Testimony before the Human Services Committee
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Good afternoon Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Deidre S. Gifford, and I am the Commissioner of the Department of Social Services.

I am pleased to appear before you today to offer remarks on several of the bills on today's agenda.

S.B. 909 - AN ACT CONCERNING CHANGES TO THE HUSKY B PROGRAM

In 2010, the Department made changes to HUSKY B copayments to conform to section 8 of Public Act 10-3 that required HUSKY B copayments to align with the state employee point-of-enrollment health care plan. Since that time, state employee copayments have risen considerably (notably, physician office visits rose from $10 to $15). The $15 per visit cost is high for children in low-income HUSKY B families who may need to see outpatient providers on a regular or frequent basis. This proposal repeals the requirement that copayments under HUSKY B align with copayment levels under the state employee point-of-enrollment health care plan and replaces it with language that provides that HUSKY B copayments may not exceed the levels under the state employee point-of-enrollment health care plan. Because the Department had not increased copayments, this legislative language is requested to align with current practice.

The proposal also eliminates the separate "HUSKY Plus" program that provides certain supplemental services, such as long-term therapies to members who have medical needs that go beyond the HUSKY B covered benefits. Those services will not be eliminated, rather they will be made part of the basic HUSKY B benefit package.

The elimination of the separate HUSKY Plus program will bring the physical health side of HUSKY B in line with the behavioral health side. When the HUSKY B program was created in 1998, HUSKY Plus had two components: HUSKY Plus Physical and HUSKY Plus Behavioral. When behavioral health services were carved out of the HUSKY program in 2006, the behavioral health services offered under HUSKY Plus Behavioral were folded into the services offered under the Behavioral Health Partnership. This proposal would do the same for HUSKY Plus physical services by making them part of the regular HUSKY B medical benefit package. The separate administrative cost of administering the HUSKY Plus program through the Department's contract with Community Health Network of CT, Inc., (CHNCT) and the process for members to qualify for the supplemental services would be eliminated. The scope of supplemental services currently offered under HUSKY Plus would be maintained. The

Department does not anticipate that there would be an increase in utilization as those children who have required the additional services that HUSKY Plus offers (long-term physical therapy, speech therapy, occupational therapy and certain types of specialized medical supplies and equipment) have received those services and will continue to do so under the proposed bill.

The Department supports this bill and urges its passage.

S.B. 910 - AN ACT EXPANDING MEDICAID COVERAGE FOR POST-PARTUM CARE TO TWELVE MONTHS AFTER A MEDICAID BENEFICIARY GIVES BIRTH TO A CHILD.

This bill expands Medicaid coverage for post-partum care to twelve months after a Medicaid beneficiary gives birth. The Department appreciates the intent of this bill.

Currently, HUSKY Health covers pregnant women with income up to 263% of the federal poverty level (currently $3,817 per month for a family size of two, including the unborn child) for the duration of their pregnancies and for two months following birth. While the overwhelming majority of Medicaid eligible women continue to be covered by HUSKY Health under another coverage group with either no lapse in coverage or a very brief lapse, a small percentage of Medicaid eligible women lose coverage.

This is problematic because it affects continuity of care for women in the crucial first year following the birth of a child or children and may also impede access to and utilization of services for children, even though they remain eligible. This is a challenge for all women, but notably for African American and Latinx women because of their increased risk of adverse health outcomes as compared to White women. The Connecticut Maternal Mortality Review Committee (MMRC) completed a review of maternal deaths from 2015 through 2017 and found that most maternal deaths occurred between the seventh and eighth month post-partum. The Connecticut MMRC and the Women and Children's Health sub-committee of the Medical Assistance Program Oversight Council (MAPOC) are in support of this policy.

The budget reconciliation package that is currently being negotiated in Congress includes a provision that would allow states, for a period of five (5) years, to extend Medicaid eligibility to women for twelve months postpartum. If this provision is signed into law, there would not be a need to include language in state statute requiring DSS to seek an 1115 waiver.

While funds to support this extension of eligibility are not included in the Governor's budget, the Department has initiated preliminary modeling of the expected costs of this coverage expansion. We will be finalizing our projections shortly and will share them with the Committee at that time. There would also be some one-time system implementation costs, as well as potentially some operational costs to support ongoing eligibility processes.

