
OLR Bill Analysis

sSB 848

AN ACT IMPLEMENTING PROVISIONS OF THE BUDGET CONCERNING PUBLIC HEALTH.

SUMMARY:

This bill makes various changes to the public health statutes. It:

1. establishes licensing and inspection fees for home health care agencies and assisted living service agencies (§ 1);
2. increases the fee the Department of Public Health (DPH) can charge for the technical assistance it provides for the design, review, and development of certain health care facilities' construction (§ 1);
3. increases the license renewal fee by \$5 for physicians, surgeons, nurses, nurse-midwives, and dentists and requires all except nurse midwives to renew their licenses online (§ 2);
4. requires DPH, within available appropriations, to establish and administer a program to provide financial assistance to community health centers and establish a formula to disburse funds based on the care centers provide (§ 3);
5. requires the Office of Policy and Management (OPM) secretary to annually determine the amount appropriated to administer the Connecticut Vaccine Program (§ 4);
6. requires DPH's Office of Health Care Access (OHCA) to consider, when evaluating a certificate of need (CON) application, the applicant's provision of services to Medicaid recipients and indigent people (§ 5);
7. requires nonprofit hospitals to make widely available to the

public the community health needs assessment and implementation strategy they are required to complete every third year under federal law (§ 6); and

8. allows the OPM secretary, at the Chief Medical Examiner's request, to waive the \$150 cremation certificate fee required for the cremation of a body for which a death certificate has been issued (§ 7).

EFFECTIVE DATE: July 1, 2013, except for the provisions on the (1) increased license renewal fees and online licensure, (2) CON, and (3) cremation fee waiver, which take effect October 1, 2013.

§ 1 – LICENSURE FEES FOR HOME HEALTH CARE AGENCIES AND ASSISTED LIVING FACILITIES

The bill establishes a licensing and inspection fee for home health care agencies of \$300 per agency and \$100 per satellite office. The fee must be paid biennially to DPH, except for Medicare- and Medicaid-certified agencies, which are licensed and inspected triennially.

The bill also establishes a \$500 biennial licensing and inspection fee for assisted living services agencies, except those participating in the state's congregate housing pilot program in Norwich.

§ 1 – HEALTH CARE FACILITY TECHNICAL ASSISTANCE FEE

By law, the DPH commissioner may charge a \$565 fee for technical assistance the department provides for the design, review, and development of a health care facility's construction, sale, or ownership change. The bill allows the commissioner to also charge this fee for technical assistance provided on a facility's renovation or building alteration.

The bill applies the \$565 fee only to projects costing \$1 million or less. For projects costing more than this amount, the bill allows the commissioner to charge one-quarter of 1% of the total project cost.

The bill specifies that the fee includes all DPH reviews and on-site inspections and does not apply to state-owned facilities.

§ 2 – ONLINE LICENSURE RENEWAL AND INCREASED FEES

The bill requires, rather than allows, physicians, surgeons, nurses and dentists to renew their licenses using DPH’s online license renewal system. It increases their renewal fee by \$5 (presumably to cover the associated transaction fees). It removes the provision in current law allowing the department to charge a \$5 service fee for online license renewals.

The bill increases the license renewal fee by \$5 for nurse-midwives, but does not require them to renew their licenses online.

It also removes an obsolete DPH reporting requirement regarding the online license renewal system.

§ 3 – FINANCIAL ASSISTANCE FOR COMMUNITY HEALTH CENTERS

The bill requires the DPH commissioner, within available appropriations, to establish and administer a financial assistance program for community health centers.

The commissioner must establish a formula to disburse program funds to the centers, which must include (1) the number of uninsured patients the center serves and (2) the types of services it provides.

The bill allows the commissioner to establish program participation requirements, provided she gives reasonable notice of the requirements to all community health centers. Centers may only use the funds for commissioner-approved purposes.

The bill defines a “community health center” as a public or private nonprofit medical care facility that (1) meets community health center statutory requirements and (2) is designated by the U.S. Department of Health and Human Services as a federally qualified health center (FQHC) or FQHC look-alike (i.e., is eligible for but does not receive federal Public Health Service Act Section 330 grant funds).

§ 4 – CONNECTICUT VACCINE PROGRAM

The bill requires the OPM secretary, in consultation with the DPH

commissioner, to determine annually by September 1 the amount of the General Fund appropriation to administer the Connecticut Vaccine Program (CVP) and inform the insurance commissioner of the amount. The law already requires the secretary to annually determine the appropriated amount to purchase, store, and distribute vaccines under the program and inform the insurance commissioner.

The CVP is a state- and federally-funded program that provides certain childhood vaccinations at no cost to health care providers. The state-funded component is funded by an assessment on certain health insurers and third-party administrators.

§ 5 – CERTIFICATE OF NEED (CON)

The bill adds to those factors OHCA must consider when evaluating a CON application whether an applicant who failed to provide, or reduced access to, services by Medicaid recipients or indigent people demonstrated good cause for doing so. It specifies that good cause is not demonstrated solely based on differences in reimbursement rates between Medicaid and other health care payers.

By law, OHCA must consider several factors when evaluating a CON application, including the applicant's past and proposed provision of health care services to relevant patient populations and payer mix. The bill specifies that this includes access to services by Medicaid recipients and indigent people.

The law requires OHCA to also consider, among other things, whether the applicant satisfactorily demonstrated how the proposal will improve the quality, accessibility, and cost effectiveness of health care delivery in the region. The bill specifies that this includes the (1) provision of, or change in, access to services for Medicaid recipients and indigent people and (2) impact on the cost effectiveness of providing access to Medicaid services.

§ 6 – COMMUNITY HEALTH NEEDS ASSESSMENT

Requirements

Federal health care reform law requires non-profit hospitals to

triennially submit to the Internal Revenue Service (IRS) (1) a community health needs assessment and (2) an implementation strategy to meet the health needs the assessment identifies. The bill requires these hospitals, by January 1, 2014, to make the assessment widely available to the public (as defined in IRS guidelines) within 15 days after submitting it to the IRS. After completing the initial assessment, the bill requires hospitals to do this once every three years.

The bill requires non-profit hospitals to make publicly available, unless it is contained in the assessment, a description of the community they serve. This must include (1) a geographic description; (2) a description of the general population served; (3) information on the leading causes of death; (4) chronic illness levels; (5) and descriptions of the community's medically underserved, low-income, minority, and chronically ill populations.

Implementation Strategy

Federal law requires non-profit hospitals to complete an implementation strategy within the same tax year as the community health needs assessment. The strategy is a written plan addressing each health need identified in the assessment by (1) describing how the hospital plans to meet the need or (2) identifying the need as one it does not intend to meet and explaining why.

The bill requires these hospitals to make the strategy widely available to the public within one year after completing the assessment. In developing the strategy, the hospital must consult with community-based organizations and stakeholders, local public health jurisdictions, and any others it chooses.

Hospitals must provide, unless it is contained in the strategy, a brief explanation for not accepting recommendations for proposals identified in the community health needs assessment through the stakeholder consultation process, such as the proposal's excessive cost or infeasibility. It requires (1) strategies to be evidence-based, when available or (2) the development and implementation of innovative programs and practices to be supported by evaluation measures.

BACKGROUND

Related Bill

sSB 1066, favorably reported by the Public Health Committee, requires OHCA to consider, when evaluating a CON application, whether the proposal is consistent with the overall goals of federal health care reform.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 18 Nay 9 (04/02/2013)