



Testimony Before the Human Services Committee

H. B. No. 5906 (RAISED) AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL REVISIONS TO THE HUMAN SERVICES STATUTES.

H. B. No. 5910 (RAISED) AN ACT CONCERNING LEGISLATIVE OVERSIGHT OF THE DEPARTMENT OF SOCIAL SERVICES.

S. B. No. 662 (RAISED) AN ACT CONCERNING MEDICAID ELIGIBILITY AND REIMBURSEMENT.

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S. B. No. 666 (RAISED) AN ACT CONCERNING THE REDUCTION OF CHILD POVERTY.

S. B. No. 660 (RAISED) AN ACT CONCERNING ESTABLISHMENT OF A FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM AND FUND.

S. B. No. 665 (RAISED) AN ACT CONCERNING CONTINUING CARE FACILITIES AND CONTINUING CARE AT HOME.

H. B. No. 5907 (RAISED) AN ACT CONCERNING THE TEMPORARY FAMILY ASSISTANCE PROGRAM.

H. B. No. 5913 (RAISED) AN ACT APPROPRIATING FUNDS FOR CANCER PREVENTION AND TREATMENT.

Michael P. Starkowski
Commissioner
March 11, 2008

Testimony

Good morning, Senator Harris, Representative Villano and members of the Human Services Committee. My name is Michael P. Starkowski. I am the Commissioner of the Connecticut Department of Social Services (DSS). I am pleased to submit this testimony for the record on several bills on today's public hearing agenda which concern the programs, services or operations of DSS.

H. B. No. 5906 (RAISED) AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL REVISIONS TO THE HUMAN SERVICES STATUTES.

DSS commends the committee for again raising a technical revisions bill this session. In addition, to the provisions contained in the bill for technical revision, we recommend the repeal of 17b-665. This section is outdated and unnecessary, and should therefore be repealed for the following reasons:

1. This statute was enacted as part of the transfer of the Bureau of Rehabilitation Services to the Department of Social Services, which occurred sixteen years ago.
2. As the designated state unit authorized to provide vocational rehabilitation services under federal law, the Bureau is already subject to extensive oversight by the federal government. This oversight is significantly more comprehensive than that required by this statute, and includes virtually every aspect of the program. As a major part of this oversight, federal law requires that the Bureau submit a State Plan to the U.S. Office of Special Education and Rehabilitation Services (OSERS). A copy of each approved State Plan is submitted to the state Office of Management and Budget. In addition, OSERS requires that the Bureau meets a number of quality indicators as a condition of continued federal funding.
3. The Bureau produces an Annual Report, which is disseminated to all interested parties as well as the Legislature. This report provides a comprehensive picture of the services provided to Connecticut citizens.
4. In addition to being outdated, C.G.S. §17b-665 requirements are duplicative of the above reports and oversight.

H. B. No. 5910 (RAISED) AN ACT CONCERNING LEGISLATIVE OVERSIGHT OF THE DEPARTMENT OF SOCIAL SERVICES.

Section 1.

DSS is opposed to these new onerous reporting requirements on the status of new budget initiatives as they will serve only to divert scarce resources away, thereby delaying, the implementation of the new initiatives.

Sections 2, 3 and 4.

The Department strongly opposes this bill as its requirements would completely hamstring our ability to timely make program initiatives and changes operational.

There is already a well established and practiced statutory process under which Department's proposed regulations are subject to public scrutiny, comment and ratification by the General Assembly. This bill would require our regulations to be separately submitted to and reviewed by the Human Services Committee, Managed Care Council and Behavioral Health Partnership Council for their recommendation to the Regulations Review Committee. These councils and committee already have the opportunity to review any proposed regulation and make comment. This proposed process is duplicative and burdensome.

The Department strongly opposes the repeal of its authority to implement and operate under certain policy while in the process of adopting policy as a regulation. Without such authority, the department will be unable to timely implement policy changes or operationalize new programs as is necessary to comply with federal or state law. Any failure to comply with federal requirements leaves us open to sanction by the federal government.

The Department's Uniform Policy Manual (UPM) has two components: (1) the guidelines for determining eligibility for specific programs and basic calculations of benefits; (2) the policy and procedures regarding benefit issuance and benefit error, recovery of assistance, special programs and special benefits. Both components are subject to federal and state law mandates and, without the authority presently granted to the Department under section 17b-10 of the Connecticut General Statutes, the department will lack the authority to provide the necessary guidance to department staff concerning eligibility determinations and benefit calculations. Moreover, the department will be unable to issue policy to reflect increases in benefits or new programs and benefits.

For example, frequently the federal government changes the manner in which assets and income are to be treated by the department in determining eligibility in the Medicaid and Food Stamp Programs. Without the authority to implement these policy changes prior to final adoption as a regulation, department personnel will be using outdated guidelines to determine eligibility, which could result in either an erroneous denial of benefits or an improper granting of benefits, which would then need to be recovered.

Our authority under section 17b-10 allows us to promptly and efficiently respond to new mandates and must be preserved.

Section 5

As background, the committee should understand that Section 17b-2 of the CGS designates the Department of Social Services as the state agency for the administration of programs for the elderly pursuant to the Older Americans Act. In meeting these requirements, DSS provides a

supportive organizational environment to the Office of the Long Term Care Ombudsman Program (LTCOP) to fulfill its critical mission under federal law to improve the quality of life and quality of care of Connecticut citizens residing in nursing homes, residential care homes and assisted living communities. All Ombudsman activity is performed on behalf of, and at the direction of residents. In addition, the LTCOP remains an independent advocate for the needs of those living in nursing homes, RCHs and Assisted Living Facilities. There have been no concerns expressed that the current arrangement is in any way undermining the program's mission. To the contrary, the program is demonstrating robust independent advocacy for nursing home residents. Moreover, the State LTC Ombudsman and the LTCOP benefits administratively by working collaboratively on issues of concern to DSS as well as the Ombudsman program.

