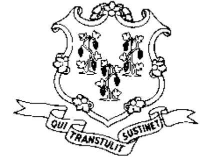

Testimony before the Human Services Committee
William Gui Woolston,
February 14, 2023

Good morning, Senator Lesser, Representative Gilchrest, and distinguished members of the Human Services Committee. My name is Gui Woolston, Director of Medicaid and Division of Health Services for the Department of Social Services, testifying on behalf of Andrea Barton Reeves, Commissioner-Designate of the Department of Social Services (DSS).

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

SB-412 - AN ACT INCREASING MEDICAID RATES FOR COMPLEX CARE NURSING SERVICES

This bill would increase the rate paid for complex care nursing services provided in the home to align with the rate paid to nursing homes for medically complex care. Additionally, it would increase adult complex care nursing services rates to that of pediatric care. The legislature recently approved significant rate increases for pediatric complex nursing care to address unique access issues and specific challenges for pediatric providers. The Administration believes that significant rate changes should be guided by evidence and access barriers as reviewed holistically through the DSS rate study in the Governor's budget proposal.

Over the years, the state has invested a significant amount of resources toward rebalancing long-term services and supports (LTSS) for Medicaid members, including creating an environment where Medicaid nursing facility residents are aware of their option to receive home and community-based services (HCBS) at home. As part of ongoing rebalancing efforts, DSS has actively engaged in rebalancing supports for members who choose to receive care at home. DSS has implemented many Medicaid initiatives to support member choice including Money Follows the Person and Community First Choice, which have significantly increased the proportion of Medicaid-funded home and community-based services in Connecticut's LTSS system. DSS projects these and other initiatives will increase the utilization of home care in Medicaid from the 2019 level of 68.6% to 82.3% by 2040.

To further strengthen rebalancing efforts, the state is making significant investments in HCBS pursuant to the American Rescue Plan Act (ARPA). The ARPA HCBS reinvestment plan includes, but is not limited to, stabilization payments estimated at 5% of total FY 2020 expenditures and value-based payments contingent on participation in race-equity training, connection to the state's HIE and reporting of quality and financial data. Additionally, in recognition of the costs incurred by providers due to the increases in the state's minimum wage and to ensure provider participation and access to services under Medicaid, rate increases have been provided for home health aides and low-wage workers under the applicable waivers.

This bill risks federal match as it would establish a reimbursement method for home and community-based services that is not allowed under federal and state regulations. Nursing home reimbursement methodologies approved under the Medicaid state plan were developed to support not only the direct care of the resident, but also costs associated with maintaining the infrastructure and the operations required to run a nursing facility. Nursing facilities have complex structures that require capital expenditures needed for building improvements such as roof, HVAC maintenance, costs of utilities, fair rental allowances for property taxes and mortgage, maintenance costs, housekeeping, laundry, vendor contracts, plumbing, and other non-direct care costs that are necessary to support nursing facility operations.

Compared to reimbursement methods for nursing home services, the HCBS reimbursement methods are approved to support direct care and limits the state from paying for capital building costs which are not appropriate cost considerations for state funding. Care provided in the home setting does not have the same facility operations costs that are allowed under the nursing home reimbursement system. Home care setting costs are limited to those costs that relate to the direct care the patient receives. Additionally, DSS has a mechanism in place for medically complex cases where costs may exceed the current level of reimbursement. DSS will review cost documentation from the home health agencies to determine if an increase in the rate is needed to support care that is deemed medically necessary.

Rate parity between home care and nursing homes would be an inefficient use of taxpayer dollars and risks federal match as each setting location is different and the supporting rate methodologies established by the state and federal regulations were specifically designed to support care in the setting it is delivered.

The Department does not support this bill for the reasons outlined above.

SB-990 – AN ACT CONCERNING COST-BASED REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS

This bill would require the Department to change the existing Medicaid reimbursement methodology for payments to federally qualified health centers (FQHCs).

