social Services; (D) is needed to care for a child under two years of age or to care for an incapacitated child or spouse; (E) is a full-time high school student in good standing; or (F) is a VISTA volunteer; and (3) a "transitional **[**individual**]** person" means **[**a person**]** one (A) who has a documented physical or mental impairment which prevents employment and is expected to last at least two months, but less than six months, as determined by the commissioner, and who has a recent connection to the labor market, unless circumstances precluded participation in

the labor force, as determined by the commissioner; or (B) whose determination of unemployability or disability, as defined by the commissioner, is pending and who provides medical documentation of a severe physical or mental impairment which is expected to last at least six months. A person who is a substance abuser shall be required to participate in treatment, including counseling, and shall be eligible for assistance while waiting for treatment.

Sec. 4. Section 17b-195 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

Notwithstanding any provision of the general statutes, when a person who is ineligible for financial assistance due to his or her employability status is currently in or enters a residential substance abuse treatment facility, **[**the town**]** the Department of Social Services or the Department of Mental Health and Addiction Services shall pay his or her room and board while at such facility **[**as an expense reimbursable under the general assistance program by the Department of Social Services or the Department of Mental Health and Addiction Services**]**, provided the person is eligible to receive medical assistance. **[**The town shall be responsible for these costs until the date upon which the administration of the general assistance program is assumed by the state or is officially delegated to a town by the Commissioner of Social Services, at which time the Department of Social Services or the Department of Mental Health and Addiction Services shall assume these costs.**]** Such assistance shall be paid directly to the treatment facility at a rate established by the Department of Social Services or negotiated by the Department of Mental Health and Addiction Services.

Sec. 5. Section 17b-196 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

[A**]** Notwithstanding the provisions of subsection (c) of section 17b-191 of the general statutes, a person (1) at least eighteen years of age and under twenty-one years of age, (2) living with his or her family **[**which**]** that is receiving benefits under the temporary family assistance program, and (3) who would be an eligible dependent in such program if under the age of eighteen shall be eligible for state-administered general assistance in the amount of assistance such person would be eligible for as a dependent in such family under the temporary family assistance program.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): DSS_ChildSupport_Name Change

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Department of Social Services

Liaison: **Heather Rossi**
Phone: **860.424.5646**
E-mail: **heather.rossi@ct.gov**

Lead agency division requesting this proposal:
Bureau of Child Support Enforcement

Agency Analyst/Drafter of Proposal:
David Mulligan, Director; Beth Rude, Public Assistance Consultant

Title of Proposal
An Act Concerning Renaming the Bureau of Child Support Enforcement to Office of Child Support Services.

Statutory Reference CGS §: 1-24; 4a-12; 17b-93; 17b-179; 29-1g; 46b-88; 46b-130; 46b-172; 46b-213d; 46b-213f; 46b-213w; 46b-218; 46b-231; 52-362; 52-362f; 52-362i.

- **Origin of Proposal** **_x__ New Proposal** **___ Resubmission**

Change the name of the Bureau of Child Support Enforcement to the Office of Child Support Services to better reflect the nature of the services we provide to all parents and caretakers of children.

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name**: Judicial Branch, Court Operations, Support Enforcement Services, Family Support Magistrates**
Agency Contact (name, title, phone): **David Iaccarino, Deputy Director, Family, Support and Juvenile Matters, 860/263-2734; Charisse Hutton, Director, Support Enforcement Services, 860/569-6233 x 3361; Sandra Sosnoff Baird, Chief Family Support Magistrate.**
Date Contacted:

Approve of Proposal **_x__** YES ___NO ___Talks Ongoing

Agency Name: **Office of the Attorney General, Collections/Child Support Unit**
Agency Contact (name, title, phone): **Sean Kehoe, Assistant Attorney General, Department Head of the Collections and Child Support Unit, 860/808-5150.**
Date Contacted:

Approve of Proposal **_X__** YES ___NO _Talks Ongoing
Summary of Affected Agency's Comments: **The IV-D partners generally agree that the name change will be beneficial to our program and clients by better communicating our mission**.

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) **None.**
State **Within existing resources. There will be printed and electronic resources which will need to be updated with the new name.**
Federal **None.**
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The name Bureau of Child Support Enforcement is not adequate to fully describe the programs and services our Office has to offer the public. These services include those offered within the John S. Martinez Fatherhood Initiative of Connecticut that is focused on changing the systems that can improve fathers' ability to be fully and positively involved in the lives of their children, as well as: case initiation; location of parents; establishment of legal paternity; establishment of financial and medical support orders; collection, distribution and disbursement of child support payments in IV-D and Non-IV-D cases.

Insert fully drafted bill here

An Act Concerning Renaming the Bureau of Child Support Enforcement to the Office of Child Support Services.

Section 1. Subdivision (20) of section 1-24 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(20) family relations counselors employed by the Judicial Department and support enforcement officers and investigators employed by the Department of Social Services [Bureau of Child Support Enforcement] Office of Child Support Services and the Judicial Department, in the performance of their assigned duties;

Sec. 2. Subsection (c) of section 4a-12 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(c) For purposes of this section, "liable relative" means the husband or wife of any person receiving public assistance or aided, cared for or treated in a state humane institution, as defined in said section 17b-222, and the father and mother of any such person under the age of eighteen years, but shall not include the parent or parents whose financial liability for a child is determined by the [Bureau of Child Support Enforcement] Office of Child Support Services under subsection (b) of section 17b-179. The Commissioner of Administrative Services, in consultation with the Secretary of the Office of Policy and Management, shall adopt regulations in accordance with the provisions of chapter 54 establishing: (1) A uniform contribution scale for liable relatives based upon ability to pay and the administrative feasibility of collecting such contributions, provided no such liable relative shall contribute an amount in excess of twelve per cent of the remainder, if any, after the state median income, adjusted for family size, has been deducted from such liable relative's taxable income for federal income tax purposes, or if such federal income tax information is unavailable, from such relative's taxable income, as calculated from other sources, including, but not limited to, information pertaining to wages, salaries and commissions as provided by such relative's employer; (2) the manner in which the Department of Administrative Services shall determine and periodically reinvestigate the ability of such liable relatives to pay; and (3) the manner in which the department shall waive such contributions upon determination that such contribution would pose a significant financial hardship upon such liable relatives.

