House of Representatives

File No. 772

General Assembly

January Session, 2021

(Reprint of File No. 265)

Substitute House Bill No. 6470
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
June 1, 2021

AN ACT CONCERNING HOME HEALTH, TELEHEALTH AND UTILIZATION REVIEW.

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

Section 1. Section 17b-242 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Department of Social Services shall determine the rates to be paid to home health care agencies and home health aide agencies by the state or any town in the state for persons aided or cared for by the state or any such town. **[**For the period from February 1, 1991, to January 31, 1992, inclusive, payment for each service to the state shall be based upon the rate for such service as determined by the Office of Health Care Access, except that for those providers whose Medicaid rates for the year ending January 31, 1991, exceed the median rate, no increase shall be allowed. For those providers whose rates for the year ending January 31, 1991, are below the median rate, increases shall not exceed the lower of the prior rate increased by the most recent annual increase in the

consumer price index for urban consumers or the median rate. In no case shall any such rate exceed the eightieth percentile of rates in effect January 31, 1991, nor shall any rate exceed the charge to the general public for similar services. Rates effective February 1, 1992, shall be based upon rates as determined by the Office of Health Care Access, except that increases shall not exceed the prior year's rate increased by the most recent annual increase in the consumer price index for urban consumers and rates effective February 1, 1992, shall remain in effect through June 30, 1993. Rates effective July 1, 1993, shall be based upon rates as determined by the Office of Health Care Access except if the Medicaid rates for any service for the period ending June 30, 1993, exceed the median rate for such service, the increase effective July 1, 1993, shall not exceed one per cent. If the Medicaid rate for any service for the period ending June 30, 1993, is below the median rate, the increase effective July 1, 1993, shall not exceed the lower of the prior rate increased by one and one-half times the most recent annual increase in the consumer price index for urban consumers or the median rate plus one per cent.**]** The Commissioner of Social Services shall establish a fee schedule for home health services to be effective on and after July 1, 1994. The commissioner may annually modify such fee schedule if such modification is needed to ensure that the conversion to an administrative services organization is cost neutral to home health care agencies and home health aide agencies in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality. The commissioner shall increase the fee schedule for home health services provided under the Connecticut home-care program for the elderly established under section 17b-342, effective July 1, 2000, by two per cent over the fee schedule for home health services for the previous year. The commissioner may increase any fee payable to a home health care agency or home health aide agency upon the application of such an agency evidencing extraordinary costs related to (1) serving persons with AIDS; (2) high-risk maternal and child health care; (3) escort services; or (4) extended hour services. In no case shall any rate or fee exceed the charge to the general public for similar services. A home health care agency or home health aide agency which, due to any

material change in circumstances, is aggrieved by a rate determined pursuant to this subsection may, within ten days of receipt of written notice of such rate from the Commissioner of Social Services, request in writing a hearing on all items of aggrievement. The commissioner shall, upon the receipt of all documentation necessary to evaluate the request, determine whether there has been such a change in circumstances and shall conduct a hearing if appropriate. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. The commissioner may implement policies and procedures to carry out the provisions of this subsection while in the process of adopting regulations, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal not later than twenty days after the date of implementing the policies and procedures. Such policies and procedures shall be valid for not longer than nine months.

(b) The Department of Social Services shall monitor the rates charged by home health care agencies and home health aide agencies. Such agencies shall file annual cost reports and service charge information with the department.

(c) The home health services fee schedule shall include a fee for the administration of medication, which shall apply when the purpose of a nurse's visit is limited to the administration of medication. Administration of medication may include, but is not limited to, blood pressure checks, glucometer readings, pulse rate checks and similar indicators of health status. The fee for medication administration shall include administration of medications while the nurse is present, the pre-pouring of additional doses that the client will self-administer at a later time and the teaching of self-administration. The department shall not pay for medication administration in addition to any other nursing service at the same visit. The department may establish prior authorization requirements for this service. Before implementing such change, the Commissioner of Social Services shall consult with the chairpersons of the joint standing committees of the General Assembly having cognizance of matters relating to public health and human

services. The commissioner shall monitor Medicaid home health care savings achieved through the implementation of nurse delegation of medication administration pursuant to section 19a-492e. If, by January 1, 2016, the commissioner determines that the rate of savings is not adequate to meet the annualized savings assumed in the budget for the biennium ending June 30, 2017, the department may reduce rates for medication administration as necessary to achieve the savings assumed in the budget. Prior to any rate reduction, the department shall report to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services provider specific cost and utilization trend data for those patients receiving medication administration. Should the department determine it necessary to reduce medication administration rates under this section, it shall examine the possibility of establishing a separate Medicaid supplemental rate or a pay-for-performance program for those providers, as determined by the commissioner, who have established successful nurse delegation programs.

(d) The home health services fee schedule established pursuant to subsection (c) of this section shall include rates for psychiatric nurse visits.

(e) The Department of Social Services, when processing or auditing claims for reimbursement submitted by home health care agencies and home health aide agencies shall, in accordance with the provisions of chapter 15, accept electronic records and records bearing the electronic signature of a licensed physician or licensed practitioner of a healthcare profession that has been submitted to the home health care agency or home health aide agency.

