



*Testimony before the Human Services Committee
Roderick L. Bremby, Commissioner
March 7, 2019*

Good morning Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick L. Bremby, and I am the Commissioner of the Department of Social Services.

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

SB 943 - AN ACT CONCERNING MEDICAID TREATMENT OF AN INACCESSIBLE ASSET

This bill would prevent an applicant for Medicaid from being determined ineligible on the basis of a single, unliquidated asset, provided that the individual provides evidence to the Commissioner of Social Services that such asset is inaccessible. The Department of Social Services (DSS) has multiple issues with this bill.

The proposed change pertains to a single disqualifying asset that causes the institutionalized individual's total assets to exceed the Medicaid limit. The term "unliquidated asset" is ambiguous and undefined, as it is not a term that is used in Medicaid or by the Social Security Administration.

Medicaid law, instead, uses the term "countable asset," which is defined as cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and can convert to cash to be used for his or her support and maintenance. If the individual has the right, authority or power to liquidate the asset, then it is countable towards the Medicaid limit. Also, a delay in accessing funds does not remove the right to the funds.

Further, there is no standard in the statute as to what constitutes "evidence acceptable to the Commissioner of Social Services." The lack of an evidentiary standard could lead to inconsistent decisions. It is not clear whether the individual would have the right to an administrative hearing if the Commissioner of Social Services determined that the individual did not present acceptable evidence that an asset was inaccessible. The Department of Social Services is already overwhelmed with the number of administrative hearing requests and, under present law, those decisions must be issued within ninety days of the hearing request. Expanding the basis for which an individual can request an administrative hearing would place an additional burden on an already overburdened administrative hearings unit.

The exclusion of a single disqualifying asset would effectively allow institutionalized individuals

to have assets in excess of the Medicaid asset limit, and still qualify for assistance. This would remove any incentive for individuals or their representatives to reduce their assets in a timely manner by paying nursing facilities. This section would increase Medicaid expenditures by allowing applicants to be eligible for Medicaid services earlier.

For these reasons, the Department must oppose this bill.

SB 944 – AN ACT CONCERNING THE PROVISION OF SERVICES TO CHILDREN BY OCCUPATIONAL THERAPISTS

This bill would permit occupational therapists (OTs) to enroll as an independent Medicaid provider and submit claims for self-care management and motor skills therapy provided to children enrolled in HUSKY A. It would require the Department of Social Services to reimburse these therapists for such service under the independent occupational therapy fee schedule (OT fee schedule).

The Department wishes to express our appreciation for the care Connecticut's OTs provide to our child members who are already enrolled in the Medicaid program. We enjoy a collaborative relationship with them and seriously consider their requests for changes to the OT fee schedule. This proposal, however, would result in additional costs to the State. The Department is unable to support the changes required under the bill because there are no funds included in the Governor's budget proposal to support such costs.

Furthermore, it is neither necessary nor appropriate to require payment for specific services in statute. Fee changes should be addressed using our standard methodology that uses Medicare's recommended coverage of new services and procedures, and supplements Medicare's rules with other coverage rules appropriate for populations not covered by Medicare. When the Department receives a request from providers to change a fee schedule, we carefully evaluate each request before making a decision whether or not to implement the requested changes (including requesting federal approval for the change). To etch a specific service into statute would require subsequent statutory changes as new services and procedures become the standard of care, thus subverting the existing process and eliminating the Department's ability to adapt to changes in clinical practice, national billing code changes, and other areas that may require adjustments in the future, potentially on short notice.

If funding is available to support it, the Department is open to considering the addition of self-care management and motor skills therapy to the fee schedule- but further information on the procedures and specific codes the OTs envision using is needed. Notably, the Department has not received any requests from providers for new procedures codes/services to be added to the independent therapy fee schedule in a number of years and would therefore welcome the chance to sit with the providers regarding this and other proposed updates, as well as potential value-based purchasing strategies. Lastly, we cannot discern the reason the proposed legislation only targets HUSKY A and does not speak to adding the services under HUSKY B, C, and D.

