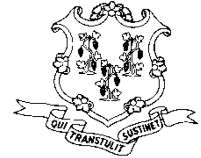

Testimony before the Human Services Committee
Commissioner Deidre S. Gifford, MD, MPH
March 8, 2022

Good morning, Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Deidre S. Gifford, and I am the 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.

S.B. 191 - AN ACT CONCERNING FEDERALLY QUALIFIED HEALTH CENTER PAYMENTS AND THE PROVISION OF NONEMERGENCY DENTAL SERVICES AT SUCH CENTERS.

Since 2001, the Department of Social Services (DSS) has reimbursed federally qualified health centers (FQHCs) an all-inclusive encounter rate based on a prospective payment system (PPS). Pursuant to the Medicaid State Plan amendment 16-015 and section 17b-262-1002 (a) of the Regulations of Connecticut State Agencies, "Each FQHC shall bill for FQHC services per encounter. Claims are limited to one all-inclusive encounter per day to include all services received by a client on the same day unless the client suffers an illness or injury subsequent to the first encounter that requires additional diagnosis or treatment or if the client has different types of visits on the same day such as medical and dental or medical and behavioral health. Medicaid pays for one medical, one dental, and one behavioral health encounter per day."

As such, DSS proposes deleting outdated language in section 17b-245b of the general statutes, which directs DSS to "make changes to the cost-based reimbursement methodology in the Medicaid program for federally qualified health centers. To the extent permitted by federal law, the commissioner may reimburse a federally qualified health center under the Medicaid program for multiple medical, behavioral health or dental services provided to an individual during the course of a calendar day, irrespective of the type of service provided. On or before January 1, 2008, the commissioner shall report to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services on the status of the changes to the cost-based reimbursement methodology." As FQHCs are no longer reimbursed based on costs, this language is no longer relevant.

The Department also proposes language to delineate that nonemergency periodic dental services be included in a single periodic dental visit unless there is a medical reason for providing the services on separate dates. As has been observed through claims data directly, the sequencing of preventive dental care over multiple visits at federally qualified health centers contradicts the prevailing community standards of care and the conditions outlined in reasons of medical

necessity. Providing the routine preventive procedures on separate dates of service adds unnecessarily to program costs when services are unbundled; and imposes additional, unnecessary barriers to accessing dental care on members who must navigate the impacts of multiple dental visits. When compared to private practice dentists and non-FQHC clinics who are paid for treating patients on a fee-for-service basis, this scheduling practice is being utilized solely for the convenience of the provider. It is also a hardship for Medicaid members who may have difficulty finding transportation to and from visits, obtaining time off from work without pay, or finding care for dependents.

If such dental services are provided on separate dates due to medical necessity in accordance with section 17b-259b, then the FQHC is required to document those reasons in the patient's dental record. To further discourage FQHCs from requiring multiple visits for services that would typically be provided in one day, the Department also proposes language expressly stating that FQHCs are prohibited from providing the following services on separate dates for purposes of billing multiple dental encounters (absent medical necessity): screening or examination, prophylaxis, fluoride treatments, and radiographs.

Separating services (screening, prophylaxis, fluoride treatments, and radiographs) that would normally be included in one periodic dental visit unfairly requires the patient to come back for a second, third and sometimes even a fourth visit when it would not normally be required. Again, this is a hardship for Medicaid members who may have difficulty finding transportation to and from visits, obtaining time off from work without pay, or finding care for dependents.

Limitations on the "unbundling" of certain nonemergency periodic dental services by FQHCs have been established in a number of states, including California, Florida, Oregon, New York, Pennsylvania and Louisiana.

The Department urges passage of this bill.

S.B. 192 - AN ACT CONCERNING EMPLOYMENT SERVICES ASSESSMENT INTERVIEWS AND SANCTIONS FOR TEMPORARY FAMILY ASSISTANCE BENEFICIARIES WHO FAIL TO COMPLY WITH EMPLOYMENT SERVICES REQUIREMENTS.

In order to provide better customer service while improving administrative efficiency, and to ensure that participating families with children have access to a benefit that helps them to pay for basic needs, DSS proposes to (1) provide Temporary Family Assistance (TFA) program applicants with the option to complete an application interview over the phone and (2) change the way that non-compliance penalties are calculated.