This proposed section would have OPM complete a study of whether should be moved to the Office of the Health Care Advocate. No funding has been budgeted for such a study.

***S. B. No. 662 (RAISED) AN ACT CONCERNING MEDICAID ELIGIBILITY AND REIMBURSEMENT.**

Section 1.

Section 1 of this bill would establish a presumptive eligibility program for the Medicaid program in accordance with federal law and regulations. There are currently only three provisions in federal law to operate Medicaid presumptive eligibility programs; presumptive eligibility for children and presumptive eligibility for individuals screened for breast and cervical cancer, both of which are already in statute and operational; and presumptive eligibility for pregnant women, which the department has proposed implementing in Raised Bill 659. We therefore see no purpose for this provision of the bill as we expect to be operating all PE programs permitted by federal law within the next few months.

The next provision of this section would provide for a temporary exclusion of assets less than \$10,000 that a Medicaid applicant is unable to liquidate within the normal application processing period because of circumstances beyond their control. The department supports this provision of the bill, as it will result in the department being able to provide appropriate Medicaid coverage beginning after the period that the excluded asset would cover the cost of care privately. It will also assure that the department does not deny benefits for months when such an asset causes the applicant's assets to exceed the Medicaid \$1600 asset limit.

The department does ask that the committee make minor change to wording to improve its clarity: in (k)(3), delete "or an amount in excess of then thousand dollars" and insert "the amount of the asset does not exceed ten thousand dollars [or an amount in excess of then thousand dollars], except as otherwise approved by the commissioner, and does not consist of the corpus of a trust that may be liquidated at the discretion of the trustee. ...

Sections 2 and 3 – Nonemergency Medical Transportation (NEMT)

Sec. 2 (a) lines 78 to 84 would require our contracted NEMT brokers to inform its contracted NEMT providers of the source of payment at the time that a trip is assigned to the NEMT provider. This language should be clarified to say that we would require that the NEMT broker inform the provider when Medicaid is the payment source for the trip. We cannot require the NEMT broker to divulge non-Medicaid payment sources as that would be outside our jurisdiction.

Sec. 3 (a) would require prior authorization exceptions for ambulance NEMT under certain circumstances. All the exceptions listed in this section would contribute to escalating costs for NEMT by increasing the use of ambulance trips even in circumstances when wheelchair vans or sedans would be appropriate to meet the needs of the patient. The NEMT brokers currently have nurses on staff, who take the patient's medical condition and diagnosis into consideration in determining which level or mode of transportation is appropriate. Subsections 1 and 2 don't even provide individual consideration for the patient's individual needs – for example a patient who is ambulatory and who was walking around in the hospital or the nursing home would be transported unnecessarily in an ambulance at a higher cost. Subjecting these trips to prior authorization ensures that individuals are placed in the least restrictive mode of transportation that accommodates their individual needs and that ambulances are available for individuals who really need a stretcher.

Under the current system, we have seen that the facilities sometimes bypass the NEMT broker and contact the ambulance companies directly and that the authorization request, submitted after the fact, does not always justify the higher cost of an ambulance versus wheelchair van or sedan. When ambulance level was justified, the brokers have authorized that level even after the fact so that the ambulance company could be paid. More consistent submittal of the prior authorization request would ensure that the appropriate mode of transportation meeting the patient's individual need is provided and that payment would be guaranteed to the transportation provider.

Subsection 3 (b) would require 24/7 coverage for ambulance prior authorization requests. This is not necessary because Medicaid clients and/or their providers routinely schedule medical transportation at the same time that the medical appointment is made, which in the majority of cases fall during the brokers' hours of operation. The RFP for the re-procurement extends the call center hours to 9:00 a.m. to 8:00 p.m., Monday through Thursday, 9:00 a.m. to 6:00 p.m. on Friday, and Saturday from 10:00 a.m. to 2:00 p.m.

Section 4- Home Health Rates and Services

This bill would require annual increases to home health fees based on the Consumer Price Index- Urban (CPI-U). The increase in the CPI-U between January 2007 and January 2008 was 4.3%. A 4.3% increase would increase SFY 2009 budget requirements by approximately \$8.0 million. Medicaid expenditures for home health services were

approximately \$192.4 million in SFY 2007. Under current statute, annual increases are permissive and the Department has historically provided updated fees based upon funds budgeted for that purpose by the General Assembly.

Home health fees were increased by 3% effective July 1, 2007. Prior to July 1, 2007, the fee schedule was increased by 2% effective July 1, 2005. The budget for SFY 2008 does not include funding for a fee schedule update.

The Department is opposed to indexing the home health fee schedule as budget increases need to be assessed based upon available revenues and in consideration of the other funding needs/priorities of the state.

The Department pays for home health services based on a fixed fee schedule except that providers may apply for add-ons to account for extraordinary costs associated with 1) serving persons with AIDS; 2) high-risk maternal and child health care; 3) escort/security services; or 4) extended hour services. Five of approximately 95 providers qualify for adjustments to standard fees.

The standard nursing visit fee is \$94.26 per hour (\$60.52/visit for medication administration visits) and \$6.10 per quarter hour (24.40/hour) for home health aide services. Fees are also in place for physical therapy, speech therapy and other services.

The bill requires that a special nursing fee be established for visits to patients with, "serious and persistent mental illness that require the intervention of a psychiatric nurse." Home health agencies currently are reimbursed for medication administration visits for clients with SPMI, which includes mental status assessment. On those occasions when a client is experiencing an acute exacerbation, the visit can qualify for payment as a full skilled nursing visit with notification to the physician at the time of the visit and an authorization request to the department for a change of procedure code. Also, psychiatric treatment and symptom management are already covered under Medicaid as clinic services for this population. In addition most of the clients with SPMI who receive home health services are also clients of the Department of Mental Health and Addiction services, which provides symptom management and support services through grants for community based services.