Sec. 3. Subsection (d) of section 17b-93 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(d) Notwithstanding any provision of the general statutes, whenever funds are collected pursuant to this section or section 17b-94, and the person who otherwise would have been entitled to such funds is subject to a court-ordered current or arrearage child support payment obligation in a IV-D support case, such funds shall first be paid to the state for reimbursement of Medicaid funds granted to such person for medical expenses incurred for injuries related to a legal claim by such person which was the subject of the state's lien and such funds shall then be paid to the [Bureau of Child Support Enforcement] Office of Child Support Services for distribution pursuant to the federally mandated child support distribution system implemented pursuant to subsection (j) of section 17b-179. The remainder, if any, shall be paid to the state for payment of previously provided assistance through the state supplement program, medical assistance program, aid to families with dependent children program, temporary family assistance program or state-administered general assistance program.

Sec. 4. Subsections (a) to (h), inclusive, of section 17b-179 of the general statutes are repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(a) There is created within the Department of Social Services the [Bureau of Child Support Enforcement] Office of Child Support Services. The bureau shall be administered by a director and shall act as the single and separate organizational unit to coordinate, plan and publish the state child support enforcement plan for the implementation of Title IV-D of the Social Security Act, as amended, as required by federal law and regulations. The bureau shall provide for the development and implementation of all child support services, including the administration of withholding of earnings, in accordance with the provisions of Title IV-D of the Social Security Act, as amended.

(b) (1) The Commissioner of Social Services shall investigate the financial condition of the parent or parents of: (A) Any child applying for or receiving

assistance under (i) the temporary family assistance program pursuant to section 17b-112, which may be referred to as "TFA" for the purposes of this section, or (ii) the Medicaid program pursuant to section 17b-261, (B) any child seeking IV-D child support enforcement services pursuant to subdivision (1) of subsection (h) of this section, and (C) any child committed to the care of the Commissioner of Children and Families who is receiving payments in the foster care program and for whom a referral to the [Bureau of Child Support Enforcement] Office of Child Support Services is made under section 46b-130, and shall determine the financial liability of such parent or parents for the child.

(2) The [Bureau of Child Support Enforcement] Office of Child Support Services may, upon notice to the obligor and obligee, redirect payments for the support of all such children to either the state of Connecticut or the present custodial party, as their interests may appear, provided neither the obligor nor the obligee objects in writing within ten business days from the mailing date of such notice. Any such notice shall be sent by first class mail to the most recent address of such obligor and obligee, as recorded in the state case registry pursuant to section 46b-218, and a copy of such notice shall be filed with the court or family support magistrate if both the obligor and obligee fail to object to the redirected payments within ten business days from the mailing date of such notice. All payments shall be distributed as required by Title IV-D of the Social Security Act.

(3) Notwithstanding subdivision (2) of this subsection or subparagraph (F) of subdivision (1) of subsection (u) of section 46b-231, the [Bureau of Child Support Enforcement] Office of Child Support Services or a support enforcement agency under cooperative agreement with the[Bureau of Child Support Enforcement] Office of Child Support Services shall redirect payments for the support of children described in subparagraphs (A)(i) and (C) of subdivision (1) of this subsection to the state of Connecticut effective on the date of the assistance grant. Upon such redirection, the [Bureau of Child Support Enforcement] Office of Child Support Services or support enforcement agency shall notify the obligor and obligee as described in subdivision (2) of this subsection if assistance is being received by a new custodial party on behalf of such child and, if an objection to redirection is received in accordance with said subdivision (2), shall refund to the obligee of the support order any money retained by the state during the period of redirection that is due such obligee.

(c) The [Bureau of Child Support Enforcement] Office of Child Support Services shall enter into cooperative agreements with appropriate officials of the Judicial Branch and law enforcement officials to assist in administering the child support enforcement plan and with respect to other matters of common concern in the area of child support enforcement. Officers of the Judicial Branch and law enforcement officials authorized and required to enter into cooperative agreements with the [Bureau of Child Support Enforcement] Office of Child Support Services include, but are not limited to, officials of the Superior Court and the office of the Attorney General. Such cooperative agreements shall contain performance standards to address the mandatory provisions of both state and federal laws and federal regulations concerning child support.

(d) The [Bureau of Child Support Enforcement] Office of Child Support Services shall have authority to determine on a periodic basis whether any individuals who owe child support obligations are receiving unemployment compensation. In IV-D cases, the bureau may authorize the collection of any such obligations owed by an individual receiving unemployment compensation through an agreement with the individual or a court order pursuant to section 52-362, under which a portion of the individual's unemployment compensation is withheld and forwarded to the state acting by and through the IV-D agency. As used in this section, "unemployment compensation" means any compensation payable under chapter 567, including amounts payable by the administrator of the unemployment compensation law pursuant to an agreement under any federal law providing for compensation, assistance or allowances with respect to unemployment.

(e) The [Bureau of Child Support Enforcement] Office of Child Support Services shall enter into purchase of service agreements with other state officials, departments and agencies which do not have judicial or law enforcement authority, including, but not limited to, the Commissioner of Administrative Services, to assist in administering the child support enforcement plan. The [Bureau of Child Support Enforcement] Office of Child Support Services shall have authority to enter into such agreements with the Labor Commissioner and to withhold unemployment compensation pursuant to subsection (d) of this section and section 31-227.

(f) The [Bureau of Child Support Enforcement] Office of Child Support Services shall have the sole responsibility to make referrals to the federal Parent Locator Service established pursuant to 88 Stat. 2353 (1975), 42 USC 653, as amended, for the purpose of locating deserting parents.

(g) The [Bureau of Child Support Enforcement] Office of Child Support Services shall have the sole responsibility to make recommendations to the Governor and the General Assembly for needed program legislation to ensure implementation of Title IV-D of the Social Security Act, as amended.

