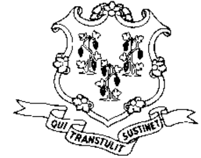

Testimony before the Human Services Committee
February 28, 2023

Good morning, Senator Lesser, Representative Gilchrest, and distinguished members of the Human Services Committee. My name is Andrea Barton Reeves, and I am the Commissioner-Designate for 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 978 AN ACT CONCERNING EXPANSION OF THE COVERED CONNECTICUT PROGRAM

This bill proposes to expand the Covered CT health care insurance program to families and individuals with income up to 200% of the federal poverty level (FPL) and develop a plan for a second tier of the Covered CT program to provide state-assisted health care coverage to individuals whose income exceeds 200% FPL but does not exceed 300% FPL. The Department appreciates the intent of this bill and supports the goal of reducing uninsured rates in the state. The Department also appreciates this Committee's support for, and interest in, expanding Covered CT.

Background on the current Covered CT program
Covered CT was established during the 2021 legislative session. There was initial debate prior to the establishment of the Covered CT program on whether to pursue Medicaid expansion or subsidies for Qualified Health Plans (QHPs) offered through Access Health CT. Connecticut lawmakers and Governor Lamont decided to pursue subsidizing QHPs offered via Access Health CT; this approach allows the state to maximize state dollars via an 1115 Medicaid waiver that would allow for federal financial participation of 50% of program costs.

The program was developed to provide no-cost health care coverage for individuals with income too high to qualify for HUSKY but not exceeding 175% FPL or $52,500 for a family of four. Coverage is centered around silver-level qualified health plans that eligible residents can select on the state-based marketplace (Access Health CT), with the addition of dental and non-emergency medical transportation benefits through the HUSKY provider network. The program pays for all premiums and cost-sharing that would otherwise be the responsibility of the eligible individual, so that eligible individuals will have no out-of-pocket costs.

The Department, in partnership with the Office of Health Strategy (OHS), the Connecticut Insurance Department, and Access Health CT, is still in the early stages of transferring administrative and budgetary authority from OHS per Public Act 22-118, § 252(b) while simultaneously operationalizing the program following eligibility expansion in July 2022 to include not only parents and needy caretaker relatives but also non-pregnant low-income adults that meet the age and income

requirements of the Covered CT program. In addition, federal approval of the 1115 Medicaid waiver on December 15, 2022, will ensure federal funding is available to support the program.

To date, individuals have been able to retain their Medicaid coverage due to the numerous extensions of the federal public health emergency. With those extensions, DSS was required to suspend most discontinuances under Medicaid. Pursuant to the federal Consolidated Appropriations Act, 2023, that continuous enrollment requirement ends on March 31, 2023. Thus, individuals who are no longer eligible for Medicaid could begin coming off Medicaid following a redetermination starting in April 2023, which is when we expect enrollment in Covered CT to start to increase at a more accelerated pace. By June 2025, consistent with earlier projections, the Department anticipates that over 40,000 individuals will be enrolled in the program

This program receives substantial federal financial support, both through enhanced subsidies for individuals purchasing qualified health plans through the state-based marketplace, as well as from Medicaid through the 1115 waiver. These federal enhanced subsidies are currently authorized at the federal level until December 31, 2025and federal financial participation through the 1115 waiver is authorized until December 31, 2027. State costs for the current program are anticipated to be $20 million in SFY 2023 (based upon end of year enrollment of 19,700 enrollees), $29.9 million in SFY 2024 (based upon end of year enrollment of 36,800 enrollees), and $42.2 million in SFY 2025 (based upon end of year enrollment of 40,400 enrollees). Overall, approximately 50% of all funding for Covered CT comes from the federal government, with the remainder coming from the state.

The projected level of federal funding for this program is important for the financial sustainability of the program at the current 175% FPL income eligibility threshold. This federal funding is contingent on both high levels of ongoing federal subsidies, as well as federal financial participation with the recent approval of the 1115 waiver.

Discussion of the proposed bill
Expanding eligibility as proposed in this bill would require a significant amount of funding for both services and administration. Moreover, this funding is not included in the Governor's budget. Finally, the federal approval of the current program has only recently been secured and, with the expansion of eligible populations with income up to 175% FPL still being rolled out, anticipated enrollment is expected to take several years to reach targeted levels. For these reasons, the Department cannot support this bill at this time.

Expanding the program by the scope proposed in this bill will require the Department to request an amendment to the recently approved waiver. Application, review and approval of an amended waiver for Covered CT would likely take up to six-months and would include updates to supporting budget neutrality reports and revisions to the monitoring protocol and the evaluation design plan required of the state under the special terms and conditions of the waiver. The Department respectfully suggests that it would be prudent for the state to allow more time for program performance under the currently designed structure to assess utilization trends and costs as well as to allow time for the program to become fully operational under the administration of the Department of Social Services before contemplating expansion to a significantly larger population. Moreover, it is difficult to predict if CMS would approve federal Medicaid funding to support an expansion beyond the current threshold of 175% FPL.

The estimated cost of the expansion of the program as proposed in the bill is also expected to be significant. Preliminary estimates of the incremental, annualized state share of the cost of expanding

from 175% to 200% FPL could be in the range of $30 to 40 million. This assumes the approval of the expansion and the availability of federal funds under a revised 1115 waiver, as well as the continuation of additional federal QHP cost sharing provisions included under the American Rescue Plan Act. Increasing eligibility to 300% FPL with some cost share above 200% FPL would be a significant increase above that amount given the additional number of individuals that would be in the 200 to 300% FPL range. In addition to the programmatic and fiscal concerns, the overall costs that are not included in the Governor's budget and the uncertainty of federal funding to help subsidize any expansion, the Department notes that it would require substantial ongoing administrative resources to support this change, as well as start-up resources to implement related system changes.

Finally, the Department notes that the volume of operational, system and administrative work being performed to conduct the unwinding of the Medicaid continuous enrollment provisions and the implementation of the significant new eligibility expansions over the past year has stretched Department resources. In order to expand the Covered CT program at the scope contemplated under the proposed bill, the Department would be required to divert key resources from the unwinding process and the implementation of other eligibility expansions, thereby jeopardizing the success of that important work.