With regards to the first proposal, pursuant to federal law TFA applicants must be evaluated for potential participation in employment services programs as a condition of eligibility. Current state law requires DSS to refer TFA applicants who are subject to the program's work requirements to the Department of Labor (DOL) for an employment services assessment interview within ten days of receiving the application. If DSS is unable to meet this ten-day requirement, the statute precludes DSS from delaying benefits. As explained in more detail below, this statutory requirement was designed around an in-person process and limits the

agency's ability to provide applicants with a more flexible telephonic and online-based eligibility process.

With regards to the second proposal, current state law requires that DSS impose a percentage-based benefit-reduction penalty against the entire household if a household member subject to the employment services requirements violates a program rule, with each sequential violation causing a deeper cut in the benefit amount until benefits are terminated entirely for a three-month period. If the violation in question is the failure to attend a scheduled employment services assessment interview or appointment related to the establishment of an employment services plan, or occurs during an extension of TFA benefits, current law provides for the termination of the entire household's benefits. This legislative proposal would change the penalty calculation process to ensure that the children in families who are sanctioned for noncompliance do not lose access to funding required for basic needs such as diapers, clothing, and shelter.

Proposal #1: Interview process changes

Under this proposal, the ten-day clock for scheduling an assessment interview with DOL would start on the day DSS completes an application interview concerning eligibility, rather than on the day the application is filed. This change is needed to facilitate a permanent change that would permit TFA applicants to complete the eligibility interview over the phone by calling DSS at a convenient time within a span of several days, rather than requiring applicants to come into a DSS office for a scheduled in-person interview on very short notice. This "on-demand" interview model is already the norm in other programs administered by DSS, and has been used with success in TFA during the COVID-19 pandemic. However, because an applicant may not call DSS to complete the eligibility interview until several days after filing an application, it is not possible in many cases for DSS to process an application, schedule a TFA eligibility interview, and then schedule the employment services assessment interview with DOL within ten days of receiving the application. To remedy this problem and make telephonic interviews a permanent option, DSS is proposing to start the 10-day clock for scheduling the assessment interview with DOL on the day the eligibility interview is completed, rather than the day the application is filed. Should DSS fail to timely schedule the assessment interview with DOL, the existing law precluding DSS from delaying assistance would still be applicable.

DSS believes that a shift to an on-demand interview model in TFA is more client friendly and will also improve administrative efficiency. The telephone interview option eliminates the need for applicants with children to travel to apply for benefits, thereby saving applicants time, and allows applicants the flexibility to identify a convenient time for completing a TFA application interview. The telephone interview option also increases administrative efficiency by connecting the applicant with the next available worker within the statewide workforce, rather than requiring that a specific worker carve out a window of time in a specific location to complete the interview. After the public health emergency ends, DSS will need this proposed change to facilitate the continued use of on-demand phone application interviews while staying within statutory timing requirements.

Without these changes, the Department will likely need to continue with its pre-pandemic process, which requires face-to-face interviews that often result in procedural application denials

for families that may be otherwise eligible. Applicants who apply online or by mail have a small window of time to complete their initial interview before their application is denied because of the Department's need to meet the compressed statutory timeline for scheduling the employment services assessment interview within ten business days of the application. Further, it will force DSS to revert to a process that has been proven less efficient than the current model.

Proposal #2: Sanction penalty changes

Under this proposal, the Department would change the process for calculating benefits when a family member who is required to participate in the employment services program fails to comply with an employment services requirement without good cause. Instead of reducing benefits to the full family for the first violation by 25% for three months, for the second violation by 35% for three months, and for the third violation by 100% for three months, the Department would reduce the benefit award by excluding the noncompliant family member from the benefit calculation for each month that the member is out of compliance. If only one member of a family is eligible for TFA and such member fails to comply with an employment services requirement, the Department would reduce benefits by 25% for each month that the member is out of compliance.

Lastly, the proposal eliminates a permanent program termination penalty that applies under current law whenever someone fails to attend a scheduled employment services assessment interview or appointment related to the establishment of an employment services plan, or commits any employment services violation during an extension of TFA benefits. These latter two changes will ensure that the children in families who are sanctioned for noncompliance do not lose access to funding required for basic needs such as diapers, clothing, and shelter.

Seven states, including Maine and Rhode Island, reduce benefits by excluding the noncompliant family member from the benefit calculation rather than imposing a full family benefit reduction that penalizes other family members. Vermont and California are states that allow a family to continue to receive a reduced benefit amount while sanctioned for not participating in employment services in order to ensure that the family can meet basic needs.