(h) (1) The [Bureau of Child Support Enforcement] Office of Child Support Services shall provide, or arrange to provide through one or more of the state officials, departments and agencies, the same services for obtaining and enforcing child support orders in cases in which children are not beneficiaries of TFA, Medicaid or foster care as in cases where children are the beneficiaries of TFA, Medicaid or foster care. Such services shall also be made available to residents of other states on the same terms as to residents of this state. Support services in cases other than TFA, Medicaid or foster care will be provided upon application to the [Bureau of Child Support Enforcement] Office of Child Support Services by the person seeking to enforce a child support obligation and the payment of an application fee, pursuant to the provisions of subsection (i) of this section.

(2) In addition to the application fee, the [Bureau of Child Support Enforcement] Office of Child Support Services may assess costs incurred for the establishment, enforcement or modification of a support order in cases other than TFA, Medicaid or foster care. Such assessment shall be based on a fee schedule adopted by the Department of Social Services pursuant to chapter 54. The fee schedule to be charged in such cases shall be made available to any individual upon request. The [Bureau of Child Support Enforcement] Office of Child Support Services shall adopt procedures for the notification of Superior Court judges and family support magistrates when a fee has been assessed upon an obligee for support services and a Superior Court judge or a family support magistrate shall order the obligor to pay any such assessment to the [Bureau of Child Support Enforcement] Office of Child Support Services. In cases where such order is not entered, the obligee shall pay an amount based on a sliding scale not to exceed the obligee’s ability to pay. The Department of Social Services shall adopt such sliding scale pursuant to chapter 54.

(3) The [Bureau of Child Support Enforcement] Office of Child Support Services shall also, in the case of an individual who never received temporary assistance for needy families and for whom the state has collected at least five hundred dollars of support in a one-year period, impose an annual fee of twenty-five dollars for each case in which services are furnished.

Sec. 5. Subsection (l) of section 17b-179 of the general statues is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(l) The [Bureau of Child Support Enforcement] Office of Child Support Services shall arrange to provide a single centralized automated system for the reporting of collections on all accounts established for the collection of all IV-D support orders. Such reporting shall be made available to the Family Support Magistrate Division and to all state agencies which have a cooperative agreement with the IV-D agency. Such automated system shall include a state case registry which complies with federal law and regulations. The state case registry shall contain information on each support order established or modified in this state.

Sec. 6. Section 29-1g of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

The Commissioner of Emergency Services and Public Protection may appoint not more than six persons nominated by the Commissioner of Social Services as special policemen in the [Bureau of Child Support Enforcement] Office of Child Support Services of the Department of Social Services for the service of any warrant or capias mittimus issued by the courts on child support matters. Such appointees, having been sworn, shall serve at the pleasure of the Commissioner of Emergency Services and Public Protection and, during such tenure, shall have all the powers conferred on state policemen and state marshals.

Sec. 7. Subdivision (1) of subsection (a) of section 46b-88 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(1)"Issuing agency" means an agency providing child support enforcement services, as defined in subsection (b) of section 46b-231, and includes the [Bureau of Child Support Enforcement] Office of Child Support Services within the Department of Social Services and Support Enforcement Services within Judicial Branch Court Operations; and

Sec. 8. Section 46b-130 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

The parents of a minor child for whom care or support of any kind has been provided under the provisions of this chapter shall be liable to reimburse the state for such care or support to the same extent, and under the same terms and conditions, as are the parents of recipients of public assistance. Upon receipt of foster care maintenance payments under Title IV-E of the Social Security Act by a minor child, the right of support, past, present and future, from a parent of such child shall, by this section, be assigned to the Commissioner of Children and Families, and the parents shall assist the commissioner in pursuing such support. On and after October 1, 2008, such assignment shall apply only to such support rights as accrue during the period of assistance, not to exceed the total amount of assistance provided to the child under Title IV-E. Referral by the commissioner shall promptly be made to the [Bureau of Child Support Enforcement] Office of Child Support Services of the Department of Social Services for pursuit of support for such minor child in accordance with the provisions of section 17b-179. Any child who reimburses the state under the provisions of subsection (l) of section 46b-129 for any care or support such child received shall have a right of action to recover such payments from such child's parents.

Sec. 9. Subdivision (3) of subsection (b) of section 46b-172 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(3) Payments under such agreement shall be made to the petitioner, except that in IV-D support cases, as defined in subsection (b) of section 46b-231, payments shall be made to the [Bureau of Child Support Enforcement] Office of Child Support Services or its designated agency and distributed as required by Title IV-D of the Social Security Act. In IV-D support cases, the IV-D agency or a support enforcement agency under cooperative agreement with the IV-D agency may, upon notice to the obligor and obligee, redirect payments for the support of any child receiving child support enforcement services either to the state of Connecticut or to the present custodial party, as their interests may appear, provided neither the obligor nor the obligee objects in writing within ten business days from the mailing date of such notice. Any such notice shall be sent by first class mail to the most recent address of such obligor and obligee, as recorded in the state case registry pursuant to section 46b-218, and a copy of such notice shall be filed with the court or family support magistrate if both the obligor and obligee fail to object to the redirected payments within ten business days from the mailing date of such notice.

Sec. 10. Subsection (a) of section 46b-213d of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(a) The [Bureau of Child Support Enforcement] Office of Child Support Services of the Department of Social Services or its designated collection agent, and any tribunal shall disburse promptly any amounts received pursuant to a support order, as directed by the order. The bureau, agent or tribunal shall furnish to a requesting party or tribunal of another state a certified statement by the custodian of the record of the amounts and dates of all payments received.

Sec. 11. Subsection (b) of section 46b-213f of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(b) Upon receipt of the documents, Support Enforcement Services, with the assistance of the [Bureau of Child Support Enforcement] Office of Child Support Services within the Department of Social Services, as appropriate, without initially seeking to register the order, shall consider and, if appropriate, use any administrative procedure authorized by the law of this state to enforce a support order or an income withholding order, or both. If the obligor does not contest administrative enforcement, the order need not be registered. If the obligor contests the validity or administrative enforcement of the order, the support enforcement agency shall file the order with Support Enforcement Services of the Superior Court to be recorded in the registry of support orders of the Family Support Magistrate Division.