SB 991 AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR COMMUNITY HEALTH WORKERS.

This bill requires the Department to amend the Medicaid state plan by October 1, 2023, to provide Medicaid reimbursement for services provided by certified community health workers (CHWs).

The Department understands that CHWs help make a positive impact on the health and well-being of the people and communities served within Connecticut. They are trusted frontline public health professionals who have a unique understanding of the socioeconomic needs of the communities and populations served. They serve as a liaison between individuals, communities, healthcare providers, and social service providers to facilitate access to care, improve the quality and cultural responsiveness of service delivery, address health-related social needs, and address health inequities disproportionally impacting historically marginalized communities.

The Department recognizes the critical role that CHWs play in serving our members and, over the years, the Department has incorporated these professionals into the Department's programs. For example, CHWs have played an important role in our medical administrative services organization, Community Health Network of Connecticut (CHN CT) for over 10 years. The CHWs' responsibilities include: supporting members in the intensive care management program, a voluntary program that supports members' abilities to manage their medical, behavioral and social health needs; connecting members to resources to address social determinants of health; and providing assistance and supporting new members in understanding their benefits. The Department is also working with the nine community action agencies to build or enhance a CHW program and, together with the Office of Early Childhood, the Department of Public Health, the Department of Children and Families, and the Office of Health Strategy, we are preparing to launch the "Family Bridge" pilot program, an innovative perinatal pilot program that combines an evidence-based nurse home visiting model with CHWs in the Bridgeport area.

The Department appreciates the intent of this bill and the valued role CHWs play as members of the healthcare team and community. However, the language in this bill is broad and does not set any parameters or definitions on the scope of coverage. Although CHWs are capable of effectively providing a diverse range of services, there may be certain services that are not deemed appropriate for provision under a Medicaid program. Additionally, the timeline set in the bill would not allow for the careful and needed review before pursuing a specific reimbursement methodology. The Department, alternatively, endorses a more focused integration of CHWs into Medicaid, primarily through the utilization of value-based models that are presently undergoing evaluation by the Department. Additionally, the Governor's proposed budget does not include funding allocated for CHW reimbursement. For the foregoing reasons, the Department cannot support this bill.

SB 1109 AN ACT CONCERNING MEDICAID REIMBURSEMENT TO COMMUNITY LIVING ARRANGEMENTS, INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES, RESIDENTIAL CARE HOMES AND NURSING FACILITIES

The Department of Social Services identified several technical revisions to Connecticut General Statutes (CGS) sections 17b-340 and 17b-340d that are necessary for nursing facility Medicaid rate setting purposes and ensure that Medicaid reimbursement supports high-need nursing home residents. Nursing homes are an important part of the Medicaid program since 70% of nursing home residents receive Medicaid. There are 198 nursing homes in Connecticut who care for Medicaid members, accounting for approximately $1.12 billion in total Medicaid spending in FY 2022.

Pursuant to Public Act 21-2, June special session, the Department began the three-year transition in the Medicaid nursing home reimbursement from a cost-based methodology to an acuity-based reimbursement system on July 1, 2022. Acuity-based reimbursement supports the goals of the Department in advocating for a meaningful continuum of long-term services and supports, modernizing Medicaid reimbursement, aligning payment with the acuity of residents, incentivizing the admission of people with higher levels of care, and preparing providers for value-based payment approaches. Under acuity-based reimbursement, the Department adjusts nursing facility Medicaid rates quarterly to ensure reimbursement aligns with the Medicaid resident mix of each nursing facility and encourages nursing facilities to accept higher acuity residents.

As part of the Department's transition to an acuity-based reimbursement methodology, the legislature passed language that requires the Department to implement the new acuity-based reimbursement methodology. The bill makes the following technical revisions to section 17b-340d, CGS, to support the current Medicaid nursing home reimbursement methodology:

- It allows the Department to continue the current practice of establishing specialized rates for populations with specialized needs, such as patients with acquired immune deficiency syndrome, traumatic brain injury or other specialized services. This practice incentivizes facilities to serve special populations, providing the supports needed to keep these residents in-state versus sending them out-of-state for specialized services.
- It recognizes reimbursement for fair rent increases for nursing facilities that have documented real property improvements. This encourages facilities to maintain and make

improvements to their buildings and supports modernization and technology upgrades. This provision is also extended to community living arrangements (CLAs), intermediate care facilities for individuals with intellectual disabilities (ICFs), and residential care homes (RCHs).

- It provides cost efficiency adjustments for indirect costs and for administrative and general costs if such costs are below the statewide median. Current reimbursement for the administrative and general component of the Medicaid rate is capped at the statewide median. Reimbursement for indirect costs is capped at 115% of the statewide median.
- It provides for rebasing of rates every two to four years after the transition to an acuity-based reimbursement system is complete and clarifies that there is no inflation adjustment during a year in which a facility's rates are rebased. Historically, nursing facility rates have been rebased no more frequently than every two years and no less frequently than every four years. Rebasing recognizes cost increases experienced by the homes such as staffing increases, food prices and increases in vendor services.
- The technical updates also include an alignment between statute and regulations regarding inflation for nursing homes. Existing regulation allows for inflation updates based on the percentage increase of the gross national product deflator but statute references use of the Consumer Price Index. Use of the gross domestic product deflator is current practice and this revision aligns language for nursing homes. This provision is also extended to CLAs, ICFs, and RCHs.

The Department urges passage of this bill.

SB 1110 ACT CONCERNING VARIOUS REVISIONS TO THE DEPARTMENT OF SOCIAL SERVICES STATUTES

Through this bill the Department proposes a number of technical revisions to existing statutes to improve the efficiencies of our staff as well as changes needed to comply with federal law.