The bill also changes the definition of a medication administration visit, which is paid at the lower rate (\$94.26/visit vs. \$60.52/visit), so that visits that involve medical evaluation procedures (e.g. blood pressure, glucometer reading) would now be eligible for the full visit rate. In Public Act 03-2, the Department proposed and the legislature approved a definition of medication administration that recognizes the brief nature of these visits and the scope of services provided in these visits including procedures to assess the client's medical and behavioral health status as ordered by the prescribing practitioner. The current pricing reflects the relative value of these brief visits performed by a skilled nurse, in comparison with visits of longer duration that are typically necessary to provide wound care, colostomy care, tracheostomy care and other more intensive physical nursing services

that warrant payment at a higher rate. Pricing based on relative value and cost is appropriate and should be preserved, even if overall rate adjustments become necessary.

In summary, establishing a special psychiatric nursing visit rate and/or changing the criteria for a medical visit will have the effect of increasing the number of medication administration visits that could be billed at a substantially higher rate. The change of criteria alone would likely cost the state in excess of \$20 million. Controlling costs while recognizing the need for more home health services to keep people with psychiatric diagnoses out of nursing homes is a balancing act that must ultimately be addressed to allow the state to care for more people in the community.

The bill requires that by October 1, 2009, the Department establish a fee schedule for supplies and administration of influenza and pneumococcal polysaccharide vaccines provided by home health agency nurses. We have met with representatives from the home health agencies and we support Medicaid reimbursement for the administration of mass vaccines by the home health agencies for our elderly and disabled population as a public health measure. We do need to craft a policy which preserves primary billing to Medicare for the dual eligible population.

Section 5 - Home Health Fee Increase of 29%

This section of Raised Bill 662 provides for an increase to the home health fee schedule of no less than 29% in SFY 2009. A 29% increase would add approximately \$56.0 million to annual Medicaid expenditures and no funding is presently provided for in the SFY 2009 budget for an adjustment to the fee schedule.

Section 6 – Telemonitoring

In concept, the department is open to exploring new health care delivery systems like telemonitoring, but there are no funds in the Governor's budget proposal to support this effort. Moreover, the department is currently charged with implementing a disease management program for similar conditions as authorized in the budget last year. We would prefer to get that effort off the ground and receive some preliminary data to verify the projected cost savings before we embark in a new direction to manage chronic disease costs.

Section 7- RHNS Nursing Facility Rates

This bill establishes the Medicaid rate for nursing facilities licensed at the Rest Home with Nursing Supervision (RHNS) at a level equal to 85% of the average rate paid to nursing facilities with a Chronic and Convalescent Nursing Home (CCNH) licensure designation. The Department is opposed to this bill as implementation would result in hardship to five facilities with RHNS rates and costs in excess of \$183.06 (85% of \$215.37) per day and it would potentially provide unwarranted profits to twenty facilities with Medicaid rates below that level. A preliminary estimate indicates that adoption of this section would increase Medicaid expenditures by approximately \$6.5 million annually.

While current Medicaid nursing facility rates vary widely (\$123.36 to \$270.40) and the range of rates may not be justified by care related resource requirements, implementation of a single payment rate for RHNS services does not improve the system. Any significant change to Medicaid nursing facility rate setting should include consideration of case mix/resident acuity (required staff ratios), building costs and wage/salary/benefit uniformity and/or guidelines.

Of the 29,136 licensed nursing facility beds in the state that participate in Medicaid, 28,235 are CCNH and 901 are RHNS. Only four facilities are solely licensed as RHNS. The other 21 facilities with RHNS licensed beds also have beds licensed under the CCNH category. Medicaid rate setting is identical for both licensure categories except that there is a separate peer group maximum for Direct Care (Nursing and Nurse Aides) costs for RHNS facilities (\$89.13 for RHNS vs. \$151.05 for CCNH).

Section 8- Nursing Facility Property Reimbursement

The proposed change to nursing facility rate setting in this section would continue reimbursement for fully depreciated facilities at the lower of \$12.00 per resident day (\$4,380 per bed fair rent for 365 days) or fair rent prior to full depreciation. Under the current Medicaid rate system, facilities with computed fair rent of less than \$5.22 per day per Section 17b-340 (f) (5) CGS (commonly referred to as minimum fair rent) receive \$5.22 per day. In SFY 2008, Medicaid cost based property allowances/fair rent range from \$5.22 to \$29.17 per day. The fair rent/property component of Medicaid rates represents an average of approximately 6% of the total allowable costs in rate determinations.

Assessing the actual cost of the proposal would require an analysis of each nursing facility fixed asset schedule (242 facilities). A preliminary analysis indicates that 149 facilities would qualify for a rate increase with adoption of this section. Initial estimates indicate associated costs of at least \$17.0 million and the SFY 2009 Medicaid budget cannot support such an increase.

This amendment is being proposed to assist facilities in meeting debt obligations that continue beyond the useful life of the facility and any bed additions. Under Medicaid reimbursement, facility fixed asset costs (original construction and subsequent capital improvements) are depreciated over 30 years (many improvements amortized over shorter periods per accounting guidelines) with application of an allowance for interest expense. For example, a 90-bed replacement facility constructed in 2002 for \$7,700,000 is provided a Medicaid rate property allowance of \$656,600 per year/\$19.98/day (30 year useful life and a 7.53% rate of return). Property reimbursement is not linked to actual borrowing costs incurred by the facility. Fair rent is the same regardless of whether the facility was built with cash, debt or a combination and also does not change in subsequent years if a facility refinances and adds debt based upon updated appraisals or is sold.

