Testimony before the Human Services Committee
Kathleen Brennan, Deputy Commissioner
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Good morning Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Kathleen Brennan, and I am the Deputy Commissioner 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 1052 – AN ACT EXPANDING MEDICAID COVERAGE OF TELEHEALTH SERVICES

DSS supports the purpose of this bill to expand access to telehealth services in Connecticut's Medicaid program. DSS welcomes the opportunity for dialogue with legislators and other proponents of this bill to discuss how best to implement telehealth in the Medicaid program.

DSS currently pays providers for electronic consultations ("e-consults") between primary care providers and specialists. The Medicaid Community First Choice (CFC) program pays for telehealth services that offset the need for physical assistance related to a health related task or increases independence.

DSS needs to ensure that expansion of various telehealth services is implemented carefully. Based on our experience with covering e-consults and other telehealth services, DSS is considering expanding Medicaid coverage of telehealth services, in the coming months, to:

- increase access to behavioral health services (mental health and substance use disorders);
- reduce the need for individuals who are homebound to travel to see their medical provider when services can be provided by telehealth; and
- reduce the need for individuals who undergo a surgery in a non-contiguous state to travel to see their providers for related services before and after the surgery.

The federal Centers for Medicare and Medicaid Services (CMS) has explained that telehealth services are already coverable under any state's Medicaid State Plan without the need for a waiver. To the extent that changes to the Medicaid State Plan are necessary to implement specific telehealth services, DSS can submit one or more Medicaid State Plan amendments to make the changes. This is a straightforward process and can be completed fairly quickly once the necessary analysis is

complete. Seeking a section 1115 demonstration waiver to implement telehealth services is not required to expand coverage of telehealth services.

The Department believes that the goals of this bill would be best accomplished simply by amending subsection (b) of section 17b-245e of the general statutes to read as follows:

> (b) The department shall, within available state and federal resources, provide coverage under the Medicaid program for telehealth services for categories of health care services that the commissioner determines are (1) clinically appropriate to be provided by means of telehealth, (2) cost effective for the state, and (3) likely to expand access to medically necessary services <u>where there is a clinical need for those services to be provided by telehealth or</u> for Medicaid recipients for whom accessing appropriate health care services poses an undue hardship. <u>The commissioner may provide coverage of telehealth services pursuant to this section notwithstanding any provision of the Regulations of Connecticut State Agencies that would otherwise prohibit coverage of telehealth services. The commissioner may implement policies and procedures as necessary to carry out the provisions of this section while in the process of adopting the policies and procedures as regulations, provided notice of intent to adopt the regulations is published in accordance with the provisions of section 17b-10.</u>

For those reasons, the Department recommends the above substitute language in lieu of the language in the raised bill. The Department welcomes further dialogue on this subject.

SB 1053 – AN ACT EXPANDING MEDICAID AND HUSKY B COVERAGE FOR CHILDREN

The Department appreciates the intent of this proposed legislation which seeks to provide health care coverage to more children in Connecticut. This bill proposes that children qualify for coverage in the Medicaid and HUSKY B program, regardless of immigration status.

However, there are limitations placed on federal funding for immigrant families in both the Children's Health Insurance Program (HUSKY B) and Medicaid programs (HUSKY A and HUSKY C). The CHIP and Medicaid programs currently cover all lawfully residing immigrant children. Connecticut is already taking advantage of section 214 of the Children's Health Insurance Program Reauthorization Act (CHIPRA), which allows coverage to be extended to lawfully residing immigrant children who have been in the country less than 5 years. This means that all lawfully residing immigrant children who otherwise qualify for the CHIP and Medicaid programs are immediately eligible for coverage. If coverage were extended to all children regardless of status, the state would be unable to claim federal financial participation for children who are undocumented. This would result in additional program costs incurred entirely by the state.

According to the Center for Children's Advocacy, there are approximately 17,000 undocumented children and youth in Connecticut under the age of 19. Other organizations such as the Migration Policy Institute estimate the number to be around 13,000 statewide. The exact number is somewhat elusive by nature as many individuals may not be inclined to report their status or the status of their children. It is also important to consider that some children may not meet other eligibility requirements (e.g., family income is too high; or families may be fearful to apply for public benefits

for their children due to public charge concerns). As a result, the actual number of individuals this bill proposes to support will likely be lower.

