General Assembly

Raised Bill No. 955

January Session, 2021

LCO No. **3831**

Referred to Committee on HUMAN SERVICES

Introduced by:
(HS)

AN ACT CONCERNING OUTDATED DEPARTMENT OF SOCIAL SERVICES STATUTES.

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

Section 1. Subsection (a) of section 16a-41a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(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 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:

(A) Criteria for determining which households are to receive

emergency **[**and weatherization**]** assistance;

(B) A description of systems used to ensure referrals to other energy assistance programs and the taking of simultaneous applications, as required under section 16a-41;

(C) A description of outreach efforts;

(D) Estimates of the total number of households eligible for assistance under the program and the number of households in which one or more elderly or physically disabled individuals eligible for assistance reside;

(E) Design of a basic grant for eligible households that does not discriminate against such households based on the type of energy used for heating; and

(F) A payment plan for fuel deliveries beginning November 1, 2018, that ensures a vendor of deliverable fuel who completes deliveries authorized by a community action agency that contracts with the commissioner to administer a fuel assistance program is paid by the community action agency not later than thirty business days after the date the community action agency receives an authorized fuel slip or invoice for payment from the vendor;

(2) Not later than January thirtieth, annually, a report covering the preceding months of the program year, including:

(A) In each community action agency geographic area **[**and Department of Social Services region,**]** the number of fuel assistance applications filed, approved and denied, and the number of emergency assistance requests made, approved and denied; **[**and the number of households provided weatherization assistance;**]**

(B) In each such area and district, the total amount of fuel **[**,**]** and emergency **[**and weatherization**]** assistance, itemized by such type of assistance, and total expenditures to date;

(C) For each state-wide office of each state agency administering the

program **[**,**]** and each community action agency, **[**and each Department of Social Services region,**]** administrative expenses under the program, by line item, and an estimate of outreach expenditures; and

(D) A list of community action agencies that failed to make timely payments to vendors of deliverable fuel in the Connecticut energy assistance program and the steps taken by the commissioner to ensure future timely payments by such agencies; and

(3) Not later than November first, annually, a report covering the preceding twelve calendar months, including:

(A) In each community action agency geographic area **[**and Department of Social Services region,**]** (i) seasonal totals for the categories of data submitted under subdivision (1) of this subsection, (ii) the number of households receiving fuel assistance in which elderly or physically disabled individuals reside, and (iii) the average combined benefit level of fuel, emergency and renter assistance;

[(B) Types of weatherization assistance provided;

(C) Percentage of weatherization assistance provided to tenants;**]**

[(D)**]** (B) The number of homeowners and tenants whose heat or total energy costs are not included in their rent receiving fuel and emergency assistance under the program by benefit level;

[(E)**]** (C) The number of homeowners and tenants whose heat is included in their rent and who are receiving assistance, by benefit level; and

[(F)**]** (D) The number of households receiving assistance, by energy type and total expenditures for each energy type.

Sec. 2. Subsection (c) of section 17a-485d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(c) The Commissioner of Social Services **[**shall**]** may take such action **[**as may be**]** necessary to amend the Medicaid state plan to provide for coverage of optional adult rehabilitation services supplied by providers of mental health services or substance abuse rehabilitation services for adults with serious and persistent mental illness or who have alcoholism or other substance use disorders, that are certified by the Department of Mental Health and Addiction Services. The Commissioner of Social Services **[**shall**]** may adopt regulations, in accordance with the provisions of chapter 54, as the commissioner deems necessary, to implement optional rehabilitation services under the Medicaid program. The commissioner **[**shall**]** may implement policies and procedures to administer such services while in the process of adopting such policies or procedures in regulation form, provided **[**notice of intention to adopt the regulations is printed in the Connecticut Law Journal within forty-five days of implementation, and any**]** the commissioner posts the policies and procedures on the eRegulations System prior to adopting the policies and procedures. Any such policies or procedures shall be valid until the time final regulations are effective.

Sec. 3. Subsection (d) of section 17b-8 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(d) The commissioner shall include with any waiver application or proposed amendment submitted to the federal government pursuant to this section: (1) Any written comments received pursuant to subsection (c) of this section; and (2) **[**a complete transcript of the joint standing committee proceedings held pursuant to subsection (a) of this section, including**]** any additional written comments submitted to the joint standing committees at such proceedings. The joint standing committees shall transmit any such materials to the commissioner for inclusion with any such waiver application or proposed amendment.