If funds were appropriated for this purpose and the clinical need was justified, the Department could amend the OT fee schedule at any time through the process outlined above.

Further, the Department does not understand the intent of section 1(b) of this proposed legislation. What follows is a discussion of how the Department reimburses for services

provided via the educational system and the Birth to Three System. We provide this information in the hope that it addresses the Committee's concerns and questions. As explained below, section 1(b) of this bill conflicts with the comprehensive, federally approved way in which the Department currently pays local school districts and Birth to Three providers.

Part B of the federal Individuals with Disabilities Education Act (IDEA) ensures that all children with disabilities between the ages of 3 and 21 have available to them a free and appropriate public education (FAPE) that emphasizes special education and related services designed to meet their unique needs and prepare them for further education. Under Part B of IDEA, local school districts must prepare an individualized education plan (IEP) which specifies all special education and related services to be provided to a child with a disability. Connecticut's Medicaid program offers school districts reimbursement for many of the covered medical services included in an IEP/section 504 plan and provided to Medicaid eligible children by the local school district.

In Connecticut, the Medicaid School Based Child Health (SBCH) program is the mechanism by which a school district may seek Medicaid reimbursement for specified Medicaid covered services that are provided to a Medicaid eligible student pursuant to the student's IEP/504. These services include assessments, audiology, medical, mental health, nursing, occupational therapy, physical therapy, respiratory care, speech/language, optometric, behavior modification, and personal care services.

As required by the state's Medicaid State Plan approved by the federal Centers for Medicare and Medicaid Services (CMS), the SBCH program uses a statistically valid Random Moment Time Study (RMTS) for determining the direct and approved administrative expenditures for the program. The enrolled school districts provide medical services throughout each fiscal year and submit claims to Medicaid for those services and are paid interim payments for such services. At the end of the fiscal year, the school districts submit a CMS-approved cost report to the Department. The Department analyzes these reported details along with the RMTS results to determine each school district's Medicaid allowable reimbursable costs. Those costs are then compared to the interim claims and the resulting settlements are processed. If the interim claims exceed the Medicaid allowable reimbursable costs, then the difference is recouped, and if the interim claims are less than the Medicaid allowable reimbursable costs, then the difference is paid to the district by the Department. Notably, only the enrolled school district bills for the services in the SBCH program, not individual practitioners.

It is critical that only the enrolled school district can bill and be paid for these services because the Department pays school districts based on their allowed costs that are coverable under Medicaid. This is a comprehensive, federally approved methodology, which requires that all of the school district's costs are reported and reimbursed collectively. Paying occupational therapists (or any other individual practitioner) separately for services provided through the school district is inappropriate because it would conflict with this payment methodology and increase the risk of double billing.

Part C of the IDEA ensures that all children with disabilities ages birth to age three have access to early intervention services (EIS) to address their disabilities. The state's Office of Early Childhood administers Part C of IDEA, which is called the Birth to Three System in Connecticut. Part C of IDEA requires that EIS is a comprehensive, multi-disciplinary package of services designed to address each child's needs holistically. Specifically, federal law requires

each child to have an Individualized Family Service Plan (IFSP), which is a plan of care individually tailored to ensure that each child receives the specific services needed.

Connecticut's Medicaid program pays qualified Birth to Three providers for services that are coverable under federal Medicaid law. The Department recently worked extensively with CMS to establish a broad set of coverable Medicaid services for Birth to Three providers and to establish a payment methodology that complies with federal Medicaid requirements, which has been approved in the state's Medicaid State Plan. Only qualified EIS (Birth to Three) programs under contract to OEC can bill for EIS provided to children receiving Medicaid.