Based on the high end of the estimates and utilizing the current HUSKY A per member per month (PMPM) rate of $315, the annual cost to support a state funded medical assistance program would be approximately $64 million. This figure may also be lower as some children in higher income families may qualify for HUSKY B with a lower PMPM of $183. This does not include system implementation and other related administrative costs.

Since this proposed bill would result in additional program and administrative costs that would be borne entirely by the State and absent the availability of appropriations, the Department is unable to support this bill.

SB 1065 - AN ACT CONCERNING LONG-TERM CARE SERVICES

The Department of Social Services commends the Human Services Committee for its attention to the need for strategic planning for Medicaid long-term care services. This is a critical need given the strong preferences of older adults and individuals with disabilities to live in home and community-based settings, the state's interest in controlling costs, and support for town-level tailoring of strategies to meet local needs. However, DSS respectfully states that this legislation is not needed.

In keeping with the legislation enacted by the General Assembly, DSS developed and implemented the Strategic Plan to Rebalance Long-Term Services and Supports in 2013. The Strategic Plan captures the data and planning strategies that are contemplated by this bill. The Strategic Plan guides the activities of the Department.

In addition, Connecticut General Statutes section 17b-337 requires the Connecticut Long-Term Care Planning Committee to prepare a long-term care plan every three years based on the fundamental principle that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting. The most recent plan, titled Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut, was released in January 2019. The work of the Connecticut Long-Term Care Planning Committee informs DSS' Strategic Plan to Rebalance Long-Term Services and Supports.

SB 1066 – AN ACT PROVIDING A VOICE FOR NURSING HOME RESIDENTS SUBJECT TO TRANSFER DUE TO NURSING HOME CLOSURES OR RECEIVERSHIPS

Section 5 of the bill requires a receiver, who is appointed by a Superior Court judge to evaluate whether a nursing facility is financially viable, to hold a hearing before any involuntary transfer or discharge from a nursing home may occur after a nursing home is placed in receivership. This change is unnecessary because a hearing process for involuntary transfers or discharges already exists.

Connecticut General Statutes § 19a-535(c)(2) provides residents the right to appeal an involuntary transfer or discharge by submitting a request to the Department of Social Services. Before a nursing facility can discharge a resident, it must notify the resident and the resident's legal representative, in writing and 30 days before the scheduled date of discharge, of the right to file an appeal with the Department.

The resident's guardian, conservator, other legally liable relative or responsible party and the Long-Term Care Ombudsman also have the right to participate in nursing facility discharge hearings held by the DSS' Administrative Hearings unit, and they often do so.

For these reasons, Section 5 of the bill is unnecessary.

SB 1079 – AN ACT CONCERNING NURSING HOME FACILITY MINIMUM STAFFING LEVELS

This bill requires chronic and convalescent nursing homes (CCNH) to maintain minimum nursing staff ratios of at least 2.3 hours of direct care per resident per day. Because the Department of Public Health is the lead agency responsible for the oversight of care provided at nursing homes, the Department of Social Services (DSS) is unable to directly comment on the appropriateness of the proposed staffing levels.

DSS, however, has concerns related to the accuracy and stability of the data that would be used to identify non-compliance of the proposed requirements and which would be used to calculate nursing home rate increases to support the additional staffing requirements. A well-defined measurement of current staffing levels would be required to accurately estimate the fiscal impact of a change in the minimum staffing levels.

In light of these reasons, the Department is not able to support this bill.

HB 7335 – AN ACT CONCERNING OUT-OF-STATE USE OF ELECTRONIC BENEFIT TRANSFER CARDS

This proposal would require DSS to notify an Electronic Benefits Transfer (EBT) cardholder that continuous use of an EBT card for more than thirty days in any quarter out of state shall give rise to a presumption that the holder has moved out of state and would require the Department to end any assistance the individual is receiving. While DSS agrees that people who have moved out of state should not continue to receive state benefits, we cannot support this bill for a number of reasons.