The current fair rent system assures that taxpayers pay only for the cost of the asset with a related rate of return/interest factor and are not burdened with debt unrelated to the original cost or purchase price. In the late 1990's facility sale prices sky rocketed due to uncontrolled cost-based Medicare Part A (SNF care) and B (Therapy) reimbursements. Facilities often borrow amounts greater than the cost basis of the home if lenders (Banks, Financing Institutions, REITS, HUD, CHEFA, etc.) believe facility revenues (Private, Medicare A & B and Medicaid) are adequate to meet debt payments. The fair rent method (in varying forms that recognize depreciation and interest associated with asset cost) is a common fixed asset reimbursement practice by states and Medicare. A few states (Maryland) do update the Medicaid property allowance for facilities through market value appraisals. This is a generous approach but can be rationalized as fair and reflecting the current real estate market/rent value of room.

From a cost reimbursement/accounting perspective, there is no reason to change the current system. However, an argument can be made that Medicaid should recognize a higher residual value of facilities. In other words, even if the asset is fully depreciated and "paid" for with interest by taxpayers, the Medicaid program should include some recognition of the rental value. The Department does not agree that fair rent allowances should be continued indefinitely at high levels as proposed in the amendment. On the other hand, in some cases debt amounts on facilities are reasonable and the reduction in allowed fair rent to the minimum of \$5.22 per day will create financial difficulties.

In addition to a Medicaid cost increase of at least \$17.0 million annually, the Department would incur additional administrative costs if this amendment were adopted. Rate setting system programming changes and property addition/new bed research would likely approximate 500 to 1,000 hours for our rate setting and audit contractor with associated additional contract requirements of between \$45,000 and \$90,000.

When the minimum was established in SFY 1991, the 25th percentile was \$4.36 per day. Due to the age of nursing home facilities and the moratorium on new homes, the 25th percentile amount has only increased by 20% in 17 years.

Section 9- Payments for Nursing Facility Hold Days for Hospitalizations

Under current statute when a Medicaid nursing facility resident requires hospitalization, the Department provides per diem payment to the nursing facility for up to seven days (plus 8 days subject to review) if the facility has no more than the greater of 3 vacant beds or a 3% vacancy rate. Section 9 of this bill would liberalize the vacancy standard to no more than the greater of 6 vacant beds or a 6% vacancy rate.

The average occupancy rate of nursing facilities has decreased from approximately 96.5% in 2000 to 93.0% presently and appears to be continuing to drop due to home care and

assisted living options. Non-payment for leave days can result in a hardship for facilities since most operating costs are fixed (building, overhead, most staffing). However, the Department does not want to pay for leaves without an occupancy requirement as there are variable cost savings when vacancy rates are significant.

Department payments for leave days will approximate \$5.0 million in SFY 2008. Based upon a preliminary review of facility occupancy data it is estimated that adoption of the proposed change will increase Medicaid payments in SFY 2009 by at least \$3.5 million. Ninety-one facilities are eligible to bill for leave days presently and an additional 61 would be eligible to bill at the 6 bed/6% vacancy standard.

Section 10- Nursing Home Bed Relocation within Cities

Facilities located in municipalities with 2004 estimated populations greater than 125,000 (Bridgeport, Hartford and New Haven) would be allowed to submit a CON application for the relocation of up to 60 Medicaid certified nursing facility beds to a new site within the municipality. It should be noted that updated estimated population statistics indicate that the census in New Haven and Hartford are now slightly below 125,000.

The moratorium on new nursing facility beds that has been effect since September 1991 was extended from June 30, 2007 to June 30, 2012 last year. While current statutory language allows for the relocation of Medicaid certified beds between facilities it does not permit facility relocation to a new site. Provided the Department retains review and approval authority with regard to the number of beds relocated and costs to be allowed for Medicaid rate setting purposes, we do not object to this proposed change.

Section 11 – Provider Audits

We are strongly opposed to these proposed revisions to the DSS audit process because they will serve only to undermine our effort ensure the integrity of our programs and expenditures. Specifically:

- Limiting the audit period to within the most recent two years precludes our ability to recover fraudulent billings. All providers sign a Provider Agreement which includes a clause that the provider will maintain documentation for five years. Most audits cover a two year period, but the Department must retain the right to review for overpayments during the entire five year period so the proper recoveries can be made.
- In a billing system where the Department processes approximately 20 million provider submitted claims per year, DSS must utilize random samples to audit the universe of paid claims and we are opposed to any restrictions on sample size.
- The Department does not take audit adjustments for clerical or record keeping errors that do not result in overpayments. Providers have argued that almost all

errors are “clerical” and that extrapolation should not apply. If a provider receives an overpayment as the result of an inaccurate record, the Department always evaluates the cause of the overpayment. Only errors that are likely to be represented in the universe of paid claims are considered for extrapolation.

- Since PA 05-195 (the audit bill) was passed the error rate for audits is under 2%. In Connecticut’s \$5 billion Medicaid program, this proposed ten percent threshold could mean that \$500 million per year can be overbilled by providers with no recourse for repayment or penalty.
- Effective July 1, 1995, legislation was enacted establishing a process whereby a provider aggrieved by a decision in a final audit report could access an impartial review within the department but outside the office of quality assurance. Since that time we have received 13 requests for review: 5 in 2005, 3 in 2006 and 5 in 2007. Reviews were completed and decisions issued in 9 of these requests, 4 were settled and withdrawn. This system seems to be working smoothly and successfully. It does not seem necessary to add the level of review of a contested case hearing. This is an administrative burden and cost. There has been no demonstration that our recently amended review process is insufficient.

Section 12 – Smoking Cessation

This section would direct the department to add coverage of smoking cessation services to the Medicaid State plan, though it removes the underlying provisions that would require funding be set aside for this purpose prior to implementation to the mandate. We understand that funds previously set aside for this purpose were designated by the state legislature to fund outreach to Medicaid clients about smoking cessation at the Department of Public Health. While we recognize the contribution that smoking makes to higher health care costs, resources would be required to implement this provision. It should be noted that the enacted budget for FY09 does not include such funding.