The Department urges passage of this bill.

S.B. 193 - AN ACT AUTHORIZING DEPARTMENT OF SOCIAL SERVICES ELIGIBILITY WORKERS TO ADMINISTER OATHS.

This proposal would authorize DSS eligibility workers and supervisors to administer an oath in connection with the taking of an affirmation or acknowledgment of parentage.

Federal and state law require the mother of a child applying for Temporary Family Assistance (TFA) to cooperate with DSS in establishing the parentage of the child, if parentage has not previously been established. One component of this cooperation is completed through the execution of either an acknowledgment of parentage or an affirmation of parentage. The acknowledgment or affirmation must be accompanied by an oral recitation of the rights and responsibilities that result from its execution, and must be notarized or witnessed, historically by

an official authorized to administer oaths under section 1-24 of the general statutes, including notaries public and DSS child support investigators.

At one time, DSS regional offices were staffed with eligibility workers who were notaries public and could administer an oath and witness the execution of an acknowledgment or affirmation. Currently, many regional offices no longer have notaries public available. Furthermore, DSS child support investigators are often unavailable to witness the execution of an acknowledgment or affirmation, as they are called upon to participate in court proceedings, serve process, and complete other duties that take them out of the office. The net result of all of this has been a depletion of the number of staff in the regional offices available to witness the execution of an affirmation or acknowledgment. This proposal would alleviate this problem by authorizing DSS eligibility workers and supervisors to administer an oath in connection with the taking of an affirmation or acknowledgment.

If this proposal were not passed, DSS regional offices may not be able to facilitate the taking of an affirmation or acknowledgment of parentage in the future, which may delay the granting of TFA benefits for needy families.

The Department urges passage of this bill.

S.B. 194 - AN ACT AUTHORIZING THE DEPARTMENT OF SOCIAL SERVICES TO CONTRACT WITH OTHER STATES

This proposal would provide the necessary legislative authority to allow DSS to contract directly with another state. As with all DSS contracts, contracts with another state would comply with the state's standard contract language and review process. Without this statutory amendment, DSS may lose the ability to efficiently enter direct contractual relationships with partners in other states for research and support of essential services for the benefit of its clients. DSS has several contract opportunities that are impaired due to the lack of statutory authority permitting the agency to directly contract with other states in support of DSS' established programs.

Specifically, DSS' Division of Health Services is developing a research agenda and would benefit from the ability to contract with public universities in other states that have unique and advantageous research skill sets. For example, DSS encountered this issue in 2020 with a research project conducted by the University of Massachusetts. Because DSS lacked authority to contract directly with the University of Massachusetts which, being a state university, is considered a contract "with another state," DSS was required to utilize an intermediary, Community Health Network of Connecticut, Inc., to execute such agreement. With specific statutory authority, such inefficiencies and more-cumbersome contractual "workarounds" would be unnecessary.

While DSS seeks the authority to contract with other states, the agency will continue to follow state procurement standards and pursue existing contracting options where available, including entering memoranda of understanding with the state's own universities and research institutions. DSS seeks this expanded authority to address those instances where services offered by another state are unique and cannot be obtained through existing contracting options.

It should be noted that the Department of Public Health has similar contracting authority that includes an express authorization to contract with other states. (See CGS 19a-2a(5) – "(5) enter into a contract, including, but not limited to, a contract with another state, for facilities, services and programs to implement the purposes of the department as established by statute.")

The Department urges passage of this bill.

S.B. 199 - AN ACT CONCERNING THE OPENING OR SETTING ASIDE OF A PARENTAGE JUDGMENT.

In the 2021 legislative session, the General Assembly passed, and the Governor signed into law, the Connecticut Parentage Act (CPA), Public Act 21-15. The CPA prescribes many avenues for establishing a child's parentage, some of which are new to Connecticut and some of which have long been established. Two existing methods for establishing parentage retained by the CPA are the voluntary completion of an acknowledgment of parentage (formerly known as an acknowledgment of paternity) and the issuance of a court order concerning parentage. While these are distinct methods for establishing parentage, they have the same legal effect because the CPA provides that, following the expiration of a 60-day rescission period, an acknowledgment of parentage is equivalent to an adjudication of parentage.