Preliminarily, the Department notes that applicants for assistance are required to meet state residency requirements in order to receive benefits. Most types of assistance require an annual review of eligibility; short-term SAGA benefits require a review every six months. If a person has permanently moved out of state, then existing rules dictate that they would not be eligible.

The Department also believes that the mere use of an EBT card out-of-state over a 30-day period is not a sufficient reason to presume that an individual has forfeited Connecticut residency, as there are various reasons a Connecticut resident may temporarily be out of state. For example,

individuals may be: commuting to work out of state; providing temporary care for an elderly or ill family member who lives out-of-state; temporarily out of state to escape a domestic violence situation; or visiting family or friends.

The Department also has concerns about the proposed process which appears to require the termination of benefits without adequate notice and verification. The right to a hearing pursuant to sections 17b-60 and 17b-61 is normally available only after the Department has taken negative action on a case. In addition to the failure to account for the many reasons a person may be temporarily out of state and the structure of the proposed process, the Department is concerned that limiting the use of federally funded benefits based upon usage in other states could raise constitutional concerns related to the right to travel.

We also believe that this bill, as written, would have a disproportionately negative effect on DSS customers who live near the Massachusetts, New York and Rhode Island borders. Those who work in and routinely visit neighboring communities across the state line may use their EBT card there because stores are closer and more convenient to visit. The Department notes that, based upon a recent review of EBT transactions, approximately 2.6% of all EBT transactions occurred out of state and approximately half of those transactions were made in our border states.

Finally, the Department does not currently differentiate between cash benefits issued pursuant to an assistance program or cash that is routed to the client's EBT card for a child support payment. It is not unusual for a custodial party to leave Connecticut and still be eligible to receive child support payments on an EBT card. As long as Connecticut is responsible for enforcing a child support order, the custodial party does not have to reside in Connecticut to receive payments on an EBT card. This bill as written appears to propose terminating child support payments to custodial parents who move, which the Department does not believe is good policy and may also violate the constitutional right to travel.

For these reasons, the Department is unable to support this bill.

HB 7336 - AN ACT EXPANDING MENTAL AND BEHAVIORAL HEALTH CARE OPTIONS UNDER THE MEDICAID PROGRAM

This bill seeks to expand access to mental and behavioral health treatment and ensure rates are equitable across the state. The Medicaid program is proud to offer a robust behavioral health benefit for children and adults and the Department of Social Services (DSS) is always interested in discussions on how to improve our service system for those individuals with behavioral health conditions. As explained below, because the Medicaid program already meets the goals of this bill, we believe that this bill is unnecessary.

This proposal looks to ensure rates are equitable in different regions across Connecticut for the same service. In general, behavioral health services provided under the Medicaid program use a uniform fee schedule for all services, regardless of region, with two exceptions – psychiatric inpatient hospital services at a general hospital and methadone maintenance. In general, DSS supports making payment methodologies uniform statewide whenever possible. However, the

Department is unable to support any change in methodology that would result in increased state expenditures for which funding is not included in the Governor's budget proposal.

The current payment methodology for psychiatric hospitals is not based on geographic regions. There are currently three rates being used for psychiatric inpatient services which are based on the hospitals' negotiated rates prior to the overall modernization of inpatient hospital reimbursement in January 2015 (which also included diagnosis-related group (DRG) implementation for general hospitals). As part of the implementation of hospital payment modernization, psychiatric inpatient hospitalization received a rate increase in aggregate in order to adjust rates into the three tiers.

The other exception to uniform statewide fee schedules is methadone maintenance, where rates are set based on historical negotiated rates, not based on geographic region. The Department understands that other bills are being considered this legislative session that explore ways to make the payment methodology for chemical maintenance services more uniform.

The proposed bill also seeks to reduce costs and increase treatment options by expanding the types of certified and licensed providers that may provide treatment under the medical assistance program. The Department already enrolls and reimburses all licensed and certified professionals whose license or certification allows them to practice independently. Currently, the Department enrolls the following behavioral health professionals who are licensed to practice independently: Physicians, Advance Practice Registered Nurses (APRNs), Physician Assistants, Licensed Psychologists (both Ph.D. and Psy.D.), Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Licensed Alcohol and Drug Counselors. For those professionals whose license or certification does not allow them to practice independently, they have the option to work at a licensed behavioral health clinic (including freestanding behavioral health clinics, federally qualified health centers [FQHCs], and hospital-based behavioral health clinics) and the Medicaid program provides reimbursement for their services as long as they are properly supervised.