Section 1. Section 17b-8(b), CGS, requires DSS to submit an annual report to the legislature detailing potential Medicaid waivers and amendments that may result in a cost savings for the state. It also requires the Commissioner to notify the committees of cognizance of the possibility of any Medicaid waiver application or proposed amendment to the Medicaid state plan that the Commissioner is considering in developing a budget for the next fiscal year before the Commissioner submits such budget for legislative approval.

The Department believes that this statute is unnecessary and that the report is duplicative, as a process already exists for the submission of cost savings ideas. Specifically, every year in early October agencies submit cost savings ideas as part of the formal budget options process. Accepted cost savings proposals are included in the Governor's recommended budget submitted in February. Finally, the Department is required to submit any and all Medicaid waivers, including those that may result in cost savings, to the legislature for their review prior to the submission of the waivers to the Centers for Medicare and Medicaid Services (CMS). As this provision is duplicative of existing requirements, the Department respectively urges repeal of this provision.

Section 2 and 3. Federal law requires a state participating in Medicaid to ensure that its laws include certain provisions about the obligations of a third-party doing business in the state when a claim for reimbursement for services and items paid for by Medicaid is received by such third party. Section 202 of the Consolidated Appropriations Act of 2022, Public Law 117-103, adds two new requirements of this nature that are not currently codified in Connecticut law. Specifically, section 202 requires that states enact laws providing that:

(1) With respect to items or services for which such third party (other than Medicare, a Medicare Advantage plan, or a Medicare Part D plan) requires prior authorization, the third party must accept the state Medicaid agency's authorization that the item or service is covered under the Medicaid state plan (or a waiver of such plan) "as if such authorization were the prior authorization made by the third party for such item or service."
(2) The third party must respond to a state Medicaid agency's inquiry about a claim for reimbursement within sixty days (current Connecticut law requires a response within ninety days).

This bill incorporates these requirements into sections 17b-265 and 17b-265g, CGS, Federal law requires states to enact these state-law changes by January 1, 2024. As such, DSS urges passage in order to comply with federal law.

Section 4. This section removes a reference to ConnMAP, which is now defunct and is being repealed by section 10 of this bill.

Section 5. DSS proposes a revision to the Connecticut Energy Assistance Program that will require fuel vendors who complete deliveries to be paid by a Community Action Agency (CAA) not later than 10 business days after the CAA receives an authorized invoice. It had previously been a 30-day time period. This revision was agreed to in response to concerns that the fuel delivery vendors raised with DSS during the beginning of the program season in October 2022. It will provide fuel vendors with additional financial security and limit the industry concerns regarding the timeframe and uncertainty of when payments will be finalized.

Section 6. This section recognizes that the Department may implement a bundled payment for maternity services, or any other alternative payment methodology (APM) or combination of methodologies, to improve health quality, equity, member experience, cost containment and coordination of care. To the extent that regulations might be required, this section would allow policies and procedures to be established pending the formal adoption of any such regulation related to alternative payment methodologies. This provision will enable the Department to implement and update the APMs efficiently while pursuing the formal regulation adoption process.

APMs are an important tool for the Department to be able to shift payments away from mostly incentivizing volume to incentivizing improving the quality of care, reducing costs, and encouraging collaboration.

1. Improving Quality of Care: APMs can incentivize healthcare providers to focus on improving patient outcomes and the quality of care they deliver, rather than simply providing more services. This can lead to better health outcomes for patients and a more efficient use of healthcare resources.

2. Reducing Costs: APMs can also help reduce healthcare costs by encouraging providers to find more efficient ways to deliver care. Providers who are paid based on patient outcomes, rather than the volume of services provided, have a strong incentive to avoid unnecessary procedures and tests, which can drive up costs.

3. Encouraging Collaboration: APMs can promote collaboration between healthcare providers, which can lead to better coordination of care and improved patient outcomes. For example, APMs may encourage primary care physicians and specialists to work together more closely to manage a patient's care, which can reduce the likelihood of complications and hospital readmissions.

The Department is finalizing the details of a maternity bundle which can be classified as an APM. Covering over 40% of births in the state, DSS understands the vital importance of addressing and remedying disparities of access, utilization and outcomes for pregnant members, with an emphasis on people of color. The approach reduces silos in a member's care experience, creates efficiencies that lower unnecessary costs, and improves the quality of care a member receives throughout the episode, ultimately leading to better patient experiences and health outcomes.

Section 7. This section removes reference to the emergency housing statute being repealed by section 10 of this bill.

Sections 8 and 9. Effective January 1, 2023, the Department implemented state-funded coverage equivalent to Medicaid and CHIP (HUSKY A and B) coverage for children aged 0-12 who cannot qualify for Medicaid or CHIP due to their immigration status. This coverage is called State HUSKY A and State HUSKY B. The enacting legislation precludes a child from enrolling if that child already qualifies for affordable, employer-sponsored insurance.

The Department is not able to verify whether an applicant does or does not qualify for such insurance beyond self-attestation. To ensure that the equivalent Medicaid and CHIP policies of being the payor of last resort can be effectuated in this program, DSS proposes to incorporate Medicaid and CHIP-equivalent third-party liability rules in the State HUSKY A and State HUSKY B programs.

Extending the third-party liability rules to these programs will enable the Department to recover the cost of any medical assistance paid under this coverage group should it be later discovered that employer-sponsored insurance was in place. Doing so will also clarify that the Department may recover from other liable third parties, such as tortfeasors who are determined liable for health coverage costs and ensure that DSS continues to be a financial steward of state and federal funding.

DSS is not seeking to make State HUSKY A/B less accessible or more restrictive – rather, the Department is seeking to guarantee that the correct party pays when appropriate – just like we do for children on the equivalent Medicaid and CHIP HUSKY programs.

Section 10: Section 17b-306a, CGS, requires the Department, in collaboration with the Department of Public Health and the Department of Children and Families, to establish a child health quality improvement program to improve the delivery of and access to children's health services and report to the legislature on its findings. The statute was enacted when Connecticut administered Medicaid through a managed care approach, contracting with multiple managed care organizations (MCOs) to provide Medicaid services across the state. This statute was enacted to ensure the availability of public information on the overall quality and ways to improve the delivery of children's health services across the Medicaid program. With multiple MCOs delivering Medicaid services across the state, this statute was necessary to support a comprehensive review of the quality of children's health services.