In instances where parentage is established by a voluntary acknowledgment, the CPA sets forth specific rules that a court should apply if parentage is subsequently challenged. As before passage of the CPA, the challenger must first show that the acknowledgment was completed as the result of fraud, duress, or material mistake of fact. However, before setting aside the acknowledgment of parentage, Section 31 of the CPA for the first time requires the court, after considering certain factors, to determine that doing so would be in the best interest of the child.

The CPA is silent, however, with respect to how a court should approach a challenge to parentage previously established by court order. This proposal would require courts to apply the same standard in these situations that it applies when parentage was established by an acknowledgment of parentage. First, the court or family support magistrate (FSM) should apply the normal standard for opening a judgment that applies to any civil judgment; then, the court should take into consideration the best interest of the child before deciding whether to set aside the judgment. This analysis is not only consistent with the CPA, but has also previously been followed in many Superior Court decisions, though there has never been a clear statutory basis for it.

Without a statutory basis for a best-interest-of-the-child analysis in these situations, an adjudicated parent seeking to open a judgment of parentage could contend that there is no legal basis for taking the child's best interests into consideration when deciding whether the previous judgment should be set aside. In other words, the challenger could argue that only biology matters in determining parentage, a position clearly rejected in Connecticut through the passage of the CPA.

The Department urges passage of this bill.

S.B. 281 - AN ACT CONCERNING PENALTIES FOR UNAUTHORIZED USE OF RATE INCREASES EARMARKED FOR STAFF WAGE ENHANCEMENTS AT NURSING HOME FACILITIES.

From time to time, legislation has directed DSS to provide rate increases to nursing facilities for specific wage or benefit enhancements. Indeed, during the 2021 legislative session, section 323 of Public Act 21-2, June special session, designated a 4.5% rate increase to nursing home facilities for both FY 2022 and FY 2023, specifically for the purpose of wage enhancements for facility employees. In certain circumstances, such designated rate increases were not timely transferred to facility employees as had been intended.

Under current statute, should a facility fail to provide such enhancements for its employees, DSS may decrease the rate and seek recoupment in the same amount as the adjustment not distributed to facility employees.

In addition to any corresponding recoupment or rate decrease that may apply, the Department proposes additional statutory authority to impose a civil penalty of up to 50% of any such rate increase not used for employee wage enhancement, thereby further incentivizing nursing home facilities to utilize specifically designated rate increases as intended. The proposal provides the Department with authority to enter into a recoupment schedule with respect to this civil penalty so as not to negatively impact patient care. This proposal, and its penalties, would be retroactive to those rate increases already issued pursuant to section 323 of Public Act 21-2, June special session, and would apply to all future wage-related rate increases.

The proposal attempts to provide significant financial incentives for facilities to timely comply with the intended transfer of designated rate increases for employee wage enhancements, now or in the future.

The Department urges passage of this bill.

S.B. 283 - AN ACT ELIMINATING INCOME AND ASSET LIMITS FOR THE MED-CONNECT PROGRAM FOR PERSONS WITH DISABILITIES.

The proposed legislation seeks to eliminate income and asset limits for working persons with disabilities to qualify for Medicaid.

Currently, the Medicaid program for employed disabled individuals, or "MED-Connect," allows certain Connecticut residents with disabilities who earn up to $75,000 per year to qualify for full Medicaid coverage under HUSKY C. As of January 2022, 3,617 individuals were enrolled in MED-Connect. Individuals above 200% of the federal poverty level pay a premium for the coverage. Currently, 895 MED-Connect enrollees have a premium obligation. MED-Connect also allows eligible individuals to work and retain assets greater than what is allowable under traditional Medicaid coverage groups. The program includes a $10,000 resource test for individuals and a $15,000 resource test for married couples. This resource test excludes home property, certain retirement accounts, ABLE accounts, and accounts maintained for the purpose of increasing employability. MED-Connect also includes the "Medically Improved" group, a

coverage component for individuals who have lost disability status through the Social Security Administration, but still have some severe medical impairment. The proposed bill would eliminate the income and asset limits for both groups.