Section 12. Subdivisions (5) and (6) of subsection (c) of section 46b-213w of the general statutes are repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(5) Notice of the right to seek the assistance of the [Bureau of Child Support Enforcement] Office of Child Support Services of the Department of Social Services and the toll-free telephone number at which the bureau can be contacted;

(6) A claim form which shall include (A) a list of the most common defenses and exemptions to such income withholding order in a manner which allows the obligor to check any of the defenses and exemptions which apply; (B) a space where the obligor may briefly explain the obligor's claim or defense; (C) a space where the obligor may initiate a request for services to modify the support order, and the address of the [Bureau of Child Support Enforcement] Office of Child Support Services of the Department of Social Services to which such request may be sent; (D) a space for the obligor to provide the obligor's address and the name of the town in which the obligor principally conducts the obligor's work for the employer; (E) a space for the obligor to sign the obligor's name; (F) the address of Support Enforcement Services to which the claim form is to be sent in order to

contest the validity or enforcement of the income withholding order; and (G) space for the employer to state the date upon which the form was actually delivered to the obligor.

Section 13. Subsection (m) of section 46b-213w of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(m) If the claim form requests services to modify the support order, the [Bureau of Child Support Enforcement] Office of Child Support Services shall assist the obligor to file a motion for modification with the appropriate tribunal of the state of continuing exclusive jurisdiction in accordance with the law of that jurisdiction. The receipt of the request for modification shall constitute a request for Title IV-D services, but the bureau may require the making of a formal application. Such assistance shall include, but is not limited to, providing the obligor with information about how such a motion is filed, contacting the state of continuing exclusive jurisdiction on behalf of the obligor to obtain appropriate forms, and transmitting such forms and applicable information to the appropriate tribunal in such state.

Sec. 14. Subsection (3) of section 46b-218 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(3) “State case registry” means the database included in the automated system established and maintained by the [Bureau of Child Support Enforcement] Office of Child Support Services under subsection (l) of section 17b-179 which database shall contain information on each support order established or modified in the state.

Sec. 15. Subdivision (4) of subsection (b) of section 46b-231 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(4) "[Bureau of Child Support Enforcement] Office of Child Support Services " means a division within the Department of Social Services established pursuant to section 17b-179;

Sec. 16. Subdivision (12) of subsection (b) of section 46b-231 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(12) "IV-D agency" means the [Bureau of Child Support Enforcement] Office of Child Support Services within the Department of Social Services, established pursuant to section 17b-179 and authorized to administer the child support program mandated by Title IV-D of the Social Security Act;

Sec. 17. Subdivision (4) of subsection (s) of section 46b-231 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(4) Review child support orders (A) in non-TFA IV-D support cases (i) at the request of either parent or custodial party subject to a support order, or (ii) upon receipt of information indicating a substantial change in circumstances of any party to the support order, (B) in TFA cases, at the request of the [Bureau of Child Support Enforcement] Office of Child Support Services, or (C) as necessary to comply with federal requirements for the child support enforcement program mandated by Title IV-D of the Social Security Act, and initiate an action before a family support magistrate to modify such support order if it is determined upon such review that the order substantially deviates from the child support guidelines established pursuant to section 46b-215a. A requesting party under subparagraph (A)(i) or (B) of this subdivision shall have a right to such review every three years

without proving a substantial change in circumstances, but more frequent reviews shall be made only if such requesting party demonstrates a substantial change in circumstances. There shall be a rebuttable presumption that any deviation of less than fifteen per cent from the child support guidelines is not substantial and any deviation of fifteen per cent or more from the guidelines is substantial. Modification may be made of such support order without regard to whether the order was issued before, on or after May 9, 1991. In determining whether to modify a child support order based on a substantial deviation from such child support guidelines, consideration shall be given to the division of real and personal property between the parties set forth in any final decree entered pursuant to chapter 815j and the benefits accruing to the child as the result of such division. No order for periodic payment of support may be subject to retroactive modification, except that the family support magistrate may order modification with respect to any period during which there is a pending motion for modification of a support order from the date of service of notice of such pending motion to the opposing party pursuant to section 52-50.

Sec. 18. Subdivision (1) of subsection (a) of section 52-362 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(1) “Dependent” means a spouse, former spouse or child entitled to payments under a support order, provided Support Enforcement Services of the Superior Court or the state acting under an assignment of a dependent’s support rights or under an application for child support enforcement services shall, through an officer of Support Enforcement Services or the[Bureau of Child Support Enforcement] Office of Child Support Services within the Department of Social Services or an investigator of the Department of Administrative Services or the Attorney General, take any action which the dependent could take to enforce a support order;

Sec. 19. Subsection (e) of section 52-362 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(e) A withholding order shall issue in the amount necessary to enforce a support order against only such nonexempt income of the obligor as exceeds the greater of (1) eighty-five per cent of the first one hundred forty-five dollars per week of disposable income, or (2) the amount exempt under Section 1673 of Title 15 of the United States Code, or against any lesser amount which the court or family support magistrate deems equitable. Subject to subsection (d) of section 46b-88, the withholding order shall secure payment of past and future amounts due under the support order and an additional amount computed in accordance with the child support guidelines established in accordance with section 46b-215a, to be applied toward liquidation of any arrearage accrued under such order, unless contested by the obligor after a notice has been served pursuant to subsection (c) of this section, in which case the court or family support magistrate may determine the amount to be applied toward the liquidation of the arrearage found to have accrued under prior order of the court or family support magistrate. In no event shall such additional amount be applied if there is an existing arrearage order from the court or family support magistrate in a IV-D support case, as defined in subdivision (13) of subsection (b) of section 46b-231. Any investigator or other authorized employee of the [Bureau of Child Support Enforcement] Office of Child Support Services within the Department of Social Services, or any officer of Support Enforcement Services of the Superior Court, may issue a withholding order entered by the Superior Court or a family support magistrate pursuant to subsection (b) of this section, and shall issue a withholding order pursuant to this subsection when the obligor becomes subject to withholding under subsection (c) of this section. On service of the order of withholding on an existing or any future employer or other payer of income, and until the support order is fully satisfied or modified, the order of withholding is a continuing lien and levy on the obligor’s income as it becomes due.