The state moved from a managed care model to a managed fee for service model in 2012. Under this model, DSS has one Administrative Services Organization (ASO) for each of the core healthcare services: physical, behavioral health and dental. The three ASOs provide a significant amount of comprehensive statewide data to the public on a regular basis. As such, this statute is no longer applicable to the Department and should be repealed.

Sections 17b-550 to 17b-554, CGS, established the Connecticut Medicare Assignment Program (ConnMAP), a state program intended to limit "balance billing" for Medicare Part B enrollees. Balance billing is now largely prohibited by federal law for enrolled Medicare providers and is further prohibited for Medicaid/Medicare dual enrollees. DSS believes the program to be effectively defunct due to these federal protections and as such, recommends repeal of these sections.

Section 17b-807, CGS, provides "No state funds appropriated for a special needs benefit for emergency housing for recipients of payments under the temporary family assistance program or state-administered general assistance shall be used to pay the costs of emergency shelter in hotels or motels except in cases of natural or man-made disasters or other catastrophic events." The statute precludes DSS from placing individuals or families in need of emergency housing in a hotel or motel unless the need for the emergency housing was caused by a natural or man-made disaster. However, in reality, DSS cannot limit such placements. Families in need of emergency housing due to events like evictions or lead abatement are sometimes located in areas where the only option is to utilize a hotel or motel, and this is what we do in practice if necessary. We do not believe we are able to limit the use of hotels and motels as a source of emergency housing to situations where the individual or family needs the housing due to a natural or man-made disaster. As such, DSS proposes repeal of this section so that there are no obstacles to our placement of families or individuals in need of emergency housing.

The Department urges passage of this bill.

SB 1111 AN ACT CONCERNING EXCESS NURSING HOME BEDS AND PAYMENT FOR NONPATIENT CARE IN NURSING HOMES

Before discussing the proposal, I would like to provide brief context on the important role that the nursing home industry plays in Connecticut and for Medicaid. Nursing homes serve medically needy residents from all walks of life. Medicaid plays a key role in nursing homes, since Medicaid covers the costs of care for approximately 70% of nursing home residents. There are 198 nursing homes in Connecticut that care for Medicaid members. On average, Medicaid pays approximately $100,000 per resident per year in a nursing home in Connecticut (including the "applied income" that residents pay). In Fiscal Year 2022, Connecticut Medicaid spent approximately $1.12 billion on nursing homes.

As outlined in the Department's October 2022 MAPOC presentation[1], Connecticut Medicaid pays for nursing homes with a per-home per diem rate using a "cost-based" methodology. This means that every home receives a fixed, home-specific, daily rate for each resident that they serve. This rate is based on a nursing home's costs. When Connecticut Medicaid rebases a home, a home's reimbursement is based on a home's "allowable costs" in five cost categories – direct care, indirect, fair rent, capital, and administrative & general. The focus of this bill is the administrative & general (A&G) component, which represents approximately 14% of the per diem rate and covers costs associated with maintenance and plant operations and plant operation expenses, salaries and related fringe benefits for administrative and maintenance personnel. This cost category does not include costs like nursing salaries or fringe benefits ("direct care") or expenses like dietary, housekeeping or laundry ("indirect care").

This bill makes two reforms to the A&G component of the nursing home per diem. First, it reduces the A&G component for facilities that are below a minimum occupancy of 90% for beds that have been empty for longer than 12 months ("excess beds"). Second, it establishes a fixed price for the A&G component by establishing peer groupings based on licensed bed capacity and geography ("peer groupings").

Excess beds

Medicaid programs may only reimburse for allowable costs, which are determined in accordance with the Medicaid State Plan, as well as state and federal regulations. Low-occupancy homes spend a higher percentage of their dollars on "non-patient care" in part because they have fewer residents to amortize fixed costs. Per Medicaid reimbursement principles, Medicaid programs cannot pay for idle capacity or space not used for resident care. (To satisfy this federal requirement, DSS applies a 90% minimum occupancy standard.) This proposal intends to incentivize homes to delicense unused space / empty beds by paying less for beds that are not occupied. Under this bill, if a home does not delicense unused beds, they would see a 10% reduction to the A&G component down from 100% to 90% effective April 1, 2025. Currently, facility costs are calculated on a per diem basis and are limited to maximums established as percentages of median costs. A&G is capped at 100% of the median under CGS. 17b-340. The current cap is $40.72.

[1] https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20221014/DSS%20Report.pdf

The changes in this bill are intended to achieve the goals of encouraging nursing homes to delicense empty beds, removing costs related to empty beds and better directing costs towards direct care.

Peer groupings

Related, this bill also works to achieve the same goal as excess beds by setting a price to the A&G component of the per diem. Beginning July 1, 2024, nursing homes would be placed into peer groupings based on a facility's licensed bed capacity and geography to establish a set price paid for the A&G component of the rate. The rationale is that similar-sized facilities can amortize costs across the same number of residents. Full evaluation is needed before the fiscal impact can be known in FY 25 and future years. Monthly monitoring of statewide census data and geographic regions will take place to ensure access and ensure that decreases align with statewide rebalancing efforts. Peer group medians and prices established under this bill will be budget neutral – both to the state and to the nursing home industry. The Department will review annual cost reports to make recommendations on A&G price rebase frequency to account for inflation, increased costs, and market adjustments.

The changes to this part of the bill are intended to achieve the goals of encouraging nursing homes to delicense empty beds, removing costs related to empty beds, and limit the amount of funding spent on A&G.

The Department urges passage of this bill.