The Department appreciates the intent to expand medical coverage options for working individuals with disabilities. While administrative efficiencies could bring some cost savings, such savings would not be enough to offset the costs of increased enrollment. It is difficult to project the financial impact of the proposed bill as removal of the income and asset limits raises uncertainty as to the number of individuals who may be eligible to enroll but do not qualify under current rules. The Department does not have data about this population readily available to assess. Assuming the 2021 average monthly cost per person of approximately $575 remained constant, even a modest increase in enrollment of 10% would result in state costs of over $1 million. The proposed expansion of eligibility without a limit on income or assets is also likely to encourage individuals currently covered through their employers and private insurance to move to Medicaid due to its broader coverage and lower cost sharing. Thus, the enrollment increase could be far more substantive, resulting in significant costs that are not included in the Governor's budget. For this reason and without the availability of appropriations, the Department cannot support this bill.

S.B. 285 - AN ACT CONCERNING TIME LIMITS IN THE TEMPORARY FAMILY ASSISTANCE PROGRAM DURING A STATE PUBLIC HEALTH EMERGENCY.

Section 347 of P.A. 21-2 of the June 2021 Special Session amended General Statutes § 17b-112(c) to provide that months during which a household receives Temporary Family Assistance (TFA) "during the public health emergency declared by Governor Ned Lamont related to the COVID-19 pandemic" shall not count towards the time limits for such program. To the extent that future extensions of the public health emergency (PHE) result from legislative action, rather than executive action, this language would not allow the Department to disregard months of TFA received by a household during the PHE.

As such, this proposal clarifies that months during which a household receives TFA during a state public health emergency do not count towards such program's time limits, regardless of whether such emergency is declared by the Governor or through an act of the General Assembly.

The Department urges passage of this bill.

S.B. 286 - AN ACT CONCERNING DEADLINES FOR MANDATORY REPORTING OF SUSPECTED ELDER ABUSE AND PENALTIES FOR FAILURE TO REPORT.

The Department proposes to reduce mandated reporting timeframes for Protective Services for the Elderly (PSE) from 72 hours to not later than 12 hours. This mirrors the statutory timeframes used by the Department of Children and Families for reporting abuse and neglect of children. In addition, this change addresses recommendations made in the 2021 performance audit of PSE conducted by the State Auditors of Public Accounts.

DSS first becomes involved with elders alleged to have been abuse, neglected or exploited, when we receive a report. Any concerned person can report suspicions of maltreatment. Most reports are made by individuals who, by their profession, are required by State law to report suspected maltreatment of Connecticut elders. These mandatory reporters typically have frequent contact with elders and are in a unique position to see or hear about abuse, neglect or exploitation concerns.

Reports are extremely important to the safety and welfare of some of Connecticut's most vulnerable residents. Expedited reports are critical because they trigger investigations that lead to interventions aimed at halting the maltreatment and securing needed supports. The sooner the Department becomes aware of a concerning situation, the sooner we can respond.

The American Bar Association compiled a table of states' mandatory reporting laws in place as of December 2019.[1] It shows that the Department's proposed 12-hour reporting timeframe is congruent with those of other New England states:

State	Timeframe
Maine	Immediately
Massachusetts	Immediately
New Hampshire	Immediately
Rhode Island	Within 48 hours
Vermont	Within 48 hours
New York	No Mandated Reporting

The Department also proposes to require mandated reporters who fail to report maltreatment within the required timeframes to retake the elder abuse training and provide the Department with proof of successful completion of such training.

With this change, it is the Department's intent to mitigate some of the concerns that some stakeholders may have about penalties for not reporting. Some factors that may cause individuals to fail to report are lack of knowledge of this obligation or a need for training on the indicators of elder abuse. While the Department is seeking mechanisms to expand access to training and information on elder maltreatment and reporting, this change will allay concerns about penalties and foster increased knowledge.

The Department urges passage of this bill.

S.B. 288 - AN ACT EXEMPTING MEDICAID WAIVER AND STATE PLAN AMENDMENT SUBMISSIONS FILED IN RESPONSE TO A DECLARED

[1] https://www.americanbar.org/content/dam/aba/administrative/law_aging/2020-elder-abuse-reporting-chart.pdf

EMERGENCY OR DISASTER FROM NOTICE AND PUBLIC HEARING REQUIREMENTS.

During a federal public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) allows states on an expedited basis, and without providing a notice and comment period, to take advantage of certain specific expedited federal approval processes. These expedited processes apply to amendments to the Medicaid state plan, waiver amendments, waiver applications, and expedited changes to other relevant federal authorities.