Sec. 20. Subsection (h) of section 52-362 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(h) Service of any process under this section, including any notice, may be made in accordance with section 52-57, or by certified mail, return receipt requested. If service is made on behalf of the state, it may be made by an authorized employee of Support Enforcement Services, by an investigator or other officer of the [Bureau of Child Support Enforcement] Office of Child Support Services within the Department of Social Services, by an investigator of the Department of Administrative Services or by the Attorney General. Service of income withholding orders by Support Enforcement Services or by an investigator or other officer of said bureau upon an employer under this section may be made in accordance with section 52-57, by certified mail, return receipt requested, by first class mail or electronically, provided the employer agrees to accept service made electronically.

Sec. 21. Subsection (p) of section 52-362 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(p) All withholding orders issued under this section shall be payable to the state disbursement unit established and maintained by the Commissioner of Social Services in accordance with subsection (j) of section 17b-179. The state disbursement unit shall insure distribution of all money collected under this section to the dependent, the state and the support enforcement agencies of other states, as their interests may appear, within two business days. Each dependent who is not receiving child support enforcement services, as defined in subsection (b) of section 46b-231, shall be notified upon the issuance of a withholding order pursuant to this section, that such services are offered free of charge by the State of Connecticut upon application to the [Bureau of Child Support Enforcement] Office of Child Support Services within the Department of Social Services.

Sec. 22. Subdivision (1) of subsection (a) of section 52-362f of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(1) "Agency" means the [Bureau of Child Support Enforcement] Office of Child Support Services within the Department of Social Services of this state and, when the context requires, means either the court or agency of any other jurisdiction with functions similar to those defined in this section, including the issuance and enforcement of support orders.

Sec. 23. Subsection (g) of section 52-362f of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014):*

(g) An income withholding order under this section shall direct payment to the [Bureau of Child Support Enforcement] Office of Child Support Services or its designated collection agent. The bureau or its designated agent shall promptly distribute payments received pursuant to an income withholding order or garnishment based on a support order of another jurisdiction entered under this section to the agency or person designated pursuant to subdivision (5) of subsection (a) of section 46b-213h. A support order entered pursuant to subsection (d) of this section does not nullify and is not nullified by a support order made by a court of this state pursuant to any other section of the general statutes or a support order made by a court of any other state. Amounts collected by any withholding of income shall be credited against the amounts accruing or accrued for any period under any support orders issued either by this state or by another jurisdiction.

Sec. 24. Sec. 52-362i of the general statues is repealed and the following is substituted in lieu thereof *(Effective October 1, 2014)*

If the court or family support magistrate finds that (1) an obligor is delinquent on payment of child support, and (2) future support payments are in jeopardy, or (3) the obligor has exhibited or expressed an intention not to pay any such support, the court or family support magistrate may order the obligor to provide a cash deposit not to exceed the amount of four times the current monthly support and arrearage

obligation, to be held in escrow by the [Bureau of Child Support Enforcement] Office of Child Support Services or Support Enforcement Services. Any funds from such cash deposit may be disbursed by the [Bureau of Child Support Enforcement] Office of Child Support Services or Support Enforcement Services to the custodial parent upon a determination by said bureau or Support Enforcement Services that the obligor has failed to pay the full amount of the monthly support obligation. Payment shall be in an amount that, when combined with the obligor's payment, would not exceed the monthly support obligation. Payment from such cash deposit shall not preclude a finding of delinquency during the period of time in which the obligor failed to pay current support.

Statement of Purpose: Changing the name of the Bureau of Child Support Enforcement to the Office of Child Support Services better communicates the mission of the program to our clients and the public.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): DSS_ChildSupport_Capias Reasonable Health Care Coverage

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Social Services
Liaison: Heather Rossi Phone: 860 424-5646 E-mail: heather.rossi@ct.gov
Lead agency division requesting this proposal: **Bureau of Child Support Enforcement**
Agency Analyst/Drafter of Proposal: David Mulligan, Director; Dean Festa, Public Assistance Consultant

Title of Proposal **An Act Concerning Capias Mittimus Orders and Reasonable Cost for Health Care Coverage in IV-D Cases.**
Statutory Reference CGS 17b-745, 46b-84, 46b-171, 46b-215, 52-56(d)
Proposal Summary 1. **Reasonable cost for health care coverage-** Standardize the methodology for determining reasonable cost for health care coverage from two percentage rates based on net income to a single gross income percentage of five percent. *2.* **Service of capias mittimus by judicial marshals-** Permit judicial marshals to execute capias mittimus orders using a copy of the original document, as state marshals and special policemen are allowed to do.
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

1. **Reasonable cost for health care coverage-** "Reasonable cost" sets the standard that courts and family support magistrates use in determining the appropriateness of various health care coverage orders. Reasonable cost is presently computed uses two different percentage rates. When a noncustodial parent is deemed a low income obligor pursuant to the child support guidelines schedule, reasonable cost is defined as five percent of net income. In all other cases, reasonable cost is seven and one half percent of net income. One uniform percentage based on gross income would be simpler for courts and family support magistrates to apply, clearer for parties and employers to understand, and easier for state agencies to administer.

2. **Service of capias mittimus by judicial marshals-** CGS §52-56(d) permits the use of a copy of a capias mittimus document for service of process. The current statute limits the use of copies to state marshals and special police officers. The present proposal would expand the statute to add judicial marshals to the list of individuals authorized to execute a capias by means of a copy.

- **Origin of Proposal** **__X_ New Proposal** **___ Resubmission**

1. Judicial Branch- Family Support Magistrate Division, Support Enforcement Services and the Department of Social Services
2. Judicial Branch- Support Enforcement Services and Department of Social Services-Bureau of Child Support Enforcement

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Judicial Branch Support Enforcement Services
Agency Contact Charisse Hutton, Director (860) 569-6233
Date Contacted: on going
Approve of Proposal **1,2,** _X__ YES ___NO ___Talks Ongoing

Agency Name: Judicial Branch Family Support Magistrate Division
Agency Contact Chief FSM Sandra Sosnoff-Baird- (203) 503-6830
Date Contacted: on going
Approve of Proposal **1** _X__ YES ___NO ___Talks Ongoing

Agency Name: Judicial Branch- Court Operations
Agency Contact Joanna Greenfield (860) 263-2734
Date Contacted: on going
Approve of Proposal **2** __X_ YES ___NO __Talks Ongoing-no position

Agency Name: Office of Attorney General
Agency Contact Sean Kehoe-Assistant Attorney General- (860) 808-5150
Date Contacted: on going
Approve of Proposal **1** _X__ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? YES _X__NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

1. None
2. None

State

1. None

2. Yes* see below

Federal

1. None
2. None

Additional notes on fiscal impact

2. **Service of capias mittimus by judicial marshals** -*The expansion of this statute to include judicial marshals would further assist in reducing capias mittimus backlogs and in reducing costs associated with the execution of the documents. Moreover, in the event that a judicial marshal executes the capias mittimus, that obviates the state's need to pay a state marshal for the service, and consequently saves the state money.