Sec. 4. Subsection (b) of section 17b-59a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(b) The Commissioner of Social Services, in consultation with the executive director of the Office of Health Strategy, established under section 19a-754a, shall (1) develop, throughout the Departments of Developmental Services, Public Health, Correction, Children and Families, Veterans Affairs and Mental Health and Addiction Services, uniform management information, uniform statistical information, uniform terminology for similar facilities, and uniform electronic health information technology standards, **[**and uniform regulations for the licensing of human services facilities,**]** (2) plan for increased participation of the private sector in the delivery of human services, (3) provide direction and coordination to federally funded programs in the human services agencies and recommend uniform system improvements and reallocation of physical resources and designation of a single responsibility across human services agencies lines to facilitate shared services and eliminate duplication.

Sec. 5. Section 17b-306a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) The Commissioner of Social Services, in collaboration with the Commissioners of Public Health and Children and Families, shall establish a child health quality improvement program for the purpose of promoting the implementation of evidence-based strategies by providers participating in the HUSKY Health program to improve the delivery of and access to children's health services. Such strategies shall focus on physical, dental and mental health services and shall include, but need not be limited to: (1) Methods for early identification of children with special health care needs; (2) integration of care coordination and care planning into children's health services; (3) implementation of standardized data collection to measure performance improvement; and (4) implementation of family-centered services in patient care, including, but not limited to, the development of parent-provider partnerships. The Commissioner of Social Services shall seek the participation of public and private entities that are dedicated to improving the delivery of health services, including medical, dental and mental health providers, academic professionals

with experience in health services research and performance measurement and improvement, and any other entity deemed appropriate by the Commissioner of Social Services, to promote such strategies. The commissioner shall ensure that such strategies reflect new developments and best practices in the field of children's health services. As used in this section, "evidence-based strategies" means policies, procedures and tools that are informed by research and supported by empirical evidence, including, but not limited to, research developed by organizations such as the American Academy of Pediatrics, the American Academy of Family Physicians, the National Association of Pediatric Nurse Practitioners and the Institute of Medicine.

(b) Not later than July 1, 2008, and annually thereafter, the Commissioner of Social Services shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations, and to the Council on Medical Assistance Program Oversight on (1) the implementation of any strategies developed pursuant to subsection (a) of this section, and (2) the efficacy of such strategies in improving the delivery of and access to health services for children enrolled in the HUSKY Health program.

[(c) The Commissioner of Social Services, in collaboration with the Council on Medical Assistance Program Oversight, shall, subject to available appropriations, prepare, annually, a report concerning health care choices under HUSKY A. Such report shall include, but not be limited to, a comparison of the performance of each managed care organization, the primary care case management program and other member service delivery choices. The commissioner shall provide a copy of each report to all HUSKY A members **]**

Sec. 6. Subsection (a) of section 17b-349 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) The rates paid by the state to community health centers **[**and freestanding medical clinics**]** participating in the Medicaid program may be adjusted annually on the basis of the cost reports submitted to the Commissioner of Social Services. **[**, except that rates effective July 1, 1989, shall remain in effect through June 30, 1990.**]** The Department of Social Services may develop an alternative payment methodology to replace the encounter-based reimbursement system. Such methodology shall be approved by the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. Until such methodology is implemented, the Department of Social Services shall distribute supplemental funding, within available appropriations, to federally qualified health centers based on cost, volume and quality measures as determined by the Commissioner of Social Services. (1) Beginning with the one-year rate period commencing on October 1, 2012, and annually thereafter, the Commissioner of Social Services may add to a community health center's rates, if applicable, a capital cost rate adjustment that is equivalent to the center's actual or projected year-to-year increase in total allowable depreciation and interest expenses associated with major capital projects divided by the projected service visit volume. For the purposes of this subsection, "capital costs" means expenditures for land or building purchases, fixed assets, movable equipment, capitalized financing fees and capitalized construction period interest and "major capital projects" means projects with costs exceeding two million dollars. The commissioner may revise such capital cost rate adjustment retroactively based on actual allowable depreciation and interest expenses or actual service visit volume for the rate period. (2) The commissioner shall establish separate capital cost rate adjustments for each Medicaid service provided by a center. (3) The commissioner shall not grant a capital cost rate adjustment to a community health center for any depreciation or interest expenses associated with capital costs that were disapproved by the federal Department of Health and Human Services or another federal or state government agency with capital expenditure approval authority related to health care services. (4) The commissioner may allow actual debt

service in lieu of allowable depreciation and interest expenses associated with capital items funded with a debt obligation, provided debt service amounts are deemed reasonable in consideration of the interest rate and other loan terms. (5) The commissioner shall implement policies and procedures necessary to carry out the provisions of this subsection while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt such regulations is **[**published in the Connecticut Law Journal not later than twenty days after implementation**]** posted on the eRegulations System prior to adopting the policies and procedures. Such policies and procedures shall be valid until the time final regulations are effective.