However, despite federal exemptions from such notice or comment periods for the purpose of accelerating federal supports in response to public health emergencies, section 17b-8 of the Connecticut General Statutes specifically requires, in part, a thirty-day period for notice and public comment (including publication within the Connecticut Law Journal) in advance of hearings before the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations, prior to submitting the necessary federal applications to CMS for implementation of such emergency supports.

Earlier in the pandemic, Governor Lamont issued Executive Order 7S, suspending the statutory notice requirements in section 17b-8 to rapidly implement federal pandemic supports. However, Executive Order 7S expired as of April 20, 2021. As a result, absent suspension pursuant to an executive order, and in the case of the current federal emergencies, DSS is required to comply with the specific statutory requirements under section 17b-8, including the notice and hearing requirements – thereby delaying the distribution of such federal supports.

This proposal would amend CGS 17b-8 to remove the requirements that DSS provide for a thirty-day public notice and comment period through the Connecticut Law Journal, to be followed by up to thirty-days for the Human Services and Appropriations Committees to hold public hearings, prior to DSS submissions of Medicaid state plan amendments, waiver amendments, or other waiver applications to CMS when necessary to respond to, and in connection with, a federal or state-declared disaster or emergency. Exemption from section 17b-8's notice, publication and hearing requirements in response to federal or state-declared disasters or emergencies, to the extent permitted under federal law, will facilitate the prompt distribution of federal funding and support to providers and the community in response to such emergencies without the need for an executive order.

In all cases, should DSS seek to make any such authorities permanent, the regular notice and comment period and committee public hearing and review process under section 17b-8 would still apply.

The Department urges passage of this bill.

S.B. 289 - AN ACT CONCERNING OVERSIGHT AND FUNDING OF THE CONNECTICUT FATHERHOOD INITIATIVE.

The Department of Social Services is the lead agency for the Connecticut Fatherhood Initiative (CFI), a broad-based, statewide multi-agency and stakeholder effort working toward a common goal: to support children, mothers and fathers by focusing on the important influence of men who

are or will be in fathering roles. CFI partners do this through systems change efforts as well as supporting direct services and programming for fathers, with a commitment to racial equity, gender equity and safe engagement of fathers with their children.

The CFI formally began with the passage of legislation in 1999, as key leaders at the local and state levels continued to see children who had been impacted by father-absence. This bill updates the existing CFI legislation to better reflect its current structure, partners, and goals, and further strengthen this robust public-private collaborative.

The bill also reflects the decisions made during the development of the CFI's Strategic Plan (Plan), which included representation by over 50 agencies and more than 80 stakeholders. The Plan is currently being implemented by numerous stakeholders under the guidance of the CFI Council.

The objectives of the CFI are to provide fathers with the skills and supports they need to get involved in the lives of their children and stay connected by: promoting public education concerning the financial and emotional responsibilities of fatherhood; assisting men in preparation for the legal, financial and emotional responsibilities of fatherhood; promoting the establishment of paternity at childbirth; encouraging fathers, regardless of marital status, to foster their emotional connection to and financial support of their children; establishing support mechanisms for fathers in their relationship with their children, regardless of their marital and financial status; and integrating state and local services available for families.

This bill reflects the current CFI Council, which outlines that members of the Council have, among other things, agreed to: provide membership and active participation on this Council and related events/activities; designate an agency liaison to facilitate communication and reporting about fatherhood activities; seek opportunities for collaboration among partners for programs, projects, or legislative proposals that support positive father, child and/or family outcomes; seek opportunities for funding, consistent with the agency's mission, to support positive father involvement; provide active participation for the implementation of the CFI Strategic Plan, including staff leadership/membership on committees and workgroups and related activities; support data development by identifying ways to collect data on men who are fathers, and opportunities to share data across agencies to obtain more accurate metrics on fathers involved with state systems; strengthen our commitment as CFI partners by communicating CFI efforts throughout the agency and with our partners; and commit to promote racial justice, with policies, beliefs, practices, attitudes, and actions that foster equal opportunity and treatment for people of all races.

The CFI Strategic Planning Workgroup developed and is currently implementing the strategic plan for the CFI. The plan, adopted by the Council in 2016, contains recommendations for short and long-term strategies to: address program, policy and system barriers; expand promising practices already being implemented; and establish new, and strengthen existing, partnerships at the state and local levels to support the results statements – "Connecticut children grow up in a stable environment, safe, healthy and ready to lead successful lives" and, "All Connecticut fathers are engaged in the lives of their children."