Finally, the Department notes that language operationalizing this coverage extension "within existing resources" could be construed to limit program access in a way that is not ordinarily applied to entitlement coverage. Costs could fluctuate based on enrollment and should not be capped based on a fixed allocation of funding.

S.B. 911 - AN ACT REQUIRING THE STATE TO PROVIDE MEDICAL ASSISTANCE FOR PRENATAL CARE

This bill seeks to expand the HUSKY B program, Connecticut's Children's Health Insurance Program (CHIP) authorized by Title XXI of the Social Security Act. The bill proposes to add the "unborn child option" to HUSKY B coverage.

The "unborn child option" was added to CHIP through regulations issued by the Centers for Medicare and Medicaid Services (CMS) in 2002 that amended the definition of "targeted low-income child" to include unborn children. This option permits states to consider a fetus as a targeted low-income child for purposes of CHIP coverage.

Providing health coverage for the fetus effectively extends CHIP coverage to the pregnant woman, allowing for the provision of prenatal and related services. This option allows for coverage regardless of the pregnant woman's immigration status. The applicant must meet all other CHIP rules, including the requirement that the she have no other health insurance coverage. As of January 2020, seventeen states have implemented the unborn child option through their CHIP state plans.

In 2009, Congress further expanded the eligibility options for pregnant women under CHIP, allowing states to cover pregnant women under their CHIP plans. In enacting this provision, Congress also continued to allow states to maintain or enact the "unborn child" option.

HUSKY B currently covers children up to the age of 19, with incomes up to 323% of the federal poverty level (FPL), after factoring in the 5% income disregard. Assuming the intent of the bill is to maintain the current income limits for HUSKY A and HUSKY B, the bill would expand HUSKY Health coverage in two ways.

It would extend HUSKY B coverage to unborn children who are above the Medicaid limit for the HUSKY A Pregnant Women coverage group (263% of FPL with the 5% income disregard) to those with income up to 323% of FPL. It would also allow coverage for unborn children who do not qualify for Medicaid because of their mother's immigration status, with income up to 323% of FPL. This includes undocumented women who do not qualify for Medicaid because they are not citizens and do not have a non-citizen status (e.g., asylee) that qualifies them for Medicaid. Currently, under federal law, coverage for undocumented individuals is limited to the treatment of emergency medical conditions, including labor and delivery.

The services available to women under the CHIP unborn child option include pregnancy services and services related to the pregnancy. States adopting the option have very broad discretion in defining those services. This may include postpartum visit(s) if the state reimburses using a global fee that includes reimbursement for all routine prenatal visits, professional delivery services, and the postpartum care bundled into one. Connecticut uses such a bundled reimbursement methodology.

The Department recognizes the merits of expanded funding for prenatal care for women who do not currently qualify under either CHIP or Medicaid due to their immigration status. There is,

however, no funding for this expansion in the Governor's budget and the Department is therefore not able to support the proposal.

In closing, I want to inform you that Governor Lamont is proposing H.B. 6447, An Act Creating the Covered Connecticut Program to Expand Access to Affordable Healthcare. If passed, that bill will sustainably fund a $50 million per year program to reduce Connecticut's uninsured rate, including through focused Medicaid expansions like this proposal.

S.B. 912 - AN ACT CONCERNING FUNDING AND OVERSIGHT OF FATHERHOOD INITIATIVES

This bill would establish an advisory council to study and make recommendations concerning the funding and oversight of fatherhood initiatives. The Department is the lead agency for the Connecticut Fatherhood Initiative (CFI), a broad-based, statewide multi-agency and stakeholder effort focused on changing the systems that can improve the ability of fathers of children of all ages to be positively involved in their children's lives. As such, the Department believes that the bill's objectives can be accomplished within the existing CFI framework for the reasons detailed below.