HB 6587 AN ACT CONCERNING MEDICAID COVERAGE FOR DIAPERS

This bill would require the Department to provide Medicaid reimbursement for diapers for any child covered by Medicaid who is in need of diapers, or to parents of such child, or to an adult directly responsible for caring for such child. The Department currently provides coverage of diapers under Medicaid for children ages 3 years and older when the diapers are medically necessary in the management of incontinence associated with a medical condition and based on the individual needs for each member. The Department anticipates that adding coverage for diapers for any child covered by Medicaid would result in a significant increase in Medicaid expenditures and would likely require the Department to go through the 1115 waiver process with no guarantee of gaining approval from the Centers for Medicare and Medicaid Services (CMS).

Funding for an expansion of coverage of diapers under Medicaid is not contemplated in the Governor's proposed budget. The Governor's budget does, however, continue to include $700,000 in annual funding for the provision of diapers to low-income families, which the Department accomplishes through a contractual agreement with the Connecticut Diaper Bank. In the first quarter of SFY 2023 the Diaper Bank provided diapers to 6,243 children in 5,557 families across the state, 81% of whom were below 100% of the federal poverty level (FPL) and all of whom were under 200% of FPL. While the Department appreciates the intent of this bill which would provide a form of financial and health support to the low-income families and children that we serve, due to the anticipated significant cost of this proposal and the fact that

such a level of funding is not contemplated in the Governor's budget, the Department cannot support this bill at this time.

HB 6612 AN ACT CONCERNING NONPROFIT HEALTH AND HUMAN SERVICES PROVIDERS

The Department of Social Services remains committed to a strong network of private nonprofit providers to deliver necessary human services for the many people who depend on state human services programs. However, this bill's proposed expansion of the surplus retention program, if fully implemented by DSS, would expose the state to federal audit and disallowance risk for Medicaid and other federal programs. It would also remove the state's ability to craft contracts to maximize quality and value for recipients and taxpayers.

As the single state Medicaid agency, DSS claims over $1 billion annually for federal Medicaid matching funds for services paid by other state agencies such as the Department of Developmental Services, Department of Mental Health and Addiction Services, and Department of Children and Families.

Federal approval for matching funds for those payments is specifically contingent on the state's ultimate reconciliation of costs – which is a complex undertaking to assure that all ***non***-Medicaid costs are appropriately excluded from any federally claimed activity.

For DSS contracted services, such retention programs may only apply to DSS contracts that are ***not otherwise funded or reimbursed by the federal government*** and could likewise not apply to programs that are funded with a combination of state and federal funds unless the contract budget ***clearly separates the activities funded under each source*** (e.g., state vs. federal) and the ***surplus*** is solely and identifiably the result of actions on the ***state-funded*** portion of the contract. It should be noted that of the hundreds of purchase of service contracts that DSS holds with private nonprofit providers, only approximately 10 to 15 are solely funded with state funds. For those that are funded jointly with state and federal funds, there is no financial distinction made between funding sources. As a practical matter, the exception as provided in subsection (c) of section 1 of the proposed bill would substantially negate the expectations contained within subsection (b) of section 1 as relates to any anticipated, categorical surplus retention by such nonprofits.

In addition, a notable portion of services provided by private nonprofit providers utilize a "grant-based payment methodology" that must be converted to a Medicaid-specific rate-based methodology for federal Medicaid claiming purposes. In these arrangements, the state claims an *estimated amount* of the provider's costs as an interim rate that is subsequently reconciled to the provider's *actual documented costs.* It is these *actual documented costs* that must be converted to a final rate to ensure that the state is only claiming for valid Medicaid services at Medicaid approvable rates. As a result of such payment methodologies, requiring payment within 30 days of provision of services as provided in section 4 of the proposed bill is simply not feasible to the extent that the contracted nonprofit does not provide immediate bills, claims or cost reporting.

In short, such proposed surplus retention adds additional complexity to the federal claiming process and puts the state at risk of audit if funds are not appropriately documented and separated

between state and federal funding streams and would not constitute an efficient or effective mechanism to provide consistent and reliable funding support to private nonprofit providers of human services in Connecticut. Additionally, the requirement in section 4 for annual cost-of-living adjustments to private provider rates has not been factored into the Governor's budget. For these reasons, the Department cannot support this bill.

HB 6617 AN ACT PROMOTING EQUITY IN COVERAGE FOR FERTILITY HEALTH CARE

This bill would require the Department to amend the Medicaid state plan to provide Medicaid reimbursement for fertility treatment services.

Currently Medicaid provides reimbursement for family planning services including those that diagnose, treat, and counsel individuals of child-bearing age. Covered family planning services include, but are not limited to, reproductive health exams and lab tests to detect the presence of conditions affecting reproductive health which include infertility. The Department's current regulations for physician and hospital services prohibit reimbursement for infertility treatment services under Medicaid. This is in line with most other state Medicaid programs. (Coverage and Use of Fertility Services in the U.S. – Appendix 2: Medicaid – 9528 | KFF)

The Department anticipates that adding coverage for fertility treatment services would result in a significant increase in Medicaid expenditures and funding to cover such an expansion was not included in the Governor's recommended budget. For this reason, the Department cannot support this bill.

HB 6618 AN ACT CONCERNING MEDICAL ASSISTANCE FOR CERTAIN PERSONS RECEIVING ABORTION CARE AND RELATED SERVICES IN CONNECTICUT

This bill directs the Commissioner of Social Services to provide medical assistance for abortion care and related services when such services are provided to a qualified patient by a family planning provider who verifies the patient's eligibility to receive services. The bill would use state funding to make abortion care and related services accessible to patients from states where abortion access is limited and would require the Commissioner to seek federal reimbursement to the extent possible, including the submission of an 1115 waiver.

The Department of Social Services strongly supports reproductive rights and access to abortion care and supports the overall intent of this bill. DSS does, however, have some concerns about the bill as drafted and proposes some adjustments for the Committee's consideration.

The Department has concerns over the potential scope of the proposal. At this time, it is not possible to accurately predict the number of individuals from other states that may seek abortion care and related services in Connecticut. The Governor's proposed budget includes a one-time pool of $2 million in state-only funding to support access to abortion care and related services, including transportation and lodging and contraceptives for individuals who come to Connecticut for such services because these services are restricted in their states. DSS cannot support spending beyond that $2 million amount, as it was not included in the Governor's budget, and

therefore recommends that this proposal be limited in an amount not to exceed the one-time pool of funding that is ultimately allocated for this purpose.