Occupational therapists are one of many qualified types of practitioners who can provide EIS as part of a qualified enrolled EIS program. Each child receives the specific services detailed in the IFSP, which could include services by various types of practitioners, including occupational therapists and others. Because of the comprehensive multi-disciplinary nature of EIS, in accordance with the federally approved Medicaid State Plan, the Department pays EIS programs the same rates for each broad category of services, regardless of the specific practitioner who performs the services. It would be inappropriate and in conflict with this methodology to pay separately only for occupational therapists. In any case, the Department's rate for EIS paid to Birth to Three programs is substantially higher than the rate paid to independently enrolled occupational therapists. That differential is primarily due to the comprehensive nature of the EIS package and additional requirements for EIS programs.

Finally, section 1(b) of this bill would also require the Department to provide annual billing training to occupational therapists. That language is unnecessary because the Department, through its fiscal agent, DXC Technology, already has various types of provider training available, including the New Provider Workshop and Professional Refreshers, which would both be available to occupational therapists who choose to receive those trainings. The Department and DXC are available to work with providers on any individual questions they may have and to provide more tailored training opportunities upon request. It is not necessary to codify specific training requirements in statute.

Lastly, although section 2 does not address DSS services, we believe it is unwise to require one screen for developmental and social delays to the exclusion of other evidence-based screens. Statute is static, whereas medical and developmental research expands daily. While the Ages and Stages Questionnaire is arguably the state of the art today, it may not be tomorrow.

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

SB 946 – AN ACT CONCERNING DEADLINES APPLICABLE TO HEARING DECISIONS BY THE DEPARTMENT OF SOCIAL SERVICES

Connecticut General Statutes § 17b-61 provides that, when a person aggrieved by a decision of the Commissioner of Social Services requests a fair hearing, the commissioner shall take “final definitive administrative action” on the case within ninety days. “Final definitive administrative action” has been held to mean the issuance of a hearing decision. The Department of Social Services strongly supports S.B. 946 and urges its passage.

In *Handel v. Commissioner of Social Services*, 183 Conn. App. 392 (2018), the Appellate Court

held that, when the Department of Social Services (DSS) fails to issue a decision on a request for a fair hearing within 90 days of receipt of the request, the appellant is entitled to the relief he or she requests. Prior to *Handel*, it was assumed that the 90-day deadline in section 17b-61 was directory and did not impose a mandatory, enforceable obligation on DSS. See, e.g., *Turley v. Wilson-Coker*, Superior Court, judicial district of New Britain, Docket No. CV 03 0520265 (June 7, 2005, Owens, J.T.R.) (39 Conn. L. Rptr. 484; 2005 WL 1524952 at *12), and cases cited therein.

In response to the *Handel* decision, DSS' fair hearings unit has already implemented certain internal changes to ensure decisions are issued in a timely manner. Still, rendering a decision within 90 days of the hearing request is not always possible due to limited agency resources and the complexity of particular cases. At the same time, many of the most complex cases reviewed by DSS' hearing officers also involve the most costly forms of public assistance. For instance, Medicaid long-term care applications often require the submission of years of financial records and the review of various legal documents, such as wills, trusts and probate decrees. These cases can take months to develop, and then must be analyzed in the context of complicated eligibility rules. During this time, the applicant may already be receiving long-term care services from a nursing home at rates in excess of \$10,000 per month. As a result of the *Handel* decision, if a hearing officer is unable to render a decision within 90 days in a particularly complex Medicaid long-term care case, these costs would be shifted to the state, even where the long-term care application was properly denied.

This bill would resolve the dilemma created by the *Handel* decision while still providing appellants with a legal remedy in the event that a hearing officer does not issue a decision in a timely manner. First, the bill indicates that DSS must "ordinarily" render a fair hearing decision within 90 days of the request for a hearing, and explicitly provides that delays caused by the appellant extend the time for issuing the hearing decision. This language, which tracks the current language in the federal Medicaid regulation upon which section 17b-61 was based, strongly indicates that the 90-day deadline in section 17b-61 is intended to be directory, not mandatory. Second, the bill explicitly provides that, when DSS fails to issue a decision prior to the expiration of the 90-day deadline, the aggrieved person's remedy is to seek a writ of mandamus from the Superior Court to compel DSS to issue the decision. Given the absence of an explicit remedy in the current language of section 17b-61, this was the presumed remedy for an aggrieved party prior to the issuance of *Handel*.