While housed within DSS, the CFI is not a single-agency effort. The established CFI Council includes representatives from Executive Branch agencies including the Office of Early Childhood and the Departments of Children and Families, Correction, Developmental Services, Education, Housing, Labor, Mental Health and Addition Services, Veterans Affairs and Public Health; representatives from the Judicial Branch including Support Enforcement Services, Court Support Services, and Family Magistrate Divisions; Board of Pardons and Parole, Connecticut State Colleges and Universities, UConn Health Disparities Institute, UConn Department of Human Development and Family Sciences, Yale Consultation Center, multiple commissions including the Connecticut Commission on Women, Children, Seniors, Equity and Opportunity; private non-profit organizations including Connecticut Coalition Against Domestic Violence, Legal Aid Services, the United Way of Connecticut; and numerous community-based partners serving families (mothers, fathers, and children). With such broad representation, including a co-chair from the legislature, the existing framework is the most appropriate venue for consideration of any new structure. The creation of a new advisory council with substantially similar membership risks diluting the important work that the CFI has undertaken.

The objectives of the CFI are to provide fathers with the skills and supports they need to get involved in the lives of their children and stay connected by: promoting public education concerning the financial and emotional responsibilities of fatherhood; assisting men in preparation for the legal, financial and emotional responsibilities of fatherhood; promoting the establishment of paternity at childbirth; encouraging fathers, regardless of marital status, to foster their emotional connection to and financial support of their children; establishing support mechanisms for fathers in their relationship with their children, regardless of their marital and financial status; and integrating state and local services available for families.

The members of the CFI Council are party to an existing Memorandum of Understanding (MOU) the purpose of which is to continue to collaborate and actively participate in the objectives of the program and to coordinate services to provide the most comprehensive services

for fathers and their families. Through the MOU, the members of the CFI Council have, among other things, agreed to: provide membership and active participation on the Fatherhood Advisory Council and related events/activities; designate an agency liaison to facilitate communication and reporting about fatherhood activities; seek opportunities for collaboration among partners for programs, projects, or legislative proposals that support positive father, child and/or family outcomes; seek opportunities for funding, consistent with the agency's mission, to support positive father involvement; provide active participation for the implementation of the CFI Strategic Plan, including staff leadership/membership on committees and workgroups and related activities; support data development by identifying ways to collect data on men who are fathers, and opportunities to share data across agencies to obtain more accurate metrics on fathers involved with state systems; strengthen our commitment as CFI partners by communicating CFI efforts throughout the agency and with our partners; and commit to promote racial justice, with policies, beliefs, practices, attitudes, and actions that foster equal opportunity and treatment for people of all races.

The Council has developed a strategic plan for the future of the Fatherhood initiative. The plan, adopted by the CFI Strategic Planning Workgroup, contains recommendations for short- and long-term strategies to: address program, policy and system barriers; expand promising practices already being implemented; and establish new, and strengthen existing, partnerships at the state and local levels to support the result statements – "Connecticut children grow up in a stable environment, safe, healthy and ready to lead successful lives" and, "All Connecticut fathers are engaged in the lives of their children."

Lastly, the Department notes that the funding requested in this bill is not provided for within current budgetary assumptions nor is it included in the Governor's proposed budget.

S.B. 913 - AN ACT REQUIRING FAIRNESS FOR FAMILIES IN MEDICAID ELIGIBILITY AND REIMBURSEMENT DETERMINATIONS.

Section 1 of this bill requires the Department to set payment rates for family caregivers equal to the rates set for non-family professional caregivers providing the same type of services.

The Department shares the Committee's interest and concern in supporting family caregivers, whose contribution of in-kind services to their loved ones is a mainstay of the public-private partnership that is reflected in our nation's continuum of long-term services and supports. To the extent permitted under federal law, the Department has enabled people who are participating in the Medicaid State Plan Community First Choice option and Medicaid home and community-based services (HCBS) waivers such as the Connecticut Home Care Program for Elders to self-direct their care by hiring and managing personal care attendants (PCAs). With certain limitations, these PCAs may be family members of the person receiving care. In Connecticut, self-directed PCAs have the benefit of collective bargaining, which has resulted in a standard, statewide schedule of wage rates and fringe benefits. Outside these parameters, the Department generally does not have the authority to reimburse family members for Medicaid covered services.

Section 2 of the bill proposes to provide up to three months of retroactive Medicaid eligibility to individuals applying for home and community-based services provided such applicant has not made a transfer of assets for less than fair market value.

Medicaid programs must provide coverage for up to three months prior to the month of application for any time during the three months prior that the applicant met the eligibility requirements, however the Centers for Medicare & Medicaid Services (CMS) does not allow retroactive coverage when an applicant requests coverage of home and community-based services.