Section 13 – Asset Transfers

Section 13 of the bill provides for the department to exclude from the category of asset transfers, presumed to have been made to qualify for Medicaid, donations of conservation easements or conservation restrictions. While such transfers may be excluded from consideration if they are determined by the department to have been made exclusively for a purpose other than to qualify for assistance, the department cannot agree and federal law does not support a blanket exception for such transfers. The department needs to determine that the transferor retained sufficient resources to meet his or her foreseeable needs before classifying the transfer as one made exclusively for another purpose. In light of this, the department must oppose this provision.

Section 14 – Nursing Home Advance Payment Account

This section would establish a non-lapsing account known as the state Medicaid pending pool account to provide state funds for advance payments to nursing home facilities to cover the cost of care for pending Medicaid applicants. The pool would be reimbursed when Medicaid is granted. However, in some cases the applications are denied or long-term care payments are denied because of the imposition of a penalty period for an improper transfer of assets. It should be clear that, should this measure move forward, any adjustments would have to include those for the denials of eligibility or payment resulting from such actions. In addition, because this provision would require the allocation of resources not provided in the Governor's budget the department must oppose this provision.

Section 16 – New 1115 Waiver

The Department recognizes the recommendations of the LTC needs assessment that identified Connecticut's system of service delivery to be a complex system that separates people by diagnosis or disability. However, the Department does not support the concept of an 1115 Waiver for 50 persons to mirror the Money Follows the Person initiative except that persons would not need to meet the 6 month requirement of residing in a nursing home.

Developing and obtaining approval for a new waiver from CMS would be an extraordinarily time consuming process once approved would only assist 50 people. Perhaps a more prudent approach is to do an analysis of existing waivers and perhaps contemplate the combination of the elder waiver with the PCA waiver. This would be a major step in the cross disabilities approach to Long Term Care, adding services to populations that they currently do not have access to. For example, PCA service is not currently available to elders as a waiver service but only as a state funded pilot. Approaching the problem of rebalancing the long term care system in CT and attaining a cross disability approach to service delivery models would not be accomplished by the addition of another waiver and one that would be on such a small scale. Perhaps it would be a reasonable approach to implement MFP and assess the strengths of this model of service delivery prior to implementing any new waiver.

***S. B. No. 664 (RAISED) AN ACT CONCERNING INDEPENDENT TRANSPORTATION NETWORKS.**

This bill amends previous legislation which enabled the Department of Social Services to fund community-based regional transportation development projects. The Department certainly supports the concept of such projects. Whether it is to make a medical appointment, run errands, get to work or shop, or gain access to vital social service programs, reliable and dependable transportation is critical to helping community members remain healthy, productive individuals.

In rural regions, transportation is critical in helping many older adults make these crucial connections, but in many places it is too often lacking or even nonexistent. Three out of four older people live in rural and suburban areas that lack the density for traditional mass transit. Moving rates among people over 65 are the lowest of any age group, and have been declining for the last thirty years. Most people will stay in their current homes as they age, and most will need access to a car. In these unserved and underserved communities, people with disabilities, older adults and other public transportation-dependent individuals suffer the most isolation.

Over the next twenty-five years, the number of older Americans will double, and older adults will make up a larger portion of the population than ever before in U.S. history. In 2002, there were 35.6 million people over 65, making up 12.3 percent of the population. By 2030, the number of older Americans will reach more than 70 million, and 1 in 5 people will be over the age of 65 in most states. Also, one out of every four drivers on the road will be 65 or older.

Older adults rely on the automobile as their primary mode of transportation – even when safety to themselves and others should dictate that they should be seeking alternatives. Many older adults lead active social lives and are reluctant to give up their freedom and the convenience of driving. Their fears of isolation and lack of independence are warranted. Research shows that more than half of non-drivers age 65 and older, or 3.6 million Americans, stay home on any given day partially because they lack transportation options. As a result, older non-drivers are less able to participate in their communities. Compared with those who still drive, older non-drivers make:

- 15 percent fewer trips to the doctor;
- 59 percent fewer shopping trips and visits to restaurants; and
- 65 percent fewer trips for social, family and religious activities.

Older adults know they face a tough decision sooner or later, changes in vision, hearing, reaction time, and other age related conditions or illnesses can affect the ability to safely remain behind the wheel. But determining when to hang up the car keys is a challenging choice for older adults and their families. It is also an important issue for communities, which often are called on to provide alternative means of transportation for aging residents who can no longer drive. Without acceptable alternatives, many older adults will continue to drive themselves, even as their capacity to do so diminishes. Despite their efforts to self-regulate their driving (e.g. avoiding congested areas, avoiding night driving), their safety remains at risk. Older adults who continue to drive suffer more serious injuries and face the highest fatal crash rate of any group.

The five initial projects received planning grants for FY 2006 and 2007 - (1) American Red Cross, Central CT Chapter (Berlin, New Britain and Plainville); (2) Town of Enfield, now ITN*NorthCentralCT (Enfield, Bloomfield, East Granby, East Windsor, Granby, Somers, Suffield, South Windsor, Windsor and Windsor Locks) will provide its first ride in July 2008; (3) St. Luke's Home now ITN*CentralCT (Cromwell, Durham, East Hampton, Middlefield, Middletown, Rocky Hill and Wethersfield) will provide its first ride in July 2008; (4) Western Connecticut Area Agency on Aging (Barkhamsted,

Colebrook, Goshen, Harwinton, Litchfield, Morris, New Hartford, Norfolk, Torrington and Winchester): (5)Town of West Hartford (West Hartford). An issue which has been raised in the planning of these projects serving as a deterrent in securing volunteer drivers and is addressed in this bill has been the possible financial impact on such drivers – the addition of surcharges to their insurance premiums. This bill places these drivers in the same category as volunteer firemen and ambulance drivers by prohibiting an insurer from refusing to renew or assign a surcharge merely by virtue of these volunteer duties.

