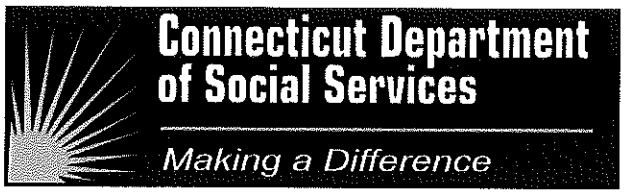

Testimony before the Human Services Committee

Commissioner Roderick L. Bremby

March 1, 2012

Good morning, Senator Musto, Representative Tercyak and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am Commissioner of the Department of Social Services (DSS). I am here today to testify on a number of bills that impact the department, including seven bills the department submitted for the committee's consideration and the Governor's budget implementation bill for human services programs. I would like to thank the Committee for raising the bills on our behalf and urge your support. I will begin my comments with the Governor's budget implementation bill, Senate Bill 30.

S.B. No. 30 AN ACT IMPLEMENTING PROVISIONS OF THE BUDGET CONCERNING HUMAN SERVICES.

The Department of Social Services provides a wide array of services and supports to over 750,000 Connecticut residents annually through over 90 programs. While the vast majority of DSS services support the medical needs of our residents through programs such as Medicaid, Children's Health Insurance Program and the Connecticut Home Care Program for Elders, our programs help to meet a broad range of needs by residents of all ages. These programs include income support services, such as Temporary Family Assistance, child support and child care; food and nutrition such as the Supplemental Nutrition Assistance Program (food stamps) and elderly nutrition; and support and safety services such as winter heating assistance, social work services, and teen pregnancy prevention.

The Governor's recommended mid-term budget for SFY 2013 represents a net reduction of $119.2 million, or 2%, from the original SFY 2013 biennial appropriation. This represents an increase of $20.5 million, or 0.4%, above current SFY 2012 estimated expenditures. Health Services comprise 90% of the total $5.8 billion recommended budget, and Medicaid alone represents 91% of the health services area. Medicaid enrollment is currently over 580,000 and has been steadily increasing.

Some of the more significant changes in the Governor's recommended budget are in DSS medical programs, including changes to the Medicaid for Low-Income Adults (MLIA) program, Money Follows the Person, and medication administration to clients living in

the community. Of these changes, the proposal for medication administration is incorporated into this bill.

The Governor's recommended changes to medication administration will strengthen the state's long-term care rebalancing efforts. Currently, with the exception of staff hired or self-directed by Medicaid Waiver program participants, only nurses may administer medication in community settings. In SFY 2011, DSS spent $128.3 million on medication administration for approximately 8,500 Medicaid clients at an average cost per visit of $54. Costs of medication administration are, in some cases, a barrier to moving clients from institutional settings into the community because these costs cause the overall plan of care to exceed the cost caps required by the federal Money Follows the Person rules. To reduce these costs, the Governor's budget proposes reducing rates for medication administration, expanding nurse delegation for medication administration, allowing agency-based personal care assistants to administer medication, and utilizing assistive technology.

There are a number of other proposed budget adjustments which are addressed in this bill. These include:

- Implementing existing dental benefit limitations based on client service levels, rather than provider service levels, to prevent multiple provider services to the same client in excess of these limits.
- Allowing for adjustments to rates for community residential providers in instances where mortgages are fully paid and property costs no longer exist, or are far less.
- Requiring clients aged 65 or over to transfer from the Personal Care Assistance Medicaid Waiver program into the Connecticut Home Care are Program for Elders in order to serve more individuals under the PCA waiver program.

Department of Social Services Bills

S.B. No. 230 (RAISED) AN ACT CONCERNING COMMUNITY CHOICES FOR LONG-TERM CARE AND DISABILITY SERVICES.

This bill establishes authority for the Department of Social Services to develop and administer a statewide Aging and Disability Resource Center (ADRC) program.

Amendments to the federal Older Americans Act (P.L. 109-365) in 2006 included substantial language to promote the development and implementation of comprehensive, coordinated systems to enable older individuals to receive long-term care in home- and community-based settings in a manner responsive to the needs and preferences of older individuals and their family caregivers. One piece of this initiative includes the development of Aging and Disability Resource Centers (ADRCs) in all states. State agencies, in conjunction with Area Agencies on Aging, were required to promote the development and implementation of such a comprehensive, coordinated system within the state and to facilitate the area-wide development and implementation.

Currently, Connecticut has three ADRCs that were established as a pilot program through a federal grant and operate out of the Area Agencies on Aging. Connecticut has been advised that if ADRCs are not available statewide by September 29, 2012, no future federal funding will be available to the state for this purpose. Therefore, this legislation is critical to establish the programmatic and authoritative language necessary for development and operation statewide.