For Medicaid services provided pursuant to a HCBS waiver, coverage is prospective-only from the date on which the state Medicaid program approves a HCBS service plan. There are provisions in the waiver that require, for example, the completion of a criminal background check for providers under the waiver. If retroactive payment were possible, there could be no assurance that such CMS requirements were met. In addition, there are specific rates and approved providers in a waiver. Private services that clients or families arrange *prior to the determination of financial eligibility* may be provided by a *non-Medicaid provider* at any range of rates. Neither of these would be permissible under a waiver program.

A waiver, such as the Connecticut Home Care Program for Elders waiver, specifies to CMS that clients are provided a choice of providers and that they receive care management services that include ongoing monthly monitoring of the clients' status and the effectiveness of the person-centered plan. This standard cannot be met retroactively. In addition, federal financial participation cannot be claimed for waiver services that are furnished prior to the development of the service plan or for waiver services that are not included in an individual's service plan. Simply put, a service plan cannot be "backdated."

Federal law also requires the imposition of a penalty when individuals transfer assets for less than fair market value for the purpose of obtaining Medicaid payment of long-term care services. Long-term care services include home and community-based services under a Medicaid waiver, as well as services provided in an institutional setting. The penalty period begins on the date when Medicaid would otherwise pay for long-term care services had the improper transfer not occurred. Medicaid does not pay for long-term care services during the penalty period as the individual could have paid for his or her care had the improper transfer not occurred. As transfer of asset penalties cannot begin until Medicaid would otherwise pay for waiver services and, since waiver services cannot begin until the application is processed, transfer of asset penalties cannot begin until the application is processed.

Because CMS guidance and federal law does not allow for the changes sought by this proposal, the Department cannot support Section 2 of this bill.

Section 3 of this bill would prohibit institutionalized individuals from being denied Medicaid on the basis of a single unliquidated asset, provided the applicant can show evidence that the asset is inaccessible. Section 3 would also prohibit institutionalized individuals from being denied Medicaid on the basis of an asset discovered during the application process, provided the applicant reports the discovery, takes steps to liquidate the asset and spends-down the proceeds

in accordance with Medicaid policy. Both proposed changes pertain to a single disqualifying asset that causes the institutionalized individual's total assets to exceed the Medicaid limit.

Federal regulations define a countable asset as cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and can convert to cash to be used for his or her support and maintenance. If the individual has the right, authority or power to liquidate the asset, it is countable towards the Medicaid limit.

The exclusion of a single disqualifying asset would effectively allow institutionalized individuals to have assets in excess of the Medicaid asset limit, and still qualify for assistance. This would remove any incentive for individuals or their representatives to reduce their assets in a timely manner by paying nursing facilities and increase Medicaid expenditures by allowing applicants to be eligible for Medicaid services earlier.

For these reasons, the Department opposes this bill.

H.B. 6469 - AN ACT CONCERNING THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY.

House Bill 6469 proposes to remove the statutory requirement that participants of the two state-funded tiers of the Connecticut Home Care Program (i.e., Categories 1 and 2) whose income is at or below 200% of the federal poverty level (currently, $2,146 per month) and who are ineligible for Medicaid make a monthly co-payment of 9% of the cost of the services that they receive.

Individual care plan limits under Category 1 and Category 2 are set at 25% (currently, $1,569) and 50% (currently, $3,137), respectively, of the monthly Medicaid cost of nursing home care (currently, $6,274) for eligible individuals.

By contrast to Category 3 of the CHCP, which serves individuals who meet the financial and functional eligibility criteria for the Medicaid waiver, participants of the state-funded tiers have fewer functional limitations, are not subject to an eligibility income limit, and may, in 2021, have assets up to $39,114 (for an individual) and $52,152 (for a couple). This means that there is no cap on the income an individual may have to qualify, only an asset test. Those in Categories 1 and 2 are not Medicaid eligible, and their services are paid for with state funding only.

While the Department acknowledges that the co-payment requirement may affect the willingness of potential participants to join the program, these individuals do have more resources than Medicaid members, and the cost share has historically been regarded as an appropriate means of contributing to their cost of care. It should be noted that this cost share offsets the overall cost of the program by approximately $2 million annually. Further, the Governor's budget does not include funding to replace this revenue. For these reasons, the Department cannot support this bill.