Legislation last year provided funding for the selection of an additional five projects. A new RFP was released on February 11, 2008 and final applications are due April 2, 2008. This bill specifically provides that the grants may be used for planning, development and implementation (unlike the initial projects) and that selection shall consider transportation needs on a statewide basis to ensure that all geographic areas of the state are included. Most notable is the current absence of the Eastern region. Also, another new and laudable provision of this bill is the inclusion of a requirement to provide for wheelchair accessible options.

In Sec. 3, the bill provides DSS with funding from the General Fund to provide an additional \$50,000 to each of the initial projects for development and implementation of their regional transportation systems. While the continued funding of the initial projects will help to ensure viability of the projects through to fruition, however no additional dollars are available in the currently enacted budget. If funding were made available, DSS would support the expansion of these transportation initiatives.

***S. B. No. 666 (RAISED) AN ACT CONCERNING THE REDUCTION OF CHILD POVERTY.**

I offer the following observations on this legislation establishing a fatherhood grant program for municipalities as well as other community based organizations to promote program expansion in areas of the state that are currently underserved or not served at all. In the event that this bill moves forward, I would recommend that OPM allocate these funds directly to DSS, given that DSS has been operating a statewide fatherhood initiative since 1999, comprised of non-profit organizations in six (6) Connecticut towns and cities. The communities currently being served are: Bridgeport, Torrington, New Haven, Waterbury, Norwich and an incarcerated population at Mason Youth Institution in Cheshire.

DSS has learned a great deal about the negative impact of father absence and it's direct correlation to child poverty, as well as the positive affects of father involvement through our initial research and demonstration pilot and over the years as we have attempted to sustain the work of our community based providers serving primarily low-income fathers and families. In an effort to ensure consistent quality services for fathers, in 2004 DSS developed and implemented a state certification process for fatherhood programs. The purpose of this project is to recognize fatherhood programs that have demonstrated exemplary practice, and to ensure consistency and quality service delivery to low-income fathers and their families. The certification process is rigorous; fatherhood programs are

measured against seven standards (Purpose and Activities, Organization and Management, Parenting Skills Development, Personal and Social Skills Development, Workforce Development, Father Support Services and Evidence of Success). Connecticut is the only state in the nation that has a certification process, which demonstrates the commitment and experience that DSS has not only to fatherhood programming, but to ensuring that the programs meet high quality standards

As lead agency for the Fatherhood Initiative (P.A. 99-193, An Act Establishing a Fatherhood Initiative, a Fatherhood Council and a Research and Demonstration Program and Concerning Other Methods to Strengthen Child Support Enforcement) and chair of a very active Fatherhood Advisory Council (FAC), which includes membership from several state (DSS, DCF, SDE, DOC, DOL, DMHAS, DPH, COC, CTF, Judicial SES & CSSD) as well as coalitions and agencies serving men, women and children, rather than creating another layer of cumbersome administrative minutia, I implore the committee to examine the existing infrastructure and build on it.

Section 3

Section 3 of the bill would require the department to develop a plan to implement an on-line application for the Food Stamp program. The department does not object to this provision, although it is probably unnecessary, as we are already in the process of developing the system this section envisions. We issued a Request for Information for such a system about a year ago and this past June had eight vendors provide presentations on their approaches to such a system. We used this information to develop an RFP released in January for a consultant to assist the department in procuring a web-based online application system for both the HUSKY and Food Stamp programs. The consulting firm will assist the department in developing an integrated approach to online applications, document imaging, and a voice response system for an RFP to be issued by the end of the summer and the systems developed and implemented by late 2009 or early 2010.

Section 4

Section 4 of the bill would require the department to make a prescreening tool available on the department's website to aid potential food stamp applicants in determining their eligibility for the program. This provision is unnecessary as there already is a link on the Food Stamp page of the department's website to just such a tool developed by End Hunger Connecticut!, in collaboration with the department. In addition, the new web-based online application system discussed in our comments on Section 3 will also have a prescreening tool for Food Stamps and the department's other programs.

Section 6

Section 6 of the bill would require the department, in conjunction with the state Department of Education, the Department of Children and Families, and the Children's Trust Fund, to establish a work-readiness program for first-time mothers exempt from

participation in the Jobs First Employment Services program. The department supports the intent of this section to prepare these mothers for participation in Connecticut's workforce so that they may avoid ongoing welfare dependency and potentially shorten the time they receive public assistance benefits.. Currently the department has approximately 2,600 mothers who are exempt from participation in the Jobs First Employment Services program, administered by the Department of Labor and the regional workforce investment boards, because they are caring for a child under the age of one, although not all of them are first-time mothers. Efforts to prepare these women for the workforce and coordinate services to strengthen their families will only enhance our subsequent welfare to work efforts.

We are concerned that the Department of Labor is not included as one of the agencies to participate in the development of this program as they have primary responsibility, along with the workforce boards, for workforce development in the state. Should this proposal move forward we would recommend including DOL as a partner in this effort. We would also propose that first-time mothers be made a priority for service by this program but not exclude participation by other mothers caring for a child under one year of age. Because this would be a voluntary program we would want to have the flexibility to potentially recruit from the entire population exempt from work requirements for this reason. Finally, because the Governor has not provided funds in her mid-term budget adjustments for such a program we cannot support this proposal at this time, particularly given the significant costs of such an expansion.

TPP Provisions

The Department of Social Services (DSS) has been operating a statewide teen pregnancy prevention initiative comprised of individual programs run by not-for profit organizations and municipalities in ten (10) Connecticut towns and cities. The communities served are: Bridgeport, Hartford, Killingly, Meriden, New Britain, New Haven, New London, Norwich, Waterbury, and Windham. The programs in these areas serve approximately four-hundred seventy (470) participants.