The CFI stakeholder network and the CFI Council as its guiding body support this proposal. The network and Council include leadership from all three branches of state government, as well as long-time partners such as the Connecticut Coalition Against Domestic Violence, local providers serving fathers and families, representatives from Connecticut's esteemed higher education institutions and experts, men's health, legal aid, and research. Amending the legislative language will strengthen the CFI infrastructure and meet the stakeholders' call to action.

The Department urges passage of this bill.

S.B. 290 - AN ACT CONCERNING CERTIFICATES OF NEED FOR LONG-TERM CARE FACILITIES.

The Department of Social Services reviews Certificate of Need (CON) requests from nursing facility providers for renovations, new construction, bed terminations, and new services, among other things. The Department considers the financial feasibility of each request and the impact on the applicant's rates and financial condition as well as other factors when making a decision. For almost 30 years, the Department has often included certain conditions in final decisions.

Generally, and where appropriate, conditions are used to document summary detail on an applicant's proposed project as well as to memorialize what the Department is agreeing to for Connecticut Medicaid reimbursement purposes. Applications are not often referenced after the final decisions are ordered and the conditions are used for audit purposes as well as for project planning purposes for the reference of both the applicant and the Department.

This bill adds language to Connecticut General Statutes (CGS) sections 17b-352 and 17b-353 that would place in statute the authority for the DSS Commissioner to include conditions in any decision approving or modifying a request for a CON. These changes reflect historical Department practice.

The Department always intended for section 17b-354 (a)(3) and (4) to apply to all relocations and new replacement facilities. To ensure that the criteria in 17b-354 (a)(3) and (4) applies to all CON applications to relocate beds from an existing facility to an existing or to a new or replacement facility, the proposal adds a reference to section 17b-354 (a)(3) and (4) in subsection (b) of section 17b-352.

Consistent with the Department's strategic plan for long-term care, the Department proposes to add language to CGS section 17b-354 (a) to encourage more nursing facilities to establish nontraditional small house style nursing facilities. The proposed language provides an exception to the moratorium on applications to increase nursing home beds if a nursing facility proposes to build a non-traditional small house style nursing home and the nursing facility is agreeable to reducing its total number of licensed beds by a percentage established by the Commissioner in accordance with the Department's strategic plan for long-term care.

Finally, the Department proposes to revise CGS section 17b-355 to establish additional criteria and revise existing criteria that are consistent with the strategic plan. The strategic plan is designed to rebalance Connecticut's Medicaid long-term services and supports, including, but

not limited to, those supports and services provided in home and community-based settings and institutional settings. The Department updated the strategic plan on January 29, 2020. At that time, there were approximately 3,000 empty nursing home beds and the plan projected a surplus of 6,000 empty nursing home beds by 2040. Current demand levels for nursing home services dropped significantly as a result of COVID 19. As of January 2022, there were 5,102 empty nursing home beds. In light of the excess bed capacity, the proposed language in section 17b-355, requires the department to consider whether the relocation of existing beds will adversely affect the availability of beds in the applicant's service area and requires the nursing facility that is relocating nursing home beds from an existing facility to a new facility to close at least one currently licensed facility. The Commissioner may also request that any applicant seeking to replace an existing facility reduce the number of beds in the new facility by a percentage that is consistent with the department's strategic plan for long-term care.

As barriers that prevent choice are eliminated, it is assumed that there will be an exponential shift towards home and community-based long-term services and supports, with the demand for the current model of institutional care projected to decrease. The new model of institutional care reflects a stronger culture of person-centered care than is currently the norm in Connecticut and is more 'home-like' in orientation than the current model. Accordingly, the proposed language requires the Commissioner to consider whether an application to establish a new or replacement facility proposes a non-traditional small house style nursing home and whether the application addresses the additional goals from the strategic plan, including promoting person-centered care, providing enhanced quality of care, creating community space for all nursing facility residents and developing stronger connections between the nursing facility residents and the surrounding community.

In addition, I would like to note that DSS has been in discussions with the Connecticut Association of Health Care Facilities and Leading Age on substitute language and would like to continue conversations in order to find mutually agreeable language.

The Department urges passage of this bill and looks forward to continued partnership on this important issue.