While the Department recognizes the important role that FQHCs serve in our community and in the continuum of care delivery for Medicaid members, the Department cannot support this bill as it is in direct conflict with federal regulations regarding reimbursement to FQHCs.

To support the mission of the FQHC, federal rules dictate to states that they must provide an enhanced rate of reimbursement under state Medicaid programs. Medicaid payment rules for FQHCs differ sharply from those for other providers because federal law sets forth a very specific prospective payment system (PPS) prescribing how FQHCs are to be paid for each encounter or visit. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L 106-554) ("BIPA") created the PPS for Medicaid FQHCs in all states and territories. Prior to the PPS established under BIPA, FQHCs were paid based on cost. Effective January 1, 2001, FQHC rates were set using the average of an FQHC's 1999 and 2000 costs and inflated annually thereafter using the Medicare Economic Index (MEI). DSS established baseline encounter rates for each FQHC in existence during fiscal years 1999 and 2000 using cost reports for those years and has

increased the encounter rate each year by the MEI. *See* 42 USC § 1396a (bb) (2) & (3). Each FQHC has a specific encounter rate for every medical, dental, and behavioral health visit they provide.

Pursuant to 42 USC § 1396a(bb), a state Medicaid agency may set rates in accordance with the PPS methodology or based on an alternative payment methodology (APM). Following the enactment of BIPA, DSS chose to follow the PPS rate methodology. In FY 2001, PPS rates were set in accordance with the following:

> Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1395l(a)(3) of this title, or, in the case of services to which such regulations do not apply, the same methodology used under section 1395l(a)(3) of this title, adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001. *See* 42 USC § 1396a (bb)(2).

This bill is in direct conflict with not only federal regulation regarding FQHC reimbursement methods, but also risks the loss of federal match which is established under the CMS-approved State Plan Amendment 16-015 effective March 1, 2016. The language is also in conflict with the Department's "Regulations Concerning Requirements for Payments to Federally Qualified Health Centers" which were approved by the Legislative Regulation Review Committee of the Connecticut General Assembly on April 28, 2015, effective May 13, 2015.

This bill requires the Department to adjust an FQHC's encounter rate based upon the average of the last two years of cost reports filed. The cost report data does not break out costs by payor source but includes volume and costs for all payors – Medicaid, Medicare, commercial insurance and the uninsured which are reimbursed through federal grants provided by Health Resources and Services Administration (HRSA). Since the cost report data includes all payors, this bill would require Medicaid to establish rates that would cover services already reimbursed by commercial payors and federal grants. As such, the Department cannot support this bill.

SB-977 - AN ACT CONCERNING MEDICAL ASSISTANCE FOR SURGERY AND MEDICAL SERVICES RELATED TO THE TREATMENT OF OBESITY

This bill would require the Department of Social Services to provide Medicaid reimbursement for surgical procedures, prescription drug treatment and nutritional counseling to treat severe obesity.

Current DSS regulations and policy authorize Medicaid reimbursement for "surgical services necessary to treat morbid obesity as defined by the International Classification of Disease (ICD) that cause or aggravates another medical illness, including illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated with the orthopedic system."

Regulations of Connecticut State Agencies § 17b-262-341(9). Based on more recent clinical practice and observation, it is likely that many individuals who have severe obesity, as defined in the proposed bill, would also have one or more complicating health conditions and, as such, DSS would be required to provide reimbursement for surgical and medical services to treat severe obesity in those circumstances. While DSS appreciates the intent of this bill, the expansions included in this bill would result in significant unanticipated costs that are not recognized in the budget.

HB-6517 - AN ACT PROVIDING MEDICAID COVERAGE FOR CERTIFIED, REGISTERED DIETITIAN-NUTRITIONIST (RDN) SERVICES PROVIDING MEDICAL NUTRITION THERAPY

This bill would require the Department of Social Services to provide Medicaid reimbursement for certified, registered dietitian-nutritionists providing medical nutrition therapy under the Medicaid program.