H.B. 6470 - AN ACT CONCERNING HOME HEALTH, TELEHEALTH AND UTILIZATION REVIEW.

This proposal would enable the Department of Social Services (DSS) to continue certain Medicaid and Children's Health Insurance Program (CHIP) home health, telehealth and utilization review policy changes that were temporarily implemented as part of the agency's COVID-19 response and pursuant to the Governor's public health emergency authority.

In regard to sections 1 and 2 of this proposal related to home health, federal Medicaid regulations in 42 CFR 440.70 recently changed to allow nurse practitioners and physician assistants to issue orders for individuals to receive home health services, in addition to physicians. On a temporary basis, pursuant to temporary executive order authority under the public health emergency, DPH and DSS also implemented this change. The state agencies, home health providers, and others have all been in favor of implementing this change on a permanent basis to improve access to home health services. Implementing this change in statute is the most efficient way to make these changes permanent as quickly as possible, thereby helping to prevent any disruption in access for people who need these services.

Section 17b-245e of the Connecticut General Statutes (CGS) authorizes DSS to implement telehealth as defined in section 19a-906, which currently excludes audio-only telephone and is also limited to a set list of practitioners. During the public health emergency, under temporary executive authority, DSS and DPH have implemented certain audio-only telephone services and telehealth for certain practitioners not listed in section 19a-906. DSS' authority to cover audio-only telehealth was also temporarily authorized in Public Act 20-2, section 6, of the July special session, but that authorization ends March 15, 2021.

Based on DSS's analysis and input from members, providers, and other stakeholders, retaining the ability to choose to cover certain specific audio-only telephone services is important to maintaining access to services for certain individuals and is a necessary step to improve access and equity. Section 3 of this bill, by removing audio-only from the list of excluded telehealth services in the definition of telehealth in CGS section19a-906, incorporates such services by reference in CGS section 17b-245e.

In order to ensure this coverage has sufficient safeguards to promote quality and prevent overbilling, fraud, and abuse, the language from Public Act 20-2 of the July special session is also being amended, in section 4 of this bill, to add certain parameters that must be met for this coverage, namely to ensure that audio-only services are provided only when it is not possible to provide audiovisual telehealth services and only for individuals who are unable to use or access audiovisual telehealth services.

Lastly, as relates to utilization review, DSS requires specific prior authorization and other methods of utilization review for specified covered health care services, some of which are specifically codified in regulation and would therefore need formal amendments to the regulation to be changed. During the public health emergency, under temporary executive authority, DSS temporarily relaxed certain prior authorization requirements in order to help individuals maintain

access to health care services during the pandemic and reduce administrative burdens on health care providers that were most directly affected by providing care to individuals with COVID-19.

Section 5 of the bill will provide the Department the ability to relax specific utilization review criteria and procedures set forth in regulation (such as numerical thresholds above which prior authorization is required) on an ongoing basis. This authority is important for DSS to efficiently adapt the program to changing clinical practices and program structure, ensure sufficient access to services, and safeguard quality of services provided. This flexibility would be relevant only for those DSS regulations that set forth specific prior authorization requirements or thresholds. This flexibility also helps minimize administrative barriers to implementing value-based payment models that focus on health outcomes and quality of care.

For the foregoing reasons we urge passage of this bill.

H.B. 6472 - AN ACT CONCERNING TELEHEALTH.

DSS strongly supports continued coverage of telehealth services under HUSKY Health, and shares policymakers' interest in examining utilization and experience with these services.

It is our view, however, that a better approach than the two-year pilot period and terms of coverage that are proposed in H.B. 6472 would be to:

- leave in effect the current statute (C.G.S. section 17b-245e) that enables DSS to implement telehealth on a broad basis;
- build on that statute by expanding the type of providers who are permitted to provide services via telehealth to include nurse midwives and behavioral analysts and also, as permitted under federal law, to cover audio-only telehealth – this is the language that is proposed in H.B. 6470;
- consider updating the reporting provision in C.G.S. section 17b-245e to require DSS to report quarterly to the Medical Assistance Program Oversight Council (MAPOC) on utilization of and experience with telehealth; and
- avoid placing specific terms of the type referenced in subsection (c) of H.B. 6472 in statute, and instead preserve the Commissioner's flexibility to design and implement telehealth consistent with federal and state law, best clinical practice, medical necessity and audit standards.