SB 947 – AN ACT ESTABLISHING A NURSING HOME PROVIDER USER TAX EXEMPTION FOR MATTATUCK HEALTHCARE FACILITY, INC.

This bill would exempt one nursing facility from the user fee applied to more than 200 nursing facilities in the state. Based on the bill's title, it appears to be designed to benefit one facility, Mattatuck Health Care Facility, Inc. ("Mattatuck"). Mattatuck is a 43 bed Rest Home with Nursing Supervision (RHNS) nursing facility. For the following reasons, the Department strongly opposes this bill.

This bill singles out Mattatuck for a financial benefit, exempting it from the user fee, without any justification. The effect of this proposal would be a windfall to Mattatuck. This proposal's impact on Mattatuck is financially equivalent to an indirect rate increase outside of the existing regulatory structure, which is not being afforded to any other nursing home operator.

Section 12-263r of the Connecticut General Statutes currently sets forth the structure for the nursing home user fee. (Note that the former user fee, in section 17b-320, was sunset as of June 30, 2017.) This structure is complex, and the state obtained a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to maintain it.

If any nursing facility is in financial distress, it can request rate relief from the Department of Social Services in accordance with the existing regulatory process. Any nursing home provider can formally request hardship rate relief from the Department. The criteria for approval would include substantiating financial distress and need for the provider's beds in the area.

The Department strongly believes it would be inappropriate to exclude this or any nursing facility from the Medicaid provider user fee requirements. There are no exceptions to the user fee based on size, level of care, or financial status of a nursing home. We also oppose any changes that would increase the complexity of the existing structure of the nursing home user fee, particularly a change designed to benefit one provider.

Exempting Mattatuck from the user fee would require significant waiver language, policy, and calculation changes as part of a revised waiver approval process that would need to be completed. There is no guarantee of CMS approval of any additional waivers, especially in this situation, where the change would specifically be designed to benefit one provider without any apparent policy justification. Absent waiver approval, this exemption would violate federal law and would subject the state to potential federal penalties.

In addition, even if federal approval could be obtained, it would set an undesirable precedent – changing the state's entire provider user fee structure solely to benefit an individual facility. If this effort was successful, other facilities would likely seek similar benefits, which would further complicate the structure, decrease the likelihood of federal approval, make administration of the user fee more complex, and result in decreased revenue to the state.

Providing any new financial benefit to all nursing homes would substantially increase expenditures (or reduce revenues), which is not included in the Governor's budget proposal. In any case, this particular facility has not demonstrated a need for rate relief or any other financial benefit. Specifically, Mattatuck's cost reports show positive net income over the past several years. It should also be noted that the facility has a related party realty company that charges rental payments that are significantly higher than the allowed fair rental allowance.

For all these reasons, DSS is unable to support SB 947.

HB 7231 - AN ACT EXPANDING THE ADULT FAMILY LIVING-FOSTER CARE PROGRAM TO PERSONS WITH INTELLECTUAL DISABILITIES.

This bill proposes to expand the Adult Family Living services currently operated by the Department of Social Services to include persons with intellectual disabilities who are between the ages of 18 and 65 and who need assistance with two activities of daily living (ADLs).

DSS currently offers Adult Family Living services through the Connecticut Home Care Program for Elders to adults 65 years of age and over under a 1915(c) home and community-based services waiver and a 1915(i) state plan option. DSS also offers Adult Family Living services through the Personal Care Assistance 1915(c) waiver for individuals between the ages of 18 and

64. DSS does not currently cover Adult Family Living services under any other administrative authority. Individuals, including individuals with intellectual disabilities, may apply for the DSS waivers if they otherwise meet the eligibility requirements and are not otherwise already covered under a different waiver.