Second, the scope of "related services" and the definition of "limited access to abortion" are not clearly defined. DSS looks forward to working with the Committee to better define these concepts as envisioned by the Committee.

Third, DSS would like to request that the language "shall apply for a waiver under Section 1115 of the Social Security Act" be removed from the bill. DSS does not advise pursuing an application for a waiver under Section 1115 of the Social Security Act for the purpose of federal reimbursement of abortion services and related care. Federal financial support for abortion care and related services is limited by the "Hyde Amendment," which prohibits federal funding for abortion care with the exceptions of cases where the pregnancy was a result of rape or incest or where the pregnant person's life would be in danger if an abortion were not performed. As these cases are relatively uncommon, the amount of federal funding that could be secured pursuant to an 1115 waiver for this specific purpose would likely be very limited. In addition, the Hyde Amendment rules may impose a personal risk on the patient in requiring disclosure of the circumstances of the abortion.

To summarize, the Department is broadly supportive of the intent behind this bill but requests that the Committee work with the Department to adjust the bill language in a way that ensures that the program structure is clear and can be administered within the funding levels contemplated by the Governor's budget.

HB 6665 AN ACT CONCERNING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HEALTH AND HUMAN SERVICES

This bill makes several changes related to the Governor's budget recommendations for the Department of Social Services which are detailed below. The Department supports this bill and the funding changes it would implement.

Sections 1 – 3 and 13 – 17 of the bill support comprehensive planning and coordination of autism services. To better coordinate autism services across several state agencies and school districts which either directly provide or oversee services for individuals on the autism spectrum, this bill requires the Office of Policy and Management (OPM) to serve as the lead agency responsible for coordinating services. Funding is included in the Governor's budget for one position in OPM to support the comprehensive planning and coordination of services for all individuals across the autism spectrum. The Department of Social Services will continue to oversee the operation of Medicaid state plan services and the autism waiver.

The Governor's budget includes funding for several changes which will provide significant supports for low-income families under the Temporary Family Assistance (TFA) program. These efforts are included under section 5 of this bill and include increases in the TFA asset limit and the earned income disregard.

1. Increase Asset Limits. This bill doubles the asset limit under the TFA program from $3,000 to $6,000 to allow families to earn and save a modest amount of money without losing access to TFA benefits and services. Increasing the asset limit will encourage

families to save and help them achieve financial security and economic independence. Costs of $760,000 in FY 2024 and $3.3 million in FY 2025 are anticipated.

2. Increase Earned Income Disregard. To encourage TFA participants to pursue and continue on career paths that lead to higher-paying jobs, the earned income disregard, which is currently at 100% of the federal poverty level (FPL), is increased and adjusted under this bill to reduce benefit cliffs. 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. Increasing the earned income disregard from 100% FPL to 230% FPL (from $30,000 to $69,000 for a family of four) will allow families to remain on TFA longer while pursuing their careers. Costs of $1.2 million in FY 2024 and $3.1 million in FY 2025 are anticipated.
3. Recognize Change in 2022 Session that Automatically Indexes TFA. Section 327 of Public Act 21-2, June special session, added language requiring the Department of Social Services, effective July 1, 2023, to provide an annual cost-of-living adjustment under TFA whenever (1) funds appropriated for TFA lapse at the end of any fiscal year, (2) such adjustment has not otherwise been included in the budget, and (3) the increase would not create a deficiency in succeeding years. Pursuant to section 236 of Public Act 22-118, this language is no longer needed since the standard of need for TFA is now tied to the federal poverty level, which is indexed to the consumer price index for urban consumers. Thus, benefit levels under TFA will automatically be increased each year. As such, this bill removes the provision in statute that was added pursuant to section 327 of Public Act 21-2, June special session, and codified under subsection (g) of section 17b-112, CGS.

Section 6 of the bill also increases asset limits under the State Administered General Assistance (SAGA) program. This bill doubles the asset limit under SAGA from $250 to $500 to help ensure recipients do not risk exceeding the asset limit due to the issuance of their monthly benefit. Costs of $140,000 in FY 2024 and $480,000 in FY 2025 are anticipated.

Section 7 of the bill allows for retroactive start dates under the State Supplement Program. Currently, the State Supplement application process is initiated when an individual requests cash assistance on a DSS application, with the date the application is signed being the earliest possible date assistance may be provided. Similar to nursing home admissions, many individuals moving into a residential care home (RCH) or rated housing facility (RHF), do not have the opportunity to apply for assistance prior to the admission or at the time of admission – many admissions are unexpected or result from an emergency placement after a serious injury or hospitalization. In order to provide a safety net for these individuals in need and ensure that the RCHs and RHFs serving this population are made whole, this bill aligns State Supplement rules concerning the start date of assistance with the rules that apply for Medicaid beneficiaries in need of nursing home care. This change will allow individuals seeking coverage under the program to receive State Supplement benefits for up 90 days prior to the date of the application if otherwise eligible for the program. This will help stabilize payments for RCHs and RHFs and will help impacted residents with the costs of care and room and board during that interim period. Costs of $380,000 in FY 2024 and $520,000 in FY 2025 are anticipated.

Sections 8, 9 and 10 remove rate increases for residential care homes and rated housing facilities. Under current statute, DSS is required to annually determine rates for residential care homes and rated housing facilities. Per DSS' regulations, rate increases are based on actual cost reports submitted by facilities, barring any legislation to remove rate increases for a particular fiscal year. This bill eliminates these rate increases over the biennium and, for rated housing facilities that choose not to submit annual cost reports, maintains the minimum flat rate at current levels. Savings of $4.4 million in FY 2024 and $7.3 million in FY 2025 are anticipated.