Sec. 7. Section 38a-479aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) As used in this part and subsection (b) of section 20-138b:

(1) "Covered benefits" means health care services to which an enrollee is entitled under the terms of a managed care plan;

(2) "Enrollee" means an individual who is eligible to receive health care services through a preferred provider network;

(3) "Health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization, and includes hospital, medical, surgical, dental, vision and pharmaceutical services or products;

(4) "Managed care organization" means (A) a managed care organization, as defined in section 38a-478, (B) any other health insurer, or (C) a reinsurer with respect to health insurance;

(5) "Managed care plan" has the same meaning as provided in section 38a-478;

(6) "Person" means an individual, agency, political subdivision, partnership, corporation, limited liability company, association or any

other entity;

(7) "Preferred provider network" means a person that is not a managed care organization, but that pays claims for the delivery of health care services, accepts financial risk for the delivery of health care services and establishes, operates or maintains an arrangement or contract with providers relating to (A) the health care services rendered by the providers, and (B) the amounts to be paid to the providers for such services. "Preferred provider network" does not include (i) a workers' compensation preferred provider organization established pursuant to section 31-279-10 of the regulations of Connecticut state agencies, (ii) an independent practice association or physician hospital organization whose primary function is to contract with insurers and provide services to providers, (iii) a clinical laboratory, licensed pursuant to section 19a-30, whose primary payments for any contracted or referred services are made to other licensed clinical laboratories or for associated pathology services, or (iv) a pharmacy benefits manager responsible for administering pharmacy claims whose primary function is to administer the pharmacy benefit on behalf of a health benefit plan;

(8) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services; and

(9) "Commissioner" means the Insurance Commissioner.

(b) No preferred provider network may enter into or renew a contractual relationship with a managed care organization or conduct business in this state unless the preferred provider network is licensed by the commissioner. Any person seeking to obtain or renew a license shall submit an application to the commissioner, on such form as the commissioner may prescribe, and shall include the filing described in this subsection, except that a person seeking to renew a license may submit only the information necessary to update its previous filing. Such license shall be issued or renewed annually on July first and applications shall be submitted by May first of each year in order to qualify for the license issue or renewal date. The filing required from

such preferred provider network shall include the following information: (1) The identity of the preferred provider network and any company or organization controlling the operation of the preferred provider network, including the name, business address, contact person, a description of the controlling company or organization and, where applicable, the following: (A) A certificate from the Secretary of the State regarding the preferred provider network's and the controlling company's or organization's good standing to do business in the state; (B) a copy of the preferred provider network's and the controlling company's or organization's financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, for the end of its most recently concluded fiscal year, along with the name and address of any public accounting firm or internal accountant which prepared or assisted in the preparation of such financial statement; (C) a list of the names, official positions and occupations of members of the preferred provider network's and the controlling company's or organization's board of directors or other policy-making body and of those executive officers who are responsible for the preferred provider network's and controlling company's or organization's activities with respect to the health care services network; (D) a list of the preferred provider network's and the controlling company's or organization's principal owners; (E) in the case of an out-of-state preferred provider network, controlling company or organization, a certificate that such preferred provider network, company or organization is in good standing in its state of organization; (F) in the case of a Connecticut or out-of-state preferred provider network, controlling company or organization, a report of the details of any suspension, sanction or other disciplinary action relating to such preferred provider network, or controlling company or organization in this state or in any other state; and (G) the identity, address and current relationship of any related or predecessor controlling company or organization. For purposes of this subparagraph, "related" means that a substantial number of the board or policy-making body members, executive officers or principal owners of both companies are the same; (2) a general description of the preferred provider network and participation in the preferred provider

network, including: (A) The geographical service area of and the names of the hospitals included in the preferred provider network; (B) the primary care physicians, the specialty physicians, any other contracting providers and the number and percentage of each group's capacity to accept new patients; (C) a list of all entities on whose behalf the preferred provider network has contracts or agreements to provide health care services; (D) a table listing all major categories of health care services provided by the preferred provider network; (E) an approximate number of total enrollees served in all of the preferred provider network's contracts or agreements; (F) a list of subcontractors of the preferred provider network, not including individual participating providers, that assume financial risk from the preferred provider network and to what extent each subcontractor assumes financial risk; (G) a contingency plan describing how contracted health care services will be provided in the event of insolvency; and (H) any other information requested by the commissioner; and (3) the name and address of the person to whom applications may be made for participation.

(c) Any person developing a preferred provider network, or expanding a preferred provider network into a new county, pursuant to this section and subsection (b) of section 20-138b, shall publish a notice, in at least one newspaper having a substantial circulation in the service area in which the preferred provider network operates or will operate, indicating such planned development or expansion. Such notice shall include the medical specialties included in the preferred provider network, the name and address of the person to whom applications may be made for participation and a time frame for making application. The preferred provider network shall provide the applicant with written acknowledgment of receipt of the application. Each complete application shall be considered by the preferred provider network in a timely manner.