The initiative is presently being restructured and went out to bid in 2007 with the purpose of procuring teen pregnancy prevention services from not-for-profit organizations and municipalities utilizing proven science-based program models. There were five (5) successful bids in the communities of Hartford, Meriden, New Britain, New Haven, and Waterbury. The newly implemented programs utilize either of two science-based models: 1) the comprehensive, long-term, holistic, youth development model, based on the Carrera program model; or 2) a service learning model, where participants engage in, reflect on, and learn from community service projects. Both of these program models have been evaluated and have shown evidence that they are among the most effective approaches to preventing teen pregnancies. In Bridgeport, Killingly, New London, Norwich, and Windham, there were no successful bidders after the recent procurement. Consequently, agencies that had been previously providing services in those communities agreed to continue until the program restructuring could be completed. Accordingly, the DSS plans to release another request for proposal (RFP) later this spring, and will target the eight (8)

remaining communities with the highest incidence of births to teens in the state: Ansonia, Bridgeport, East Hartford, Killingly, New London, Norwich, West Haven, and Windham.

The current allocation for the DSS funded teen pregnancy prevention initiative is \$2,297,710.00. The funds primarily support the individual programs, but also cover independent research and evaluation, statistical analysis, training, and special events for program participants.

The recent restructuring of the DSS Teen Pregnancy Prevention Initiative came about as a result of the growing body of literature documenting effective and ineffective program models. Teen pregnancy is a complex issue and cannot be affected by simplistic approaches that do not address the root causes: poverty; community disadvantage; family structure; academic deficiencies; intergenerational patterns of teen parenting; peer and partner attitudes and behaviors. Bill No. 666 duplicates the science-based services that the DSS is currently providing in the communities, inclusive of municipalities, with the highest incidence of births to teens. The DSS initiative does not target only municipalities to provide the direct services, as our direct service providers represent both not-for-profit organizations as well as municipalities. Further, our planned procurement invites not-for-profit organizations as well as municipalities to bid on the remaining communities slated for restructuring. Lastly, the teen pregnancy prevention program model identified in Bill No. 666 is essentially identical to the comprehensive, long-term, holistic, youth development model, based on the Carrera program model currently implemented by the DSS.

Finally, to expand Teen Pregnancy Prevention Programming beyond the anticipated procurement and number of towns anticipated in the Spring would require additional funding which this bill does not contemplate.

***S. B. No. 660 (RAISED) AN ACT CONCERNING ESTABLISHMENT OF A FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM AND FUND.**

The department supports the intent of this bill to use existing state, local or philanthropic resources to leverage matching federal funds in order to increase the capacity of the state's workforce development system to prepare Food Stamp recipients for employment or better jobs in Connecticut's workforce. In fact, the department has already amended its Food Stamp Employment and Training Plan to implement this strategy through a cooperative agreement with Capital Community College. It has always been our intent to expand the program to other providers of vocational education or workforce development services that can provide the necessary state match to draw down the available federal matching funds. However we need to work through the specific processes to assure that we can meet the requirements of the US Department of Agriculture's Food and Nutrition Service. We need to make sure that any activities funded under this initiative meet the requirements of federal law and we can secure from the service provider the necessary documentation to support our claim for the funds, including the required quarterly federal fiscal and data reports. Therefore we share the enthusiasm of the proponents of this bill for its potential

to enhance the resources available for employment and training activities in this state, but that enthusiasm is tempered by our knowledge of the significant administrative burdens that leveraging these funds entails.

We believe that the provisions providing for a non-lapsing account for these federal funds are problematic and probably not permitted by federal rules. Through our FS E&T plan the department is able to establish an allocation of funding from the USDA that can be drawn down to the state based on costs incurred by our FS E&T contractors based on the services they have delivered or will deliver in the immediate future. It is the employment and training contractors who receive the direct benefit of the additional federal match by being able to effectively double their program capacity for those Food Stamp participants who are placed in their program activities under the program. There is no provision for the state to retain the funding in a state account, except for any state costs incurred in administering the program.

We are also concerned that some of the activities that the bill envisions to be funded with Food Stamp E&T federal funding are not allowable to be reimbursed under the program. Although it is permissible to claim costs for employment and training activities, and child care and transportation costs necessary for the participant to attend the activity, such activities as income assistance, housing assistance, medical and dental services, and teen pregnancy prevention and school dropout services are most likely not allowable to be claimed under the program.

Also, the statement in subsection (d), which requires that the any program or service funded under the Food Stamp Employment and Training program be aligned with the goals of the Child Poverty and Prevention Council, is highly problematic. The Food Stamp Employment and Training program's primary target population is able-bodied adults without dependent children (ABAWDs). Such individuals are subject to durational time limits for receipt of Food Stamp benefits and therefore Congress has made them the priority for employment services under the program. The department is required by federal law to use the state's \$700,000 in 100% FS E&T funding allocation for this population. Although some of these individuals are non-custodial parents and would fall within the scope of the goals of the Child Poverty and Prevention Council, many are not. Therefore this language should either be deleted or replaced with alternative language that recognizes the federal law requirement to serve the ABAWD population.

Finally the department is concerned about the additional costs that may be incurred in administering such an expanded program. There will be additional administrative burdens created by the additional requirements for contracting, data-matching, reporting, and program support, as well as the promulgation of regulations and its annual reporting requirements. The department must be assured it will have the requisite resources to carry out these tasks, in the context of overall budget discussions, before we can support this bill.

***S. B. No. 665 (RAISED) AN ACT CONCERNING CONTINUING CARE FACILITIES AND CONTINUING CARE AT HOME.**

This bill allows Continuing Care Facilities (CCFs), often referred to as Life Care facilities, to offer continuing care contracts to persons residing at home, not only to persons for residence on the CCF campus. Proponents of this bill believe it further promotes home care services as an alternative to costly long term care facility care.