The department's intent is that this will occur within available funds and will not require additional state funding to implement. Our proposal submitted to the committee included language "within available resources"; however, the version before you today omits that language. We respectfully request that "within available resources" be added back into the bill in order to reflect the department's intent.

S.B. No. 231 (RAISED) AN ACT MODIFYING THE KATIE BECKETT HOME CARE WAIVER PROGRAM.

This bill will increase the capacity available under the Katie Beckett Waiver to accommodate individuals transitioning back into the community from the Money Follows the Person Demonstration grant.

The Katie Beckett Medicaid Waiver program has operated since 1993, targeting persons in need of an institutional level of care and providing case management services that enable them to remain in the community. Case management services assist participants in gaining access to medical, social, educational and other services as needed.

Since the waiver is at its statutory capacity of 200 and our intent is to reserve capacity beyond the 200 slots for children transitioning from institutions under the Money Follows the Person Demonstration, a statutory change is required.

The Katie Beckett Waiver was renewed for five years, effective January 1, 2012. Several changes were made to the waiver that necessitate changes to the statute. The changes are as follows:

- Added chronic disease hospital level of care to reflect the actual needs of waiver participants;
- Added an age cap of 22 to the waiver; and
- Added reserve capacity to the waiver for Money Follows the Person participants transitioning to the waiver.

In addition, the proposed bill also clarifies the target population for individuals for the Katie Beckett Waiver. The target population is children with physical disabilities who may or may not have a co-occurring developmental disability.

S.B. No. 232 (RAISED) AN ACT EXTENDING A MORATORIUM ON NURSING HOME BEDS.

This proposal extends the moratorium on new nursing home beds from June 1, 2012, to June 1, 2016. This is a technical fix that reflects the intention of the current budget, which does not include funding for bed expansions in nursing facilities. An extension of the moratorium is consistent with the department's rightsizing initiative, the purpose of which is to develop a strategic plan for the appropriate number and placement of nursing home beds in the system.

S.B. No. 234 (RAISED) AN ACT REPEALING CERTAIN OBSOLETE HUMAN SERVICES STATUTES.

This bill eliminates statutes that are no longer necessary.

- 17b-221a is a financial management mechanism for Riverview Hospital that is no longer utilized.

- 17b-342a establishes the Personal Care Assistance pilot, which no longer exists now that PCA services are a covered service under the Home Care for Elders waiver under Medicaid.

S.B. No. 235 (RAISED) AN ACT CONCERNING MUNICIPAL AGENTS FOR THE ELDERLY.

This bill amends the statutory language establishing a municipal agent for the elderly to be more in line with the provisions of CGS Sec. 7-127c, municipal agents for children. The purpose is to relieve some of the burden on municipalities relative to their responsibilities, including reporting requirements of agents, agent qualifications, and training. Further, the bill will reduce administrative and programmatic responsibilities of DSS staff and codify existing collaboration practices of the department and Area Agencies on Aging.

The enactment of both Medicare and the Older Americans Act in 1965 reflected the need to expand not only health services but also information services for older persons. At the time, the only option was to have the information come from local communities. Accordingly, Connecticut enacted legislation in 1972 requiring municipal agents for the elderly to fulfill informational and service referral needs. In 1973, the Older Americans Act Comprehensive Services Amendments established a funding stream for Area Agencies on Aging and grants to local community agencies for multi-purpose senior centers, and an extended timeframe to develop the programs.

There are currently no state or federal funding streams to support the operation or staffing of the municipal agent for the elderly program in the 169 cities and towns throughout

Connecticut. Some agents are volunteers, and others perform multiple roles, such as senior center director, social services coordinator or recreation director. Connecticut municipalities are experiencing increased financial and administrative pressures that make it difficult to meet this statutory mandate.

This bill would relieve municipalities of an unfunded mandate and allow them to utilize existing available resources. It also eliminates administrative and programmatic responsibilities when support is already available through community partners. The amended provisions, in large part, parallel the subsequently enacted municipal agent for children statute (CGS Sec. 7-127c), which recognizes the fiscal realities of our times while keeping a flow of information and services available to local municipalities.

H.B. No. 5282 (RAISED) AN ACT ADJUSTING INCOME ELIGIBILITY FOR MEDICARE SAVINGS PROGRAMS.

This proposal was raised at the request of the department. However, we are happy to report that House and Senate leadership, as well as our Committee chairs, recognizing the urgency of the matter, acted on an emergency certification bill which passed unanimously in the House and Senate on Wednesday. We thank the Committee for raising this bill, but it is no longer necessary.

H.B. No. 5283 (RAISED) AN ACT WAIVING ADVANCE PAYMENT RESTRICTIONS FOR CERTAIN NURSING FACILITIES.

This bill will allow the department to waive the two-month cap on advance payments and the 90-day recoupment to nursing homes in receivership if it is determined to be the in best interest of all parties.