Currently, the services of a certified dietitian or nutritionist are available in federally qualified health center and outpatient hospital settings when such services are prescribed by an enrolled physician, advanced practice registered nurse (APRN), or physician assistant (PA). In the outpatient office setting, nutritional counseling services rendered by a physician, APRN or PA are covered as part of the overall evaluation and management service performed.

The Department appreciates the intent of this bill and recognizes the clinical benefit that certified, registered dietitian-nutritionists provide. Poor nutrition impacts the health of Medicaid members with obesity and other chronic conditions (such as hypertension, gout, irritable bowel syndrome). While the Department is supportive in principle of the concept to cover medical nutrition therapy when provided by certified, registered dietitian-nutritionists, the Governor's proposed budget does not include funding for such an expansion. For this reason, the Department cannot support this bill.

HB-6586 - AN ACT CONCERNING SUPPLEMENTAL NUTRITION ASSISTANCE

This bill would require DSS to (1) adjust the distribution of Supplemental Nutrition Assistance Program (SNAP) benefits so that beneficiaries receive monthly benefits at multiple intervals during the month and (2) ensure that persons who received cost-of-living adjustment increases in Social Security payments in 2022 and 2023 don't lose SNAP benefits due to their increased Social Security income.

SNAP is a federally-funded program administered in Connecticut by the Department of Social Services (DSS) in accordance with program rules established by the federal government.

Regarding the first proposal, the Department cannot support the proposed adjust the distribution of SNAP benefits to multiple intervals during the month as it is not permitted by federal law. As part of the 2008 Farm Bill, federal regulations prohibit states from issuing ongoing monthly benefit allotments to households in more than one issuance during a month except with respect to

the issuance of benefits to residents of a drug and alcohol treatment and rehabilitation program or when benefit correction is necessary.

Furthermore, the Department supports the existing requirement that the entire monthly benefit allotment be issued at one time. This policy allows households to maximize their flexibility for managing how and when to purchase food within the time, transportation, and other constraints that low-income households often face. Split issuances would require families to make additional trips to the grocery store throughout each month, thus reducing the amount of time they can spend working, attending school or job-training programs, or taking care of their family.

Because SNAP benefits are "supplemental" by definition, and the monthly allotment amount is based on the very low-budget "thrifty food plan," households often exhaust their SNAP benefits before the month is over. Splitting the SNAP benefit does not address that problem, nor the likelihood that SNAP households may need to seek out other resources when food assistance is used up. A single monthly issuance, however, allows households to purchase large, economy-size containers of staple foods that they might otherwise not be able to afford and take advantage of the discounts normally associated with purchasing in bulk. It also allows households with small benefit amounts—such as seniors or individuals with disabilities as well as those with limited transportation options—to make one shopping trip during the month. Splitting issuances would limit households' ability to maximize their purchasing power and ability to coordinate their shopping frequency.

Regarding the second proposal, federal regulations also dictate the types of unearned income that DSS must consider when determining SNAP eligibility and benefit levels. Pursuant to those regulations, DSS is required to consider the full amount of any supplemental security income (SSI), survivors' benefits, and social security benefits received by a household as countable income (see 7 CFR 273.9 (b)(2)). As a result, DSS does not have the authority to disregard cost-of-living adjustment increases in Social Security payments for any year when calculating income eligibility for SNAP benefits and cannot restore any SNAP benefits that were reduced or terminated due to such cost-of-living increases.

The Department would like to note that SNAP eligibility thresholds are tied to the federal poverty guidelines, which are also adjusted each year to account for cost-of-living changes and which closely mirror Social Security benefit increases. The adjusted eligibility levels help to mitigate the impact on SNAP eligibility that might arise from an increase in Social Security benefits.

For the foregoing reasons, the Department must oppose this bill.