The Department of Developmental Services (DDS) also offers Community Companion Home as a service under the 1915(c) Comprehensive waiver and the 1915(c) Individual and Family Support waiver. Community Companion Home is an Adult Family Living model which is designed and monitored differently from the DSS model. One important difference is that in the DDS model, the caregiver must be licensed in contrast to the DSS model where a license is not required.

In each of the aforementioned Adult Family Living options, the caregiver may be a relative but may not be a legal guardian. Access to each option is further limited by the defined number of people who can receive services under each 1915(c) waiver annually.

The Department agrees that the Adult Family Living service is an important community option within the long-term services and supports delivery system. Since people with intellectual disabilities already have access to three options of Adult Family Living services, the bill represents duplication of existing services. For this reason, DSS is unable to support this bill.

HB 7233 – AN ACT PROMOTING EFFICIENCY IN STATE BENEFIT PROGRAMS

This bill would require the Commissioners of Social Services, Correction, Children and Families, Developmental Services, Mental Health and Addiction Services, Rehabilitation Services and the Office of Early Childhood to share monthly interagency reports on incidents of fraud, incarceration or death of beneficiaries and best practices regarding cost efficiencies and to submit a joint report on an annual basis to the General Assembly. The Department has several concerns with this proposal.

The bill is unclear as to the level of detail required in both the interagency report and the joint report to the General Assembly. If the individual agencies are expected to share any identifying information about clients or to match clients against lists of clients at other agencies, each agency would have to consider whether state and federal laws would permit disclosure of identifying client information.

Specifically, pursuant to Connecticut General Statutes, 17b-90, DSS is only permitted to disclose information about applicants or recipients of DSS services for purposes directly connected with the administration of DSS programs. There is no “notwithstanding” provision that would enable another state law to override that limitation. If the reports requested by this proposal require the disclosure of identified DSS client information, the Department would only be permitted to disclose the information if the Department determined that the disclosure was for the purposes of administering a DSS program. It should be noted that sharing client data solely to administer *other* agencies’ programs, i.e., reducing fraud at another agency, would be outside the administration of a DSS program.

The Department is also subject to several federal restrictions regarding the disclosure of client information which could prohibit our ability to comply with the proposed bill. These include, but are not limited to, 42 CFR Part 2 which restricts the Department's ability to disclose any client identifying information regarding diagnosis or treatment of substance use disorder and the Health Insurance Portability and Accountability Act (HIPAA) which restricts the Department's ability to disclose client-identified medical information.

The bill as written is overly broad and it is not clear what the bill seeks to accomplish. It is unclear as to what is meant by Section (b)(1) "[i]ncidences of fraud committed by beneficiaries of the state benefit programs." DSS is concerned with the ambiguous language "incidences of fraud" and its meaning. It is unclear whether a person who lies on an application will have committed fraud under this proposal and therefore have a roadblock to receiving any other state benefits.

In regards to Section (b)(2) of the bill, the language proposes an unnecessary requirement. DSS already receives information about beneficiary deaths and incarcerations. DSS currently uses monthly files from the Social Security Administration and the Connecticut Department of Correction to identify recipients of public benefits and take action on those cases.

The Department currently provides a quarterly report to the General Assembly on Fraud Early Detection pursuant to C.G.S. 17b-7a. In addition, DSS also submits an annual Program Review and Investigations report to the co-chairs and ranking members of the Legislative Programs Review and Investigations Committee. Further review and investigation into these issues will require additional resources and staffing, and will place an extra, unnecessary, layer on top of what DSS already provides. As such, we believe this proposal is unnecessary and would have a negative impact on the timeliness of eligibility determinations.

For these reasons the Department must oppose House Bill 7233.