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

1. **Reasonable cost for health insurance coverage-** This provision would standardize the percentage used to determine reasonable cost for health insurance. When making a reasonable cost finding the court or family support magistrate would now have a single percentage thus simplifying this component of the court order. The use of one standardized percentage would also eliminate future court appearances as no longer would a motion to modify be necessary should the obligors level of income change, thus removing a burden from the courts and obligor. Further, the use of one standard percentage based on gross income would be less confusing to employers, who are tasked with making the determination if the cost of the health insurance coverage they would be offering the obligor was within the percentage stipulated by the court.

2. **Service of capias mittimus by Judicial Marshals** – In 2006 CGS §52-56(d) was expanded to permit state marshals and special police officers to serve capias mittimus orders utilizing a copy of the original document. The proposed legislation would similarly permit judicial marshals to execute capias mittimus using a copy of the original document. The expansion of this statute to include judicial marshals would further assist in reducing capias mittimus backlogs and in reducing costs associated with the execution of the documents. Providing the capias mittimus order in a timely manner to the judicial marshals at a courthouse where criminal and motor vehicle matters are being heard will increase the likelihood of effectuating the arrest.


STATE OF CONNECTICUT
QUI TRANSTULIT SUSTINET

An Act Concerning Capias Mittimus and Reasonable Cost for Health care Coverage in IV-D Cases

Sec. 1. Subparagraph (A) of subdivision (2) of subsection (a) of section 17b-745 of the general statutes is repealed and the following is substituted in lieu of thereof (*effective October 1, 2014*)

(2) (A) The court or family support magistrate shall include in each support order in a IV-D support case a provision for the health care coverage of the child. Such provision may include an order for either parent or both parents to provide such coverage under any or all of clauses (i), (ii) or (iii) of this subparagraph.

(i) The provision for health care coverage may include an order for either parent to name any child as a beneficiary of any medical or dental insurance or benefit plan carried by such parent or available to such parent at a reasonable cost, as described in clause (iv) of this subparagraph. If such order requires the parent to maintain insurance available through an employer, the order shall be enforced using a National Medical Support Notice as provided in section 46b-88.

(ii) The provision for health care coverage may include an order for either parent to: (I) Apply for and maintain coverage on behalf of the child under the HUSKY Plan, Part B; or (II) provide cash medical support, as described in clauses (v) and (vi) of this subparagraph. An order under this clause shall be made only if the cost to the parent obligated to maintain coverage under the HUSKY Plan, Part B, or provide cash medical support is reasonable as described in clause (iv) of this subparagraph. An order under subclause (I) of this clause shall be made only if insurance coverage as described in clause (i) of this subparagraph is unavailable at reasonable cost to either parent, or inaccessible to the child.

(iii) An order for payment of the child's medical and dental expenses, other than those described in subclause (II) of clause (v) of this subparagraph, that are not covered by insurance or reimbursed in any other manner shall be entered in accordance with the child support guidelines established pursuant to section 46b-215a.

(iv) Health care coverage shall be deemed reasonable in cost if [: (I)] <u>such health care coverage does not exceed five percent of the gross income of</u> [T] the parent obligated to maintain such coverage<u>. Gross income shall be determined in accordance with</u> [would qualify as a low-income obligor under] the child support guidelines established pursuant to section 46b-215a, based solely on such parent's income<u>.</u>[, and the cost does not exceed five per cent of such parent's net income; or (II) the parent obligated to maintain such coverage would not qualify as a low-income obligor under such guidelines and the cost does not exceed seven and one-half per cent of such parent's net income. In either case, net income shall be determined in accordance with the child support guidelines established pursuant to section 46b-215a.] If a parent obligated to maintain insurance must obtain coverage for himself or herself to comply

with the order to provide coverage for the child, reasonable cost shall be determined based on the combined cost of coverage for such parent and such child.

(v) Cash medical support means: (I) An amount ordered to be paid toward the cost of premiums for health insurance coverage provided by a public entity, including the HUSKY Plan, Part A or Part B, except as provided in clause (vi) of this subparagraph, or by another parent through employment or otherwise, or (II) an amount ordered to be paid, either directly to a medical provider or to the person obligated to pay such provider, toward any ongoing extraordinary medical and dental expenses of the child that are not covered by insurance or reimbursed in any other manner, provided such expenses are documented and identified specifically on the record. Cash medical support, as described in subclauses (I) and (II) of this clause, may be ordered in lieu of an order under clause (i) of this subparagraph to be effective until such time as health insurance that is accessible to the child and reasonable in cost becomes available, or in addition to an order under clause (i) of this subparagraph, provided the total cost to the obligated parent of insurance and cash medical support is reasonable, as described in clause (iv) of this subparagraph. An order for cash medical support shall be payable to the state or the custodial party, as their interests may appear, provided an order under subclause (I) of this clause shall be effective only as long as health insurance coverage is maintained. Any unreimbursed medical and dental expenses not covered by an order issued pursuant to subclause (II) of this clause are subject to an order for unreimbursed medical and dental expenses pursuant to clause (iii) of this subparagraph.

(vi) Cash medical support to offset the cost of any insurance payable under the HUSKY Plan, Part A or Part B, shall not be ordered against a noncustodial parent who is a low-income obligor, as defined in the child support guidelines established pursuant to section 46b-215a, or against a custodial parent of children covered under the HUSKY Plan, Part A or Part B.