(f) If the electronic record or signature that has been transmitted to a home health care agency or home health aide agency is illegible or the department is unable to determine the validity of such electronic record or signature, the department shall review additional evidence of the accuracy or validity of the record or signature, including, but not limited to, (1) the original of the record or signature, or (2) a written statement,

made under penalty of false statement, from (A) the licensed physician or licensed practitioner of a health care profession who signed such record, or (B) if such licensed physician or licensed practitioner of a health care profession is unavailable, the medical director of the agency verifying the accuracy or validity of such record or signature, and the department shall make a determination whether the electronic record or signature is valid.

(g) The Department of Social Services, when auditing claims submitted by home health care agencies and home health aide agencies, shall consider any signature from a licensed physician or licensed practitioner of a health care profession that may be required on a plan of care for home health services, to have been provided in timely fashion if (1) the document bearing such signature was signed prior to the time when such agency seeks reimbursement from the department for services provided, and (2) verbal or telephone orders from the licensed physician or licensed practitioner of a health care profession were received prior to the commencement of services covered by the plan of care and such orders were subsequently documented. Nothing in this subsection shall be construed as limiting the powers of the Commissioner of Public Health to enforce the provisions of sections 19-13-D73 and 19-13-D74 of the regulations of Connecticut state agencies and 42 CFR 484.18(c).

(h) Any order for home health care services covered by the Department of Social Services may be issued by any licensed practitioner authorized to issue such an order pursuant to section 19a-496a, as amended by this act. Any Department of Social Services regulation, policy or procedure that applies to a physician who orders such home health care services, including related provisions such as review and approval of care plans for home health care services, shall apply to any licensed practitioner authorized to order such home health care services pursuant to section 19a-496a, as amended by this act.

[(h)**]** (i) For purposes of this section, "licensed practitioner of a healthcare profession" has the same meaning as "licensed practitioner"

in section 21a-244a.

Sec. 2. Section 19a-496a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Notwithstanding any provision of the regulations of Connecticut state agencies, all home health care agency, hospice home health care agency or home health aide agency services shall be performed upon the order of a physician or physician assistant licensed pursuant to chapter 370 or an advanced practice registered nurse licensed pursuant to chapter 378.

(b) All home health care agency, hospice home health care agency and home health aide agency services **[**which**]** that are required by law to be performed upon the order of a licensed physician, physician assistant or advanced practice registered nurse may be performed upon the order of a physician, a physician assistant or an advanced practice registered nurse licensed in a state **[**which**]** that borders Connecticut. Any Department of Public Health agency regulation, policy or procedure that applies to a physician who orders home health care services, including related provisions such as review and approval of care plans for home health care services, shall also apply to an advanced practice registered nurse or physician assistant who orders home health care services.

Sec. 3. Subsection (j) of section 1 of public act 21-9 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(j) Subject to compliance with all applicable federal requirements, notwithstanding any provision of the general statutes, state licensing standards or any regulation adopted thereunder, a telehealth provider may provide telehealth services pursuant to the provisions of this section from any location.

Sec. 4. Section 6 of public act 21-9 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "Telehealth" means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical, oral and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store and forward transfers or remote patient monitoring. "Telehealth" does not include the use of facsimile, texting or electronic mail.

(2) "Connecticut medical assistance program" means the state's Medicaid program and the Children's Health Insurance Program under Title XXI of the Social Security Act, as amended from time to time.

(b) Notwithstanding the provisions of section 17b-245c, 17b-245e or 19a-906 of the general statutes, or any other section, regulation, rule, policy or procedure governing the Connecticut medical assistance program, the Commissioner of Social Services **[**may, in the commissioner's discretion and**]** shall, to the extent permissible under federal law, provide coverage under the Connecticut medical assistance program for audio-only telehealth services **[**for the period beginning on the effective date of this section and ending on June 30, 2023**]** when (1) clinically appropriate, as determined by the commissioner, (2) it is not possible to provide comparable covered audiovisual telehealth services, and (3) provided to individuals who are unable to use or access comparable, covered audiovisual telehealth services.

(c) To the extent permissible under federal law, the commissioner shall provide Medicaid reimbursement for services provided by means of telehealth to the same extent as if the service was provided in person.

Sec. 5. (NEW) (*Effective from passage*) The Commissioner of Social Services may waive or suspend, in whole or in part, to the extent the commissioner deems necessary, any prior authorization or other utilization review criteria and procedures for the Connecticut medical

assistance program. The commissioner shall include notice of any such waiver or suspension in a provider bulletin sent to affected providers and posted on the Connecticut Medical Assistance Program web site not later than fourteen days before implementing such waiver or suspension. As used in this section, "Connecticut medical assistance program" means the state's Medicaid program and the Children's Health Insurance Program under Title XXI of the Social Security Act, as amended from time to time.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	17b-242
Sec. 2	*from passage*	19a-496a
Sec. 3	*from passage*	PA 21-9, Sec. 1(j)
Sec. 4	*from passage*	PA 21-9, Sec. 6
Sec. 5	*from passage*	New section

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: See Below

Municipal Impact: None

Explanation

The bill (1) specifies conditions under which audio-only telehealth services can be provided under Medicaid and HUSKY B, and (2) requires Medicaid reimbursement for telehealth services to be the same as if the service was provided in person, to the extent allowed under federal law. DSS currently reimburses for telehealth services (including audio-only under certain conditions) at the in-person rate. While this codifies current practice under the public health emergency, it could preclude future savings to the extent telehealth services would otherwise be provided at lower rates than those established for equivalent in-person services.

