Testimony before the Human Services Committee
Roderick L. Bremby, Commissioner
February 18, 2016

Good afternoon, Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services (DSS). I appear before you to testify in support of **Senate Bill 17, AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES**. I would like to take this opportunity today to highlight a few sections of particular interest.

Section 1 establishes an Intellectual Disabilities (ID) Partnership. This proposal is modeled after the successful Connecticut Behavioral Health Partnership that has improved health outcomes for children and adults, while achieving efficiencies in expenditures for necessary behavioral health services.

The Department of Developmental Services (DDS), DSS and the Office of Policy and Management (OPM) will develop a continuum of services between in-home supports and group home placement that allows DDS to provide efficient services while exhausting all options for private pay and other third party payments. There will also be development of supportive housing models tailored to persons with ID and exploration of the potential management of ID services by an administrative services or managed care organization. These strategies would be used to help address and fund the DDS waiting list as well. As with the Connecticut Behavioral Health Partnership, it is anticipated that these changes will bring greater focus to this important area and ultimately result in the development of a broader array of services that assist in downsizing the need and usage of public facilities while also addressing the DDS waiting list.

Section 2 requires the Commissioners of Developmental Services and Social Services to approve any change of ownership of any DDS licensed Community Living Arrangements (CLAs). CLAs are dually funded by the DSS and DDS.

DDS pays the service costs of a CLA, and DSS pays the room and board costs. (The service costs are claimed under Medicaid through DDS' Comprehensive Supports Waiver. The room and board costs are not claimable under Medicaid.)

DSS also reimburses CLAs for land and building costs through rates set and payments made by DSS over a 30-year useful life. Over the past few years, providers have been selling/transferring CLAs that are either fully paid or partially paid off. The resetting of the property reimbursement to a new 30 year period results in additional costs that are not funded in the Department's budget.

This section also provides that the useful life and value will not be reset due to the sale/transition of a CLA from one provider to another. This practice essentially results in the state paying twice for the same property.

Lastly, this section states that if a provider were to sell a property that the provider owned outright, or has a mortgage on, the amount of the value at the time of the sale would be adjusted in the next development of that provider in order to recoup profit that the provider might have received for a property that was funded through DSS room and board payments.

Sections 3 through 17 consolidate autism spectrum disorder (ASD) services under DSS by transferring lead agency responsibilities and the supporting resources from DDS to DSS. Effective January 1, 2015, the Centers for Medicare and Medicaid Services (CMS) directed states to expand and implement Medicaid State Plan coverage of medically necessary services for members under age 21 with ASD. In response the Department partnered with DDS to develop coverage guidelines, submit a State Plan Amendment and implement services.

Services for individuals with ASD will be effectively grouped with other State Plan services for individuals with disabilities, overseen by DSS. State Plan ASD services are currently offered through the Department by Beacon Health Options, the behavioral health Administrative Services Organization (ASO).

Within the Department, the Division of Health Services (DHS) Integrated Care Unit is responsible for oversight of all Medicaid State Plan services (medical, behavioral health, dental, and Non-Emergency Medical Transportation) except pharmacy, as well as contract management and liaison work with the four Medicaid ASOs. DHS is carefully reviewing the present structure of ASD services and will make a recommendation to the Commissioner with respect to situating those services within the Division.

Lastly, this bill adds language to define ASD to have the same meaning as set forth in the most recent edition of the American Psychiatric Associations Diagnostic and Statistical Manual (DSM) of Mental Disorders. This definition is consistent with section 38a-488b, CGS, which details the requirements for a health insurers' coverage of ASD services. The bill clarifies who may be eligible for these services under the state's medical programs serving ASD individuals.

Section 19 increases the score on the Salzmann Handicapping Malocclusion Index to 29 or above for which the Department would pay for orthodontic services for HUSKY members below 21 years of age. Currently, such services are covered for a score of 26 or above.

Under federal requirements, Medicaid must cover services which are medically necessary and cannot cover services that are primarily for cosmetic purposes. Conditions for which orthodontic care would be medically necessary include, but are not limited to:

- Certain impacted teeth
- Functional deviations
- Certain conditions that impact the gums
- Certain structural problems with the jaws

- Certain large overbite and bite conditions, and
- Ongoing emotional problems, if certified by a licensed child psychologist or psychiatrist.