Sec. 2. Subparagraph (D) of subdivision (2) of subsection (f) of section 46b-84 of the general statutes is repealed and the following is substituted in lieu thereof (*effective October 1, 2014*):

(2) The court shall include in each support order a provision for the health care coverage of the child who is subject to the provisions of subsection (a) or (b) of this section. Such provision may include an order for either parent or both parents to provide such coverage under any or all of subparagraphs (A), (B) or (C) of this subdivision.

(A) The provision for health care coverage may include an order for either parent to name any child as a beneficiary of any medical or dental insurance or benefit plan carried by such parent or available to such parent at a reasonable cost, as described in subparagraph (D) of this subdivision. If such order in a IV-D support case requires the parent to maintain insurance available through an employer, the order shall be enforced using a National Medical Support Notice as provided in section 46b-88.

(B) The provision for health care coverage may include an order for either parent to: (i) Apply for and maintain coverage on behalf of the child under the HUSKY Plan, Part B; or (ii) provide cash medical support, as described in subparagraphs (E) and (F) of this subdivision. An order under this subparagraph shall be made only if the cost to the parent obligated to maintain the coverage under the HUSKY Plan, Part B, or provide cash medical support is reasonable, as described in subparagraph (D) of this subdivision. An order under clause (i) of this subparagraph shall be made only if insurance coverage as described in subparagraph (A) of this subdivision is unavailable at reasonable cost to either parent, or inaccessible to the child.

(C) An order for payment of the child's medical and dental expenses, other than those described in clause (ii) of subparagraph (E) of this subdivision, that are not covered by insurance or reimbursed in any other manner shall be entered in accordance with the child support guidelines established pursuant to section 46b-215a.

(D) Health care coverage shall be deemed reasonable in cost if [: (I)] such health care coverage does not exceed five percent of the gross income of [The] the parent obligated to maintain such coverage. Gross income shall be determined in accordance with [would qualify as a low-income obligor under] the child support guidelines established pursuant to section 46b-215a, based solely on such parent's income.[, and the cost does not exceed five per cent of such parent's net income; or (II) the parent obligated to maintain such coverage would not qualify as a low-income obligor under such guidelines and the cost does not exceed seven and one-half per cent of such parent's net income. In either case, net income shall be determined in accordance with the child support guidelines established pursuant to section 46b-215a.] If a parent obligated to maintain insurance must obtain coverage for himself or herself to comply with the order to provide coverage for the child, reasonable cost shall be determined based on the combined cost of coverage for such parent and such child.

(E) Cash medical support means: (i) An amount ordered to be paid toward the cost of premiums for health insurance coverage provided by a public entity, including the HUSKY Plan, Part A or Part B, except as provided in subparagraph (F) of this subdivision, or by another parent through employment or otherwise, or (ii) an amount ordered to be paid, either directly to a medical provider or to the person obligated to pay such provider, toward any ongoing extraordinary medical and dental expenses of the child that are not covered by insurance or reimbursed in any other manner, provided such expenses are documented and identified specifically on the record. Cash medical support, as described in clauses (i) and (ii) of this subparagraph may be ordered in lieu of an order under subparagraph (A) of this subdivision to be effective until such time as health insurance that is accessible to the child and reasonable in cost becomes available, or in addition to an order under subparagraph (A) of this subdivision, provided the combined cost of insurance and cash medical support is reasonable, as defined in subparagraph (D) of this subdivision. An order for cash medical support shall be payable to the state or the custodial party, as their interests may appear, provided an order under clause (i) of this subparagraph shall be effective only as long as health insurance coverage is maintained. Any

unreimbursed medical and dental expenses not covered by an order issued pursuant to clause (ii) of this subparagraph are subject to an order for unreimbursed medical and dental expenses pursuant to subparagraph (C) of this subdivision.

(F) Cash medical support to offset the cost of any insurance payable under the HUSKY Plan, Part A or Part B, shall not be ordered against a noncustodial parent who is a low-income obligor, as defined in the child support guidelines established pursuant to section 46b-215a, or against a custodial parent of children covered under the HUSKY Plan, Part A or Part B.

Sec. 3. Subdivision (2) of section 46b-171 of the general statutes is repealed and the following is substituted in lieu thereof (effective October 1, 2014)

(A) The provision for health care coverage may include an order for either parent to name any child as a beneficiary of any medical or dental insurance or benefit plan carried by such parent or available to such parent at a reasonable cost as described in subparagraph (D) of this subdivision. If such order requires the parent to maintain insurance available through an employer, the order shall be enforced using a National Medical Support Notice as provided in section 46b-88.

(B) The provision for health care coverage may include an order for either parent to: (i) Apply for and maintain coverage on behalf of the child under the HUSKY Plan, Part B; or (ii) provide cash medical support, as described in subparagraphs (E) and (F) of this subdivision. An order under this subparagraph shall be made only if the cost to the parent obligated to maintain coverage under the HUSKY Plan, Part B, or provide cash medical support is reasonable, as described in subparagraph (D) of this subdivision. An order under clause (i) of this subparagraph shall be made only if insurance coverage as described in subparagraph (A) of this subdivision is unavailable at reasonable cost to either parent, or inaccessible to the child.

(C) An order for payment of the child's medical and dental expenses, other than those described in clause (ii) of subparagraph (E) of this subdivision, that are not covered by insurance or reimbursed in any other manner shall be entered in accordance with the child support guidelines established pursuant to section 46b-215a.

(D) Health care coverage shall be deemed reasonable in cost if [: (I)] <u>such health care coverage does not exceed five percent of the gross income of</u> [The] <u>the</u> parent obligated to maintain such coverage<u>. Gross income shall be determined in accordance with</u> [would qualify as a low-income obligor under] the child support guidelines established pursuant to section 46b-215a, based solely on such parent's income<u>.</u>[, and the cost does not exceed five per cent of such parent's net income; or (II) the parent obligated to maintain such coverage would not qualify as a low-income obligor under such guidelines and the cost does not exceed seven and one-half per cent of such parent's net income. In either case, net income

shall be determined in accordance with the child support guidelines established pursuant to section 46b-215a.] If a parent obligated to maintain insurance must obtain coverage for himself or herself to comply with the order to provide coverage for the child, reasonable cost shall be determined based on the combined cost of coverage for such parent and such child.