Section 10 rebases rates for residential care homes. Many residential care homes are experiencing financial issues, which has resulted in the closure of a number of RCHs in recent years, with more RCHs expected to close in 2023. Recognizing the importance of having this level of care available as part of the continuum of care, the Governor's budget includes funding to rebase rates to help ensure that these homes remain viable. (Rates were last rebased in FY 2013 based on 2011 cost reports.) This bill rebases rates based on the 2022 cost reports, the most recently audited rate year. Costs of $5.2 million in FY 2024 and FY 2025 are anticipated.

Section 11 of the bill removes rate increases for intermediate care facilities. To comply with DSS' regulations, the baseline budget includes an inflationary adjustment in each year of the biennium for intermediate care facilities for individuals with intellectual disabilities. This bill eliminates these increases over the biennium. Savings of $1.9 million in FY 2024 and $3.2 million in FY 2025 ($3.8 million in FY 2024 and $6.4 million in FY 2025 after factoring in the federal share) are anticipated.

Section 12 removes rate increases for nursing homes. Pursuant to DSS' regulations, the baseline budget includes an inflationary adjustment in each year of the biennium for nursing homes. DSS is required to provide these inflationary increases barring any legislation to remove rate increases for a particular fiscal year. This bill eliminates these increases over the biennium. (It should be noted that there is a separate inflationary factor that is built into the acuity-based model that is being implemented over the three-year period beginning in FY 2023 and which recognizes the additional resources required for nursing homes serving higher acuity residents.) Savings of $35.9 million in FY 2024 and $60.5 million in FY 2025 ($77.5 million in FY 2024 and $128.4 million in FY 2025 after factoring in the federal share) are anticipated.

In total, the above initiatives will result in net savings of $34.4 million in FY 2024 and $58.4 million in FY 2025 ($81.2 million in FY 2024 and $134.7 million in FY 2025 after factoring in the federal share).

HB 6701 AN ACT CONCERNING FUNERAL ASSISTANCE FOR PERSONS OF LIMITED INCOME

This bill would increase the maximum funeral benefit authorized under sections 17b-84 and 17b-131 of the general statutes from $1,350 to $1,800. As background, the Department pays up to $1,350 towards a funeral and burial for a decedent who died while receiving cash assistance from the Department, or who was otherwise unable to pay for a proper funeral and burial. This maximum benefit is, in some instances, reduced by certain resources enumerated in the statutes

as alternative methods of payment, such as prepaid funeral contracts and known liquid assets in the decedent's estate.

In recent years, this benefit has already been increased from $1,200 to the current rate of $1,350. It is also worth noting that contributions up to $3,400 from sources other than those enumerated in the statutes, such as payments made by friends, family members, and other benefit programs, are allowable before the Department will reduce or deny the funeral benefit.

The Department estimates that the cost of increasing the maximum funeral benefit to $1,800 would be at least $1.2 million per year. This figure is based on adding $450 to every benefit issued in 2022 but does not account for additional cases that would be granted due to the increased benefit amount, and thus actual costs would be higher. While the Department appreciates the intent of this bill, it is unable to support the bill at this time because the Governor's proposed budget does not account for this cost.

HB 6703 AN ACT CONCERNING THE LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM

This bill proposes to make several changes to the way deliverable fuel vendors are paid and program benefits are established under the Connecticut Energy Assistance Program (CEAP).

As background, CEAP is the state's energy assistance program for low-income households funded through the federal Low Income Home Energy Assistance Program (LIHEAP) block grant. The Department of Social Services is the state's designated agency for administration of the LIHEAP block grant. DSS receives an annual amount of block grant funding from the federal government, designs a plan for allocating those funds and, with legislative review and approval, implements the state allocation plan.

In accordance with federal rules, the large majority of allocated funding is dedicated to helping program participants afford the cost of energy regardless of the energy type used as the household's primary energy source (gas, electric, home heating oil, propane, etc.). DSS partners with the state's nine community action agencies (CAAs) for the operational administration of CEAP, including program eligibility determinations and payments to participating vendors (primarily utility companies and deliverable fuel vendors). Approximately a third of program participants use deliverable fuels (home heating oil, propane, kerosene, etc.) as their primary energy source.

The first proposed change would (a) shorten the timeframe in which the CAAs are required to make payments to a deliverable fuel vendor who has completed an authorized delivery of fuel, and (b) require that payments to vendors be made electronically. Current law requires payment within 30 business days; this bill would shorten that timeframe for payment to 48 hours. Current law does not specify a method of payment.

At the beginning of this program year, DSS established a requirement that the CAAs accommodate electronic fund transfer payment requests from any vendor who requests it. As electronic payment is already a program requirement, the Department does not believe that it is necessary to amend the statute to require electronic payment, but the Department is also not

opposed to making it a statutory requirement. This would, however, remove any flexibility for vendors who prefer to be paid through other methods, such as paper checks.

Additionally, at the beginning of this program year, DSS requested that the CAAs make every effort to pay invoices no later than 10 business days after a complete invoice is received. DSS has also proposed to make this a corresponding change to the state statute and believes that 10 business days is a reasonable timeframe for completing payments without adding administrative costs to the program. If this timeframe is shortened to 48 hours it is likely that the CAAs would incur additional administrative costs to effectuate the policy, such as needing to have staff available to work overtime on weekends or simply increasing staffing to comply with such a short payment timeframe. This, in turn, could increase CEAP administrative costs. Because CEAP is funded through a fixed federal block grant, increases to administrative costs reduce the amount of funds available to be issued to low-income households in the form of program benefits. To achieve the goal of this proposal without incurring additional administrative costs, the Department recommends setting the payment timeframe at 10 business days.

The second proposed change would require the Commissioner of Socials Service to (a) establish a county and regional pricing standard for deliverable fuel, and (b) reimburse fuel providers based on the price of fuel on the date of delivery.

The Department currently pays home heating oil vendors based on a fixed margin pricing structure with a county pricing adjustment to account for transportation, delivery, and operation costs.