Since March 2020, DSS has been broadly covering telehealth services under the state's Medicaid program. Telehealth has been and continues to be critical to enabling HUSKY Health members access to services during the COVID-19 pandemic. Current law – C.G.S. section 17b-245e – already authorizes DSS to cover most of the telehealth services proposed by H.B. 6472. Building on this current enabling language, DSS has proposed the language that is captured in H.B. 6470, An Act Concerning Home Health, Telehealth and Utilization Review. In relevant part, H.B. 6470 seeks to expand the type of providers who are permitted to provide services via telehealth and also, as permitted under federal law, to cover audio-only telehealth. The Department has submitted testimony in support of H.B. 6470.

Current law does not impose an end-date on HUSKY Health telehealth coverage. Telehealth has been successful in expanding access to services for the people we serve and is now an established part of the Medicaid service array. Nationally, telehealth has also been recognized as a core component of the healthcare system. DSS is monitoring telehealth on an ongoing basis and has regularly been providing reports to MAPOC on telehealth utilization. Further, DSS' contracted medical administrative services organization, Community Health Network of Connecticut (CHNCT), conducted member and provider surveys in the summer of 2020 that documented strong interest and satisfaction in continued telehealth coverage. These results were reported to MAPOC in September (https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20200910/COVID-19%20Impact%20and%20CHNCT%20Support.pdf).

Specifically:

CHNCT surveyed 801 HUSKY Health members concerning their experience with medical and behavioral health telehealth services from April through June of 2020. Results indicated:

- The majority of respondents (58.2%) reporting that they used "video with audio/telephone" for their appointment, compared to 47.2% of members who utilized "telephone/audio only"
- 72.0% reporting that they either strongly agree/agree that "telehealth worked just as good for [them] as an in-person appointment"
- 91.2% reporting that they either strongly agree/agree that the "quality of care [they] got from [their] doctor was very good, through telehealth"
- 79.6% reporting that they either strongly agree/agree that "overall, [they] liked using telehealth"
- 88.0% of members reporting that they strongly agree/agree that they would use telehealth again.

CHNCT surveyed 1,800 medical providers who submitted a telehealth claim. Based on 203 provider responses, key survey results showed:

- 69.6% of providers used video with audio; 27.0% audio only; and 3.3% advised they didn't offer telehealth
- 45.8% of providers noticed a decrease in missed appointments using telehealth
- 66.0% of providers did not experience any technical difficulty when visiting with their patient during a telehealth visit
- 73.9% of providers surveyed indicated they found telehealth an adequate replacement for an in person visit
- 83.3% said they would continue to use telehealth after the COVID-19 crisis.

Current law, C.G.S. section 17b-245e, provides a flexible, enabling framework within which the Commissioner is authorized to implement telehealth. The present flexible approach should be retained to:

- Ensure members receive appropriate, high quality services;
- Adapt to changes in clinical practice and technology;

- Ensure compliance with federal rules (including HIPAA-compliant billing codes and federal rules for clinic services to be provided at the clinic), and
- Prevent fraud and over-billing.

Further, the Commissioner should retain the authority to determine if it is appropriate to continue DSS' pandemic practice of paying for telehealth at parity with in-person services. Over time, it may be necessary to revise rates to reflect providers' costs, changes in technology and clinical practice, and to comply with federal rules.

For these reasons, DSS urges the committee to support H.B. 6470 as a meaningful alternative to H.B. 6472.

H.B. 6473 - AN ACT EXPANDING THE DIAPER BANK TO INCLUDE FEMININE HYGIENE PRODUCTS.

This bill would increase the funds that the Department is able to provide to the Diaper Bank of Connecticut and require that feminine hygiene products to women who meet income eligibility standards be made available with the funding.

The Department currently provides funding to the Diaper Bank of Connecticut to purchase and distribute diapers to families in need around the state. To the extent additional funding is made available, the Department supports expanding its current partnership with the Diaper Bank of Connecticut and would provide administrative support to ensure the distribution of any allocated funding.

The Department appreciates the intent and goal of this legislation.