Orthodontists enrolled with the Department may include any other conditions or concerns for consideration of medical necessity and are encouraged to include all appropriate documentation to support their request. All such requests and all supporting documentation are considered in the determination of medical necessity by an independent team of licensed dentists and orthodontists from BeneCare Dental, the ASO that manages the Connecticut Dental Health Partnership for the State of Connecticut.

HUSKY members who do not agree with dental services provided through Medicaid are eligible to request an administrative review through the fair hearing process. Related to any Medicaid service, a fair hearing request form is attached to each notice of action mailed by the Department.

Sections 20 and 21 reduce the burial benefit that the Department covers for expenses for indigent decedents with no ability to pay for the cost of a funeral, cremation or burial, from a maximum of $1,400 to $1,000. This reduction aligns the burial benefits the State of Connecticut will cover with those of neighboring states. For example, the state of New York will pay up to $900 for burial expenses, as long as the burial expenses are no more than $1700 for an indigent resident of the state. The state of Rhode Island will also pay up to $900 for burial expenses of an indigent resident of the state.

Section 22 maintains a minimum flat rate for boarding homes (including continuing care homes) that do not submit an annual cost report to the Department. The minimum flat rate is used mainly for DDS placements who reside in a person's home but also applies to residential care homes and community living arrangements. The minimum rate is used as a base because small facilities such as those hosting DDS placements find it difficult to maintain cost reports. The state also finds it difficult to implement audit protocols in such homes. This change is consistent with legislative intent, which was to freeze all boarding home rates for the current biennium.

Sections 23 and 24 of this bill ensure that hospital reimbursements, including those made in previous years, are consistent with the approved state budgets for each of those years. This language clarifies that rate increases are not made beyond the levels approved in the enacted state budget. Please note that section 23 references the federal law 42 USC 1396a (a)(30)(A), as this is the law that requires rates to be consistent with economy, efficiency, quality and access, ultimately ensuring that reimbursement rates are reasonable.

Sections 25 through 32 collectively repeal and delete statutory references to CGS section 17b-8, which requires the DSS to submit applications, renewals and proposed amendments for a federal waiver of any assistance programs to the human services and appropriations committees for review and approval. This statute also details that the Department must submit certain Medicaid state plans and proposed amendments to such state plans to the committees of cognizance.

The Department believes this statute is duplicative for the following reasons:

- Federal regulations at 42 C.F.R. 441.304(f) require public notice and a 30-day public comment period for all home and community-based waivers (including initial waiver

applications, waiver amendments, and waiver renewals). If CGS section 17b-8 was repealed, the Department would still be required to post public notice of any waiver changes and solicit public comment for a minimum of 30 days. Furthermore, CMS requires that the waiver application document also include a description of how the department secures public input into the development of the waiver. As explained by CMS, this requirement provides CMS with an appropriate oversight mechanism to review the integrity of the public comment process. The Department also includes a summary of the public comments as part of the waiver application document.

- All waiver applications, renewals and amendments must be submitted to CMS for approval. CMS completes a rigorous and comprehensive review of all waiver applications to ensure compliance with all federal requirements. This process can be viewed as an additional safeguard to guarantee all waiver changes are adopted in accordance with federal law.

Requiring the Department to comply with CGS section 17b-8 substantially extends the timeframe for processing, developing and submitting waiver applications, renewals and amendments beyond what CMS requires. These delays prevent timely compliance with CMS requirements and hamper the Department's ability to modify programs in order to improve the delivery of services for waiver program clients, adjust services in accordance with changing fiscal circumstances, and ultimately stay in compliance with CMS.

Section 33 repeals obsolete language regarding the Healthy Start program. The Governor's budget transfers this program to the Office of Early Childhood (OEC). Funding for Healthy Start is currently transferred from DSS to OEC through an interagency agreement; the transfer of the program will eliminate the need for the administration of such an agreement in the future. DSS has also examined the rules and regulations within Medicaid and has determined the program is not eligible for federal Medicaid reimbursement.

Thank you for the opportunity to testify before you today. I respectfully request that you take favorable action on this bill and will be happy to answer any questions that you may have.