The county differentials per gallon for FFY 2023 are as follows, and exclude the 50 cents fixed margin:

Fairfield County	$ 0.115
Hartford County	0.039
Litchfield County	0.067
Middlesex County	0.033
New Haven County	0.045
New London County	0.042
Windham County	0.100
Tolland County	0.099

The Department also already pays vendors based on the price of fuel on the date of delivery. Each business day within one hour of receiving the terminal wholesale price information, the Department posts the oil price for deliveries on our website. If a vendor receives authorization on one day but cannot deliver for several days, they would be paid based on the price for the day the delivery is made.

Here is an example of the price that the program pays to a heating oil vendor for one gallon of home heating oil to a household located in Fairfield county:

$3.124	New Haven Rack Average OPIS Price, Wednesday, February 15,
$0.500	Fixed Margin for FFY 2023

$0.115	County Differential – Fairfield County
$3.739	Total Fixed Margin Price for Deliveries on Thursday, Feb 16, 2023

Given that the Department already uses a county pricing standard and pays vendors based on the date of delivery, the proposed changes are unnecessary to add to statute.

The third proposed change would require the Commissioner of Social Services, within available funding, to provide an annual cost of living adjustment (COLA) to the benefits for participating households. As described above and outlined in detail in the state allocation plan, each year the Department receives a fixed amount of federal funding and must design a program plan to allocate that funding. Each year the Department develops a program benefit matrix that takes into consideration estimates of the projected program funding amount, projected enrollment, the cost of fuel and vendor payments, the projected benefit uptake for crisis assistance benefits, and the costs of other LIHEAP-funded services. Given that the benefit matrix is adjusted every year to account for the numerous program components and is not the same from one year to another, there is not a baseline from which to add a COLA while ensuring the program is administered within available funds. As this proposal cannot be practically accomplished, the Department opposes this provision.

For the forgoing reasons, the Department opposes the second and third proposed changes and respectfully requests the committee to consider the alternative payment timeframe of 10 business days put forth by the Department.

HB 6775 AN ACT CONCERNING MANDATED REPORTERS

Through this legislation the Department is seeking to amend section 17b-451 of the Connecticut General Statutes to add certain professionals to the designated list of mandatory reporters.

DSS administers the Protective Services for the Elderly (PSE) program which works to help adults 60 years of age and older to live with dignity and respect by investigating maltreatment, allegations of abuse, neglect, self-neglect and exploitation. The Department's social workers investigate reports of elder maltreatment and allegations of abuse through referrals to the Department's PSE intake line. It is through a referral to the PSE intake line that an investigation is triggered and lead to interventions aimed at halting the maltreatment and securing needed supports for the elder.

While any concerned person can report suspicions of maltreatment to the Department's PSE unit, most reports are made by individuals who, by their profession, are required by law, specifically section 17b-451, CGS, to report suspected maltreatment of Connecticut elders. Designated mandatory reporters are individuals who, by their profession, have frequent contact with elders and are in a unique position to see or hear concerns about abuse, neglect or exploitation. Currently the designated mandated reporters include but are not limited to social workers, nurses, physicians, dentists, psychologists and police officers.

In an effort to provide additional protections for elderly vulnerable residents of Connecticut, the Department has identified a number of additional professions to be added to the list of mandated

reporters. Each of the professions this bill seeks to add align with the existing mandated reporters and have frequent contact with elders. They are therefore in a unique position to see or hear about abuse, neglect or exploitation.

Specifically, we propose to add licensed professional counselors; dental hygienists; adult probation officers; adult parole officers; physician assistants; residential service coordinators; and employees at housing authorities, municipal developments, and elderly housing projects to the list of mandated reporters.

The rationale for the addition of these professions are as follows:

> Licensed Professional Counselors: to align with that of mental health professionals who are mandated reporters under this law, this includes social workers and psychologists.
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> Dental Hygienists: to align with that of dentists who are mandated reporters under this law. The practice of dental hygiene services has evolved and may be performed without the presence of a dentist. This means that independent interaction with elder patients is likely to occur.
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> Adult Probation Officers and Adult Parole Officers: to align with Connecticut child welfare mandated reporting laws and that of adult protective services laws in other states, including Massachusetts and Missouri. Also, as professionals in the criminal justice system they are in a position to learn of situations of elder maltreatment.
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> Physician Assistants: to align with that of other health professionals who are mandated reporters under this law, such as physicians and nurses.
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> Residential Service Coordinators and Employees at Housing Authorities, Municipal Developments, and Elderly Housing Projects: tasked with helping elderly residents to address issues impacting their health and well-being, these professionals are in a unique position to identify elder abuse neglect or exploitation.

In addition, this bill proposes a to revise "clergyman" to "member of the clergy," in an effort to be gender neutral.

The Department urges passage of this bill.

HB 6776 AN ACT CONCERNING A PASSIVE MEDICAID REDETERMINATION PROCESS FOR CERTAIN AGED, BLIND OR DISABLED RECIPIENTS

While the Department appreciates the intent of this bill and shares the goal of streamlining eligibility processes to the extent permitted by federal law, the Department must oppose this bill because it is duplicative and potentially conflicting with controlling federal law that establishes renewal requirements for Medicaid. *See* 42 C.F.R. § 435.916(b) (requiring states to renew Medicaid eligibility determined on a basis other than modified adjusted gross income (MAGI)

without requiring additional information from the beneficiary "if sufficient information is available to do so").

The Department is already in compliance with this federal law and conducts ex parte or "passive" renewals for a significant and growing percentage of the HUSKY C population, including those beneficiaries receiving long-term care services, when possible. In the month of November 2022, the Department had a HUSKY C passive renewal rate of 49.8%. The Department's ability to conduct a growing number of HUSKY C passive renewals is due to investments in system technology, including establishing an asset verification system. However, to the extent that this bill would require the Department to conduct a passive renewal for HUSKY C beneficiaries receiving long-term care services even when the Department does *not* have access to sufficient information needed to do so, it conflicts with federal law. Accordingly, because the bill is duplicative of, and in some instances conflicts with, existing renewal requirements established by federal law, the Department must oppose this bill.