HB-6616 (Raised) - **AN ACT CONCERNING EXPANSION OF HUSKY HEALTH BENEFITS TO THOSE INELIGIBLE DUE TO IMMIGRATION STATUS**

This bill would provide state-funded medical assistance to all non-citizen, Connecticut residents age 25 or younger who would otherwise qualify for HUSKY A, C, or D (Medicaid) but for their immigration status and who do not qualify for the Children's Health Insurance Program (CHIP, otherwise known as HUSKY B in Connecticut) or affordable, employee-sponsored insurance, . The population to be covered under this proposal includes non-citizens through age 25 who lack

lawful immigration status as well as those age 21 to 25 who are lawfully present in the United States, but who do not have an immigration status that qualifies them for federal means-tested public benefits such as Medicaid, or who have not been in the United States long enough to qualify (typically five years).

Individuals age 20 or under would gain eligibility on January 1, 2024, and the remaining individuals would gain eligibility on June 1, 2024. In addition, effective January 1, 2024, the bill would extend state-funded medical assistance to children between the ages of 13 and 18 who would qualify for HUSKY B coverage but for their immigration status, provided there is no eligibility for Medicaid or affordable, employee-sponsored insurance.

While the Department appreciates the bill's intent to extend medical coverage to a greater swath of the uninsured population within the state, the Department estimates that the cost to the state of extending coverage to this population would be at least $15 million annually (see Table 4.5 on page 19 of the Rand Corporation Report "Expanding Insurance Coverage to Undocumented Immigrants in Connecticut" available online at Expanding Insurance Coverage to Undocumented Immigrants in Connecticut | RAND), an amount not contemplated in the Governor's proposed budget. Therefore, the Department is unable to support this proposal.

To provide some context on where Connecticut stands in providing medical coverage to the state's non-citizen residents, it is worth noting that the state has long-since exercised an option under federal law that allows it to provide Medicaid and CHIP coverage to *lawfully present* non-citizen residents under the age of 21. During the 2021 legislative session, state-funded medical assistance equivalent to HUSKY was established, effective January 1, 2023, for non-citizen children 8 years of age or younger who would be eligible for HUSKY coverage, but for their lack of lawful immigration status. *See* Public Act 21-176. Last legislative session, this program was expanded so as to cover children 12 years of age or younger effective January 1, 2023, and guarantee continuing coverage until age 19 for children who otherwise remained eligible. *See* sections 234 and 235 of Public Act 22-118.

Since this program only began providing coverage at the beginning of January 2023, the Department has not yet had a chance to evaluate the effectiveness of the program or its actual cost to the state. This is particularly relevant because existing law indicates that the program can only provide assistance to otherwise eligible beneficiaries within available appropriations. The Department does not yet know whether funds appropriated for the program in its existing format will be sufficient to cover all eligible individuals through the end of the fiscal year. Accordingly, the Department believes any further expansion of the program is premature until there has been an opportunity to take stock of the program in its current form and, as noted previously, such an expansion would come with a cost not contemplated in the Governor's proposed budget. Accordingly, the Department must oppose this bill.

HB-6628 - AN ACT CONCERNING MEDICAID COVERAGE OF BIOMARKER TESTING

This bill would require the Department of Social Services to provide Medicaid coverage for biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing

monitoring of a Medicaid enrollee's disease or condition. Biomarkers are a wide variety of tests that can include testing for strokes, specific diseases like lupus and rheumatoid arthritis, genetic sequencing of cancers, cancer subtyping, specific tumor genetic testing, and genetic testing of an individual's entire genome for specific mutations, and whole exome sequencing. The Department currently covers biomarker testing and biomarkers not explicitly covered can be covered and reimbursed when such services are deemed medically necessary as specified by section 17b-259b of the Connecticut General Statutes.

The Department maintains established policies and procedures, including specific criteria, for providers to follow when requesting coverage of services that require prior authorization that detail the minimum criteria that must be met for consideration of coverage. These criteria are used as guidelines for reviews and all requests are assessed based on the individual needs of the HUSKY Health member, with medical necessity used as the final deciding factor for approval or disapproval of coverage. This same process is used for determining coverage of services such as biomarker testing. Maintaining the requirement for prior authorization is important as it ensures the Department can continue to validate the clinical utility of the service being requested. The Department routinely reviews established policies and procedures, including those used for determining coverage of laboratory services, and makes necessary updates utilizing evidence that supports changes to clinical standards. For this reason, the Department does not see the need for this bill and thus does not support.