It is unclear whether potential purchasers of such CCF home service contracts would have obtained home health and/or home care services from the current provider network if CCF-provider option did not exist. Also, CCF contracts, both those currently marketed for residential units and community contracts proposed under this bill, inherently involve some financial risk for purchasers. The Department is hesitant to endorse the addition of a financial risk product aimed at seniors and, further, any potential benefit to state and/or federal taxpayers in the form of any Medicaid or other government program savings due to the availability of this product is uncertain.

There are eighteen CCF's in the state. In August, 2007, the Department denied a request by a CCF to offer contracts to persons in the community as under current statute (Sec. 17b-520 CGS) a CCF contract must include the provision of "shelter". Shelter is defined as, "a room, apartment, cottage or other living area in a facility set aside for the exclusive use of one or more persons pursuant to a continuing-care contract.

If adopted, CCFs would be allowed to market contracts requiring an up front fee from persons in the community that would be subject to a time based declining refund. Community CCF contract holders would receive all or a portion of home care services on a fee-for-service basis and the right to future access to care and shelter at the CCF. The bill includes technical changes to continuing care contract and disclosure statement requirements to distinguish provisions that do not apply for contract holders receiving care at home.

The bill also allows the Department to grant one or more three-year extensions to the period during which a CCF may admit to their nursing facility persons from the community, not just their CCF contract holders. Currently, a CCF may accept non-CCF patients for a period of up to 10 years after opening. The admission restriction on CCFs is intended to assist existing Medicaid participating facilities from the loss of private pay admissions due to the development of a new CCF recognizing that the CCF nursing home must be able to admit patients from outside the campus to be viable in the initial years of operation. The Department supports this provision as it retains approval authority for extensions and can deny extensions in cases where it appears the facility has too large of a capacity for the CCF population and a reduction in licensed beds can be recommended.

***H. B. No. 5907 (RAISED) AN ACT CONCERNING THE TEMPORARY FAMILY ASSISTANCE PROGRAM.**

This bill makes several changes to the Temporary Family Assistance (TFA) Program that expand eligibility and program benefit levels.

Section 1 creates a new transition program for families who have lost eligibility because their benefits are above the TFA payment standard at the end of their time limit or their income exceeds the federal poverty level. Families would receive reduced ongoing benefits for a one-year period. The department recognizes that research has demonstrated that ongoing work support programs of this type can have a positive impact on families in the form of improved child outcomes. In addition, by having more working families continuing to participate in the state's TANF program the state's work participation rate will benefit, helping the state to avoid potential federal penalties. However, the costs associated with the provisions of this bill would be substantial and are not contemplated in the Governor's budget. The department must therefore oppose this provision.

Section 2 adds to the category of individuals who are exempt from time-limited benefits those with a parent whose employment is limited due to a disability that does not prevent employment, along with an additional assessment responsibility to identify any needed accommodations to allow the individual to participate in employment service activities. The department has encountered a small number of individuals that fit into this category and believes that adding this category to those exempt from time limits, but not exempt from employment services requirements, is appropriate.

Section 2 also adds homelessness or risk of homelessness as an additional barrier to employment that can allow a recipient with two barriers to qualify for a first or second extension to the time limits. The department believes that homelessness can be a barrier to employment, but the particular circumstances of the homeless family need to be examined to determine if it creates a significant barrier. For example, families residing in the stable environment of a transitional living program are considered homeless, but their homeless condition does not constitute a substantial barrier to employment. On the other hand, families in emergency shelters, on the street, or in other unstable living arrangements would be considered to have a significant barrier. Finally, being at risk of homelessness, but not yet homeless, probably is not a significant barrier to employment. The department is therefore opposed to this provision as it is currently worded, but would consider supporting a revision for homeless families when the homelessness reasonably prevents the family for seeking or securing employment.

This section also provides for an increase from the current \$50 child support disregard to \$100 for a family with one child and to \$150 for a family with two or more children. The Governor's budget includes the increase to \$100 and the department supports such an increase. Having a second disregard level for larger families is overly complex administratively and would result in additional costs that are not contemplated in the Governor's budget. We therefore must oppose that part of this provision.

Section 3 of the bill increases the benefit levels for TFA recipients by 30 percent effective July 1, 2008. We believe the intent of this provision is to increase the benefit level for non-parent caretaker relatives. The bill refers to section 17b-112 for the meaning of term "caretaker relatives." That section refers to "parents and other caretaker relatives" appropriately implying that parents are caretaker relatives. The section also provides for

an additional 30 percent increase for families with more than one child based on the "aggregate temporary family assistance benefit". We are unclear what the intent of this provision might be as the aggregate benefit is the total TFA benefit and we always provide benefit increases based on this aggregate benefit level. Regardless of the specific intent of these provisions, they clearly would result in substantial additional costs to the state that are not supported by the Governor's budget and therefore the department must oppose.

***H. B. No. 5913 (RAISED) AN ACT APPROPRIATING FUNDS FOR CANCER PREVENTION AND TREATMENT.**

This legislation is consistent with Governor Rell's recommended budget and its provisions to increase the number of women who could eventually become eligible for Medicaid coverage of follow-up treatment due to a positive screening of breast or cervical cancer. Currently, Medicaid coverage is available for any woman who has been screened at one of the 18 sites or approved satellite locations under the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program and is found to need treatment for either breast or cervical cancer. A woman qualifies for this specific Medicaid coverage only if CDC funds were used to perform the screening tests and is eligible for Medicaid until her course of treatment is completed or until she no longer meets all eligibility requirements. This proposal allows the use of other funds, such as donations, to be treated as if they were CDC funds, thereby expanding the number of women who would qualify for screening and Medicaid coverage. Annually, it is expected that DSS will provide coverage to 300 additional individuals at cost of approximately \$3.6 million.

Thank you again for this opportunity to submit testimony. I would be happy to answer any questions you may have.