Upon the appointment by the Superior Court of a receiver to a skilled nursing facility, immediate funds are needed to stabilize the facility, including payroll and vendor payments. On average, Medicaid payments account for 70% of nursing facilities' total revenue. Advances on future Medicaid billings are paid to a facility, based on the receiver's request for funds. Sometimes, the funding requests required can be more than the two months allowed under statute. In order to protect the health, safety, and welfare of the residents, there needs to be some flexibility in providing these payments when they are deemed necessary.

In addition, effective upon the date of receivership, provider billings are to be preserved by the receiver, which requires numerous certification, financial, and provider billing procedural changes. These required changes make it difficult to recoup payments made to the facilities within the required 90 days. This change will allow that 90-day timeframe to be waived in situations when required.

It was the department's intention that this bill be effective on passage, however the version before you today reflects an effect date of July 1. We would, therefore, respectfully request the effective date be changed to effective on passage.

H.B. No. 5284 (RAISED) AN ACT CONCERNING RECOUPMENT OF STATE ASSISTANCE PAYMENTS.

This proposal will enhance the state's ability to collect Medicaid overpayments made on behalf of state assistance recipients who have third-party liability. The additional data requirements will help to accurately match Medicaid clients with third-party coverage that may be liable to cover medical expenses. This will allow for more efficient recoupment of Medicaid payments for which third-party insurers should be responsible. The addition of "third-party administrator" makes the intent to include the administrator in these statutes explicitly clear. It avoids any questions about the authority of a third-party administrator, thereby preventing questions that could impede its ability to recoup state funds on the department's behalf.

Bills with Department Impact

S.B. No. 208 (RAISED) AN ACT CONCERNING REDUCING INMATE HEALTH CARE COSTS.

This bill proposes that all inmates in correctional institutions be screened for Medicaid eligibility, be enrolled in the program during incarceration, and that eligibility not be discontinued during that time. It further would require that eligible inmates be enrolled in Medicaid if they are admitted to a hospital or receive other treatment outside of the prison.

Federal Medicaid law precludes states from claiming for federal financial participation for costs of medical care for patients who are incarcerated, except for services provided while the patient is admitted to an inpatient hospital, nursing facility, juvenile psychiatric facility or intermediate care facility. Accordingly, there would be no federal revenue for services other than those described above.

Furthermore, DSS and the Department of Correction have already implemented procedures to establish Medicaid eligibility for inmates admitted for inpatient treatment at any of the state's acute-care general hospitals. These inmates are screened for eligibility upon admission. Hospitals fax completed Medicaid applications to a centralized unit in DSS, where our staff determine eligibility. Medicaid payments for eligible individuals are limited to the hospital admission, and the hospitals are currently billing Medicaid for the services they provide to these patients.

In addition to providing Medicaid to inmates who have been admitted to hospitals, DSS staff determine Medicaid eligibility for inmates that will be leaving DOC custody. DOC notifies DSS approximately one month prior to the scheduled release of inmates. DSS then reinstates Medicaid if the inmate had received Medicaid within 24 months of

incarceration or determines eligibility based on an application filed by the inmate. This ensures that individuals leaving the custody of DOC have medical assistance upon their release, if eligible.

Finally, we have concerns about the language that requires that eligibility not be discontinued during incarceration for any reason. This language fails to recognize that there are many legitimate reasons why the department might discontinue coverage when a person is Medicaid-eligible before entering the correctional system. For instance, an inmate may fail to complete a redetermination or experience a change in family financial circumstances. The language as written would preclude the department from disenrolling the client in these and many other legitimate circumstances.

S.B. No. 209 (RAISED) AN ACT INCREASING EDUCATIONAL INCENTIVES IN THE JOBS FIRST EMPLOYMENT SERVICES PROGRAM.

This bill would establish a pilot program for a minimum of 1,000 Temporary Family Assistance (TFA) Jobs First Employment Services (JFES) participants. The participants in the pilot would receive vocational education **and** take courses leading to the attainment of a high school diploma or its equivalent. Participation would be an "allowable activity" in a participant's employability plan. The bill also would require DSS to grant two extensions if the participant was complying in good faith with the program and had income less than 100 percent of the federal poverty level.

The bill as drafted, however, poses several implementation challenges and could be unworkable.

First, the language says the pilot will happen "within available appropriations." Given current JFES funding levels and the required minimum 1,000 participants, this would have the unintended effect of restricting participation in vocational education to **only** those individuals without a high school diploma. There would not be enough funding to serve pilot participants as well as other participants who have graduated from high school who may want vocational education.

Second, this bill could potentially limit people's choices in acceptable employment plans. Some individuals without a high school diploma may be ready to enter vocational education and high school coursework, but for others, vocational education is not the appropriate activity for them. Moreover, some individuals may not test