There are two potential certifications and/or licensures that we do not enroll as independent practitioners; Certified Alcohol and Drug Counselors and Licensed Master Social Workers. It is our understanding that both professions require supervision as part of their scope of practice under state law and professional guidelines and for this reason we do not enroll them as individual or group providers. Certified Alcohol and Drug Counselors may enroll as Licensed Alcohol and Drug Counselors once they receive their licensure and Licensed Master Social Workers may enroll once they receive their license as a Licensed Clinical Social Worker.

For these reasons, we believe that this bill is unnecessary.

HB 7337 – AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES' ENERGY ASSISTANCE PAYMENTS

The Department does not support this bill as it is unnecessary and, as written, could result in a significant hardship to individuals eligible for fuel assistance. Pursuant to subsection (e) of Connecticut General Statutes §16a-41a, community action agencies that administer a fuel assistance

program must make payments to vendors of deliverable fuel not later than thirty days after the community action agency receives a metered fuel slip or invoice for payment from the vendor. This statutory requirement was added during the 2018 legislative session. This bill proposes to prevent community action agencies from authorizing a fuel vendor to delivery fuel unless funds for such delivery have been transferred from the Department to the community action agency and are available to pay the vendor for such delivery. This would require community action agencies to withhold vendor authorizations, thus preventing eligible individuals from receiving fuel until that agency has received the funds from the Department.

The Department recognizes and understands the importance of ensuring timely payments to deliverable fuel vendors. We also recognize and understand that the community action agencies are unable to make payments unless they are in receipt of the funds from the Department. At the start of the FFY 2019 energy assistance program, the Department was required to execute new three-year contracts with the community action agencies. While the contracts for some agencies were not fully executed and approved by November 14, 2018, the start of fuel deliveries for this program year, all of the contracts were fully approved and all of the community action agencies received funds in sufficient time to make payments to the deliverable fuel vendors within the thirty-business-day timeframe required by statute.

If this proposed bill had been in effect for the FFY 2019 program year, many clients needing a fuel delivery during the first week of the program would have been unable to receive the deliveries, and would have been in jeopardy of being without heat.

Further, the Department is concerned that the proposed prohibition on fuel delivery authorizations could potentially result in the Department violating federal LIHEAP regulations [42 U.S.C. § 8623(c)] which requires the Department to provide assistance within 48 hours, or 18 hours if there is a life-threatening situation, following the receipt of an application from a household experiencing an energy crisis.

Going forward, for the next two program years, the community action agencies should receive their initial funds from the Department earlier than they did this program year, as the existing contracts will simply need technical amendments. The federal government also recognizes the importance for states, especially those in the northern tier of the country, to have funding in place prior to the start of the heating season and has made efforts to provide funding as soon as it becomes available through either a Continuing Resolution or spending bill. Even if the federal funding is delayed, states are allowed to carry forward up to ten percent of their current year's allocation. The Department has had sufficient carry forward funds in most of the previous years to have carryforward funds in place to be used to pay for fuel deliveries made in November of each program year.

The Department makes every effort to ensure that once contracts are executed, funds are made available to community action agencies so that payments are made within thirty business days. In fact, the Department strives to provide enough funding so community action agencies can pay vendors within two weeks after the agency receives a metered fuel slip or invoice.

Finally, following the issues that occurred in the New Haven catchment area two years ago, the Department improved the process both from a timing and accuracy perspective, and emphasized to both the deliverable fuel vendors and the Connecticut Energy Marketers Association (CEMA) that they should immediately advise the Department of any payment delays and issues. The Department has been advised by the community action agencies that, of the over 63,000 deliveries in each of the last two years, very few have resulted in late payments, and all were minor delays attributed to isolated administrative processing issues. The processes implemented by the Department, and the existing statutory language, are clearly working.