H.B. 5332 - AN ACT PROHIBITING HOME CARE AGENCY CONTRACTS THAT PENALIZE CLIENTS FOR DIRECTLY HIRING AGENCY STAFF.

This bill would make void and unenforceable any contract between a homemaker-companion agency or home health agency and a client of such agency that seeks to impose a financial penalty against that client for directly hiring an employee of such agency. Absent this language, it is possible that home care clients that would like to self-direct their care and to do so, hire their agency-based caregiver, may be subject to a fee or be liable for damages incurred by the agency.

Effectively, the bill will allow clients of a home health agency the freedom in which to hire caregivers with whom they have developed a relationship. While this language is not restricted to Medicaid, the Department has seen in Medicaid members that an established relationship and connection between the member and their caregiver is highly valuable to the members and helps to ensure both quality and continuity of care. The bill would ensure that no Medicaid member who wishes to hire their caregiver directly will be forced to pay a penalty or fee or fear litigation. These fees can range anywhere from $5,000 to $10,000 depending upon the terms of the contract. If a consumer is on Medicaid, the consumer would not have the ability to pay this type of fee, nor should they have to.

Additionally, current practices limit economic opportunities for personal care assistants and caregivers to remain and grow in the home care field, further straining our shortage of direct care workers. Caregivers should have the right to accept employment opportunities, including from their current clients, without being forced out of the industry to increase their wages and career advancement.

For these reasons, the Department urges passage of this bill.

H.B. 5333 - AN ACT CONCERNING THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY.

This bill would permit DSS to submit a Medicaid state plan amendment to add the Program of All-Inclusive Care for the Elderly (PACE) in the Medicaid state plan, as well as establish participation criteria for individual eligibility.

PACE is a program that integrates Medicare and Medicaid-funded services to help people meet their health care needs in the community instead of going to a nursing home or other care facility. With PACE, there is a team of health care professionals working to deliver care through a coordinated model. In many states, the PACE model provides an additional community-based option which plays an integral role in the long-term services and support continuum.

The Department supports the concept and intent of this bill, however it is unclear at this time what the fiscal and operational implications would be. DSS will analyze the overall cost and impact of adding PACE as an option under the Medicaid state plan. Were PACE to be implemented, DSS would need additional staff to administer and oversee the program. We are happy to work with the committee to define the potential additional costs and benefits to the state of adding PACE to our Medicaid program.

H.B. 5341 - AN ACT EQUALIZING MEDICAID RATES FOR PROVIDERS OF IN-PATIENT MENTAL HEALTH SERVICES IN EASTERN CONNECTICUT.

This bill requires DSS to compare Medicaid payment rates for providers of inpatient mental health services in eastern Connecticut to Medicaid payment rates for such providers in other areas of the state, and to adjust rates as necessary to achieve payment parity.

Currently, there are three payment tiers for inpatient psychiatric services. These payment tiers were developed during the transition to Medicaid diagnosis-related group (DRG)-based inpatient rates in 2015. These rates were developed based upon reported costs by the institutions themselves, not on the basis of geography. As a general rule, Medicaid does not develop rates based on geography. Any variances in payment rates between inpatient psychiatric hospitals would be attributed to the costs reported to the agency. Of note, hospital rates in general have since been modified in accordance with the 2020 hospital settlement agreement which adjusts those per diem rates by 2% per year.

As examples of how geography is not necessarily correlated to rates, Charlotte Hungerford Hospital in Torrington is in the highest cost tier, Day Kimball Hospital in Putnam is in the middle cost tier, and Greenwich Hospital is in the lowest cost tier. Eastern Connecticut hospitals, however, generally are in the lower cost tiers, most likely given their historical cost basis. All inpatient mental health rates can be provided to the committee if helpful in your review.

Any review of rates should be based upon reasonable cost standards that will be subject to federal approval as reasonable and efficient. An approach to standardize rates without recognizing federal requirements would potentially affect federal reimbursement.

It should also be noted that, in collaboration with DCF and DMHAS, the Department is in the early stages of developing a value-based payment model for inpatient psychiatric services for children. DSS would like to develop a similar model for adults. This planned cost neutral, value-based payment model would consider reasonable costs while focusing on equity, access, member experience, and outcomes.

Finally, as such rate parity increases are not included in the Governor's recommended budget adjustments, we cannot support this bill at this time.