HB-6629 - AN ACT CONCERNING TEMPORARY FAMILY ASSISTANCE

This bill proposes to increase the time limit on the Temporary Family Assistance program and gradually reduce benefits for newly employed beneficiaries over a 90day period.

The Temporary Family Assistance (TFA) program is Connecticut's cash assistance program for low-income families with dependents funded through a state appropriation with expenditures claimed under the federal Temporary Assistance for Needy Families (TANF) block grant. Federal TANF rules restrict recipients to a 60-month (five year) time limit, and states are permitted to set shorter limits. When Connecticut created the TFA program in 1997, it opted to set a 21-month time limit\. All recipients of TFA are subject to this time limit unless they meet an exemption as outlined in section 17b-112 of the general statutes. "Time-limited" beneficiaries can also qualify for two 6-month extensions if they meet ongoing eligibility requirements. Program rules also place a limit on wages a family can earn while being a recipient of TFA. Currently, the earned income limit is 100% of the Federal Poverty Level (FPL), or $1,526 a month for a family of two. Once a beneficiary's earnings exceed that limit, their TFA benefits are discontinued. As noted below, the Governor is proposing to increase and adjust the earned income disregard from 100% FPL to 230% FPL to allow families to remain on TFA longer while pursuing their careers.

This bill increases the maximum length of time that a family subject to time limits can receive TFA benefits, from the current 21 months to 60 months (the federal maximum). The bill also removes the provisions that currently permit the Department to grant benefit extensions after month 21 as there would be no need for extensions if the state time limit was aligned to the federal time limit. In addition to allowing currently enrolled families to participate in the program for a longer period of time, this change would allow those families who previously used

fewer than 60 months to re-enroll in the program. Finally, the bill directs the Department to gradually reduce the benefits of a family who has newly earned income that would otherwise make it ineligible for continued assistance, rather than discontinue assistance immediately, as is current practice, though the bill does not provide guidance on how this gradual reduction of benefits should occur beyond indicating that the tapering should occur over a ninety-day period.

Currently, most families in Connecticut who are subject to and reach the 21-month limit become eligible for two 6-month extensions if they meet the stricter eligibility criteria that apply to extensions, effectively creating a 33-month state time limit (and under limited circumstances, extensions beyond 33 months). Also, if a family has newly earned income that would make it ineligible for the program, under current program rules the Department immediately discontinues benefits (after notice and a period in which the family can contest the Department's decision at an administrative hearing, if it chooses to do so).

Regarding the proposal to taper benefits over 90 days before losing access to the program based on an increase in a family's income, the Department agrees that there is an opportunity to be more supportive of families in this position. To encourage TFA participants to pursue and continue on career paths that lead to higher-paying jobs, the Governor's budget includes a proposal to increase the earned income disregard and mitigate the "benefit cliff" effect that can occur when families begin to increase their earnings. Under Governor's Bill 6665, families with income (1) at or below 100% FPL can remain on the TFA program with no impact to their benefits; (2) above 100% FPL but at or below 170% FPL can remain on the program for six months with no impact to their benefits; and (3) above 170% FPL but at or below 230% FPL can remain on the program for six months with a 20% reduction in their benefit level. The Department believes that the proposal included in the budget will provide greater assistance to families and respectfully asks the committee to consider that proposal in lieu of the proposal in this bill.

While the Department appreciates the intent of the policy changes identified in this bill, we cannot support the extension of the program time limit at this time due to the potential costs that have not been included in the Governor's budget, and respectfully suggest that the proposal in the Governor's budget will support working families participating in TFA will help address the policy concern identified in this proposal. The Department is open to working together with the legislature and other program stakeholders to identify how best to modernize the TFA program within available resources.