For the reasons mentioned above, the Department is not in support of Raised Bill 7337.

HB 7338 – AN ACT INCREASING FUNDING FOR ELDERLY NUTRITION, ENSURING EQUITABLE RATES FOR PROVIDERS OF MEALS ON WHEELS AND COLLECTING DATA ON MALNUTRITION

This bill would require DSS to increase the fee schedule for Medicaid reimbursement to Meals on Wheels by no less than the consumer price index (CPI). It would also allow the Department to increase fees to Meals on Wheels providers who provide evidence of extraordinary costs for delivery in sparsely populated rural areas.

The Department appreciates the valued service Meals on Wheels provides to recipients of our Medicaid home and community-based services. Note the Department increased rates for these services by 2% effective 1/1/19. Prior to that, the Department revised reimbursement guidelines for the delivery of meals under its programs, effective October 1, 2016. The revision allows providers to receive reimbursement for multiple meal deliveries in a single day as appropriate (maximum of 7 units/days of meals per delivery). Providers can now be reimbursed for a full multiple meal delivery as long as the client is present to accept the full delivery.

Unfortunately, the Department is unable to support a provision that requires an additional Medicaid rate increase at this time. Furthermore, the Department is concerned that this bill selects and provides a rate increase to one specific service provider in contrast to the hundreds of different service providers that provide vital home and community-based services to Medicaid participants.

As drafted, the reference to the CPI is ambiguous. Assuming this bill intends for the rate increase to equal to the average calendar year increase in the consumer price index for urban consumers (CPI-U), the most recent CPI-U increase is 2.4%. Based on these assumptions, the Department estimates an increased state cost of approximately $102,000 in SFY 2020. This assumes no additional cost adjustments for any extraordinary costs of providing meal in sparely populated rural areas.

Finally, as the Governor's budget does not include funding for this bill, the Department must oppose this rate increase.

HB 7358 –AN ACT CONCERNING A STUDY OF MEDICAID-FUNDED PROGRAMS

This bill requires the Commissioner of the Department of Social Services to conduct a study of Medicaid programs to assess factors pertinent to quality of care, gaps in care, and necessary actions to comply with the Affordable Care Act (ACA).

The DSS Division of Health Services is already charged with these functions on a standing basis, regularly reporting to the Commissioner on quality of care (through such means as annual reports on HEDIS measures, measures of the effectiveness of Intensive Care Management, and consumer and provider satisfaction), access (through such means as geo-access analysis and mystery shopper surveys) and necessary actions to comply with the ACA (documented by a compliance tracking tool; 100% of mandated provisions have been fulfilled).

For detailed recent, publicly available information on HUSKY Health (Connecticut Medicaid and Children's Health Insurance Program) quality and access, please see the following:

- Extensive overview of HUSKY Health medical services: https://www.cga.ct.gov/med/council/2018/0608/20180608ATTACH_CHNCT%20Presentation.pdf
- Extensive overview of HUSKY Health behavioral health services: https://www.cga.ct.gov/med/council/2018/0713/20180713ATTACH_Beacon%20Presentation.pdf
- Extensive overview of HUSKY Health dental services: https://www.cga.ct.gov/med/council/2018/0309/20180309ATTACH_CTDHP%20Presentation.pdf

The Department also provides detailed monthly reports - see this link for our posted materials https://www.cga.ct.gov/med/mh-meetings.asp?sYear=2018 - to the Medical Assistance Program Oversight Council (MAPOC), which is charged under statute with a broad range of oversight activities that encompass the goals of HB 6171.

Consistent with 2013 legislation, MAPOC convened an ad hoc Medicaid Network Access Committee that ultimately produced a detailed report, incorporating DSS material, on access to care as well as other factors relevant to provider participation (ACA Ordering, Prescribing and Referring requirement) - see this link for the posted report: https://www.cga.ct.gov/med/council/2014/0314/20140312ATTACH_Network%20Adequacy%20Report.pdf.

While the Department does not oppose the general concept of this bill, we respectfully suggest that the legislation is duplicative and unnecessary. It would divert resources the Department needs to focus on the provision of services.