(d) (1) Each preferred provider network shall file with the commissioner and make available upon request from a provider the general criteria for its selection or termination of providers. Disclosure

shall not be required of criteria deemed by the preferred provider network to be of a proprietary or competitive nature that would hurt the preferred provider network's ability to compete or to manage health care services. For purposes of this section, criteria is of a proprietary or competitive nature if it has the tendency to cause providers to alter their practice pattern in a manner that would circumvent efforts to contain health care costs and criteria is of a proprietary nature if revealing the criteria would cause the preferred provider network's competitors to obtain valuable business information.

(2) If a preferred provider network uses criteria that have not been filed pursuant to subdivision (1) of this subsection to judge the quality and cost-effectiveness of a provider's practice under any specific program within the preferred provider network, the preferred provider network may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that the provider's practice fails to meet.

(e) Each preferred provider network shall permit the Insurance Commissioner to inspect its books and records.

(f) Each preferred provider network shall permit the commissioner to examine, under oath, any officer or agent of the preferred provider network or controlling company or organization with respect to the use of the funds of the preferred provider network, company or organization, and compliance with (1) the provisions of this part, and (2) the terms and conditions of its contracts to provide health care services.

(g) Each preferred provider network shall file with the commissioner a notice of any material modification of any matter or document furnished pursuant to this part, and shall include such supporting documents as are necessary to explain the modification.

(h) Each preferred provider network shall maintain a minimum net worth of either (1) the greater of (A) five hundred thousand dollars, or (B) an amount equal to eight per cent of its annual expenditures as

reported on its most recent financial statement completed and filed with the commissioner in accordance with sections 38a-53 and 38a-54, as applicable, or (2) another amount determined by the commissioner.

(i) Each preferred provider network shall maintain or arrange for a letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the commissioner for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment except that any remaining security may be used for the purpose of reimbursing managed care organizations in accordance with subsection (b) of section 38a-479bb. Such outstanding amount shall be at least an amount equal to the greater of (1) an amount sufficient to make payments to participating providers for four months determined on the basis of the four months within the past year with the greatest amounts owed by the preferred provider network to participating providers, (2) the actual outstanding amount owed by the preferred provider network to participating providers, or (3) another amount determined by the commissioner. Such amount may be credited against the preferred provider network's minimum net worth requirements set forth in subsection (h) of this section. The commissioner shall review such security amount and calculation on a quarterly basis.

(j) Each preferred provider network shall pay the applicable license or renewal fee specified in section 38a-11. The commissioner shall use the amount of such fees solely for the purpose of regulating preferred provider networks.

(k) In no event, including, but not limited to, nonpayment by the managed care organization, insolvency of the managed care organization, or breach of contract between the managed care organization and the preferred provider network, shall a preferred provider network bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or an enrollee's designee, other than the managed care organization, for covered benefits provided, except that

the preferred provider network may collect any copayments, deductibles or other out-of-pocket expenses that the enrollee is required to pay pursuant to the managed care plan.

(l) Each contract or agreement between a preferred provider network and a participating provider shall contain a provision that if the preferred provider network fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the participating provider for any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred provider network.

(m) Each utilization review determination made by or on behalf of a preferred provider network shall be made in accordance with section 38a-591d.

[(n) The requirements of subsections (h) and (i) of this section shall not apply to a consortium of federally qualified health centers funded by the state, providing services only to recipients of programs administered by the Department of Social Services. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to establish criteria to certify any such federally qualified health center, including, but not limited to, minimum reserve fund requirements.**]**

Sec. 8. Section 17b-608 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

For the purposes of **[**sections 17b-609 and 17b-610**]** section 17b-609, "persons with disabilities" means persons having disabilities which (1) are attributable to a mental or physical impairment or a combination of mental and physical impairments; (2) are likely to continue indefinitely; (3) result in functional limitations in one or more of the following areas of major life activity: Self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency; and (4) reflect the person's need for a

combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated.

Sec. 9. Sections 17b-184, 17b-274a and 17b-610 of the general statutes are repealed. (*Effective July 1, 2021*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2021*	16a-41a(a)
Sec. 2	*July 1, 2021*	17a-485d(c)
Sec. 3	*July 1, 2021*	17b-8(d)
Sec. 4	*July 1, 2021*	17b-59a(b)
Sec. 5	*July 1, 2021*	17b-306a
Sec. 6	*July 1, 2021*	17b-349(a)
Sec. 7	*July 1, 2021*	38a-479aa
Sec. 8	*July 1, 2021*	17b-608
Sec. 9	*July 1, 2021*	Repealer section

Statement of Purpose:

To delete outdated or obsolete provisions of statutes concerning the Department of Social Services.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]