The bill makes other technical and conforming changes, which have no fiscal impact.

House "A" strikes the language in the underlying bill and the associated fiscal impact and results in the impact described above.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sHB 6470 (as amended by House "A")*

AN ACT CONCERNING HOME HEALTH, TELEHEALTH AND UTILIZATION REVIEW.

SUMMARY

This bill requires the Department of Social Services (DSS) commissioner, to the extent permissible under federal law, to provide Medicaid reimbursement for telehealth services to the same extent as services provided in person. Existing law requires DSS to provide Medicaid coverage for categories of telehealth services if the DSS commissioner determines they are (1) clinically appropriate to be provided through telehealth, (2) cost effective for the state, and (3) likely to expand access in certain circumstances (CGS § 17b-245e).

Current law allows the DSS commissioner, at her discretion, to cover audio-only telehealth services under the state's medical assistance programs (e.g., Medicaid) until June 30, 2023. The bill instead requires her to do so, without a sunset date, when (1) she determines doing so is clinically appropriate; (2) providing comparable covered audiovisual telehealth services is not possible; and (3) audio-only services are provided to people who are unable to use or access comparable, covered audiovisual services. Both the authorization under current law and the requirement under the bill are applicable to the extent permissible under federal law.

The bill also expands the types of health care providers who can order home health care services to include advanced practice registered nurses (APRNs) and physician assistants.

It also allows DSS to waive or suspend prior authorization requirements and other utilization review criteria and procedures for

Medicaid and the Children's Health Insurance Program (CHIP).

The bill makes a minor change to a provision allowing telehealth providers to provide services from any location. It also removes obsolete provisions and makes conforming changes.

*House Amendment "A" (1) eliminates provisions in the underlying bill allowing licensed nurse midwives and behavior analysts to provide telehealth services, and (2) makes minor changes to provisions on orders for home health care services and telehealth providers providing services from any location.

EFFECTIVE DATE: Upon passage

§§ 1 & 2 — ORDERS FOR HOME HEALTH CARE SERVICES

Current Department of Public Health (DPH) regulations generally require physicians to sign patient care plans that include a needs assessment for home health services (Conn. Agencies Regs. § 19-13-D73). The bill supersedes this and any other state regulation and allows APRNs and physician assistants, as well as physicians, to order home health care agency, hospice home health care agency, and home health aide agency services. (An April 27, 2020, DPH order enacted a similar policy for the duration of the COVID-19 public health and civil preparedness emergencies; the authorizing executive order (Executive Order 7K) has since expired.)

The bill also allows APRNs and physician assistants in states that border Connecticut to order home health care agency services, in addition to physicians in bordering states under current law. The bill expands this provision to also explicitly apply to hospice home health care agency services and home health aide agency services.

The bill extends any DPH regulation, policy, or procedure that applies to a physician ordering home health services to also apply to APRNs and physician assistants. This includes provisions on reviewing and approving care plans for these services.

The bill similarly allows APRNs and physician assistants to order home health care services covered by DSS (i.e., under medical assistance programs, such as Medicaid). Under the bill, any DSS regulation, policy, or procedure that applies to physicians ordering home health care services also applies to APRNs and physician assistants, including related provisions on care plan review and approval.

§ 3 — TELEHEALTH PROVIDER LOCATION

PA 21-9 establishes requirements for the delivery of telehealth services and insurance coverage of these services until June 30, 2023. Among other things, the law allows telehealth providers, regardless of any contrary state laws, to provide telehealth services from any location. Under the bill, this provision applies (1) subject to compliance with all applicable federal requirements and (2) regardless of any state licensing standards.

§ 5 — PRIOR AUTHORIZATION AND UTILIZATION REVIEW

The bill allows the DSS commissioner to waive or suspend, in whole or in part, any prior authorization or other utilization review criteria and procedures for Medicaid and CHIP. The bill requires her to include notice of any waiver or suspension in a provider bulletin sent to affected providers and posted on the Connecticut Medical Assistance Program website at least 14 days before implementing it. (An executive order issued during the COVID-19 pandemic contained similar provisions (Executive Order 7EE, § 4, issued April 23, 2020); the order was repealed on May 20, 2021.)

BACKGROUND

Related Bill

sHB 6666 (§ 52), as amended by House Amendment "A" and passed by the House, similarly allows licensed APRNs and physician assistants to order home health care agency, hospice agency, and home health aide agency services.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 19 Nay 0 (03/18/2021)