(E) Cash medical support means (i) an amount ordered to be paid toward the cost of premiums for health insurance coverage provided by a public entity, including the HUSKY Plan, Part A or Part B, except as provided in subparagraph (F) of this subdivision, or by another parent through employment or otherwise, or (ii) an amount ordered to be paid, either directly to a medical provider or to the person obligated to pay such provider, toward any ongoing extraordinary medical and dental expenses of the child that are not covered by insurance or reimbursed in any other manner, provided such expenses are documented and identified specifically on the record. Cash medical support, as described in clauses (i) and (ii) of this subparagraph, may be ordered in lieu of an order under subparagraph (A) of this subdivision to be effective until such time as health insurance that is accessible to the child and reasonable in cost becomes available, or in addition to an order under subparagraph (A) of this subdivision, provided the total cost to the obligated parent of insurance and cash medical support is reasonable, as described in subparagraph (D) of this subdivision. An order for cash medical support shall be payable to the state or the custodial party, as their interests may appear, provided an order under clause (i) of this subparagraph shall be effective only as long as health insurance coverage is maintained. Any unreimbursed medical and dental expenses not covered by an order pursuant to clause (ii) of this subparagraph are subject to an order for unreimbursed medical and dental expenses pursuant to subparagraph (C) of this subdivision.

(F) Cash medical support to offset the cost of any insurance payable under the HUSKY Plan, Part A or Part B, shall not be ordered against a noncustodial parent who is a low-income obligor, as defined in the child support guidelines established pursuant to section 46b-215a, or against a custodial parent of children covered under the HUSKY Plan, Part A or Part B.

Sec. 4. Subdivision (2) of section 46b-215 of the general statutes is repealed and the following substituted in lieu thereof: (October 1, 2014)

(2) Any such support order in a IV-D support case shall include a provision for the health care coverage of the child. Such provision may include an order for either parent or both parents to provide such coverage under any or all of subparagraphs (A), (B) or (C) of this subdivision.

(A) The provision for health care coverage may include an order for either parent to name any child as a beneficiary of any medical or dental insurance or benefit plan carried by such parent or available to such parent at a reasonable cost, as defined in subparagraph (D) of this subdivision. If such order requires the parent to maintain insurance available through an employer, the order shall be enforced using a

National Medical Support Notice as provided in section 46b-88.

(B) The provision for health care coverage may include an order for either parent to: (i) Apply for and maintain coverage on behalf of the child under the HUSKY Plan, Part B; or (ii) provide cash medical support, as described in subparagraphs (E) and (F) of this subdivision. An order under this subparagraph shall be made only if the cost to the parent obligated to maintain coverage under the HUSKY Plan, Part B, or provide cash medical support is reasonable, as defined in subparagraph (D) of this subdivision. An order under clause (i) of this subparagraph shall be made only if insurance coverage as described in subparagraph (A) of this subdivision is unavailable at reasonable cost to either parent, or inaccessible to the child.

(C) An order for payment of the child's medical and dental expenses, other than those described in clause (ii) of subparagraph (E) of this subdivision, that are not covered by insurance or reimbursed in any other manner shall be entered in accordance with the child support guidelines established pursuant to section 46b-215a.

(D) Health care coverage shall be deemed reasonable in cost if [: (I)] such health care coverage does not exceed five percent of the gross income of [The] the parent obligated to maintain such coverage. Gross income shall be determined in accordance with [would qualify as a low-income obligor under] the child support guidelines established pursuant to section 46b-215a, based solely on such parent's income.[, and the cost does not exceed five per cent of such parent's net income; or (II) the parent obligated to maintain such coverage would not qualify as a low-income obligor under such guidelines and the cost does not exceed seven and one-half per cent of such parent's net income. In either case, net income shall be determined in accordance with the child support guidelines established pursuant to section 46b-215a.] If a parent obligated to maintain insurance must obtain coverage for himself or herself to comply with the order to provide coverage for the child, reasonable cost shall be determined based on the combined cost of coverage for such parent and such child.

(E) Cash medical support means (i) an amount ordered to be paid toward the cost of premiums for health insurance coverage provided by a public entity, including the HUSKY Plan, Part A or Part B, except as provided in subparagraph (F) of this subdivision, or by another parent through employment or otherwise, or (ii) an amount ordered to be paid, either directly to a medical provider or to the person obligated to pay such provider, toward any ongoing extraordinary medical and dental expenses of the child that are not covered by insurance or reimbursed in any other manner, provided such expenses are documented and identified specifically on the record. Cash medical support, as described in clauses (i) and (ii) of this subparagraph, may be ordered in lieu of an order under subparagraph (A) of this subdivision to be effective until such time as health insurance that is accessible to the child and reasonable in cost becomes available, or in addition to an order under subparagraph (A) of this subdivision, provided the total cost to the obligated parent of insurance and cash medical support is

reasonable, as described in subparagraph (D) of this subdivision. An order for cash medical support shall be payable to the state or the custodial party, as their interests may appear, provided an order under clause (i) of this subparagraph shall be effective only as long as health insurance coverage is maintained. Any unreimbursed medical and dental expenses not covered by an order issued pursuant to clause (ii) of this subparagraph are subject to an order for unreimbursed medical and dental expenses pursuant to subparagraph (C) of this subdivision.

(F) Cash medical support to offset the cost of any insurance payable under the HUSKY Plan, Part A or Part B, shall not be ordered against a noncustodial parent who is a low-income obligor, as defined in the child support guidelines established pursuant to section 46b-215a, or against a custodial parent of children covered under the HUSKY Plan, Part A or Part B.

Sec. 5. Subsection (d) of section 52-56 of the general statutes is repealed and the following is substituted in lieu thereof (effective October 1, 2014)

(d) The execution or service of any capias issued pursuant to section 52-143 or 54-2a or any warrant or capias mittimus issued by a court or family support magistrate in a family support matter may be made in any precinct in the state by any state marshal of any precinct or any special policeman appointed under section 29-1g, or any judicial marshal subject to the authority granted pursuant to 46b-225, having such capias, warrant or capias mittimus, or a copy thereof made by any photographic, micrographic, electronic imaging or other process, which clearly and accurately copies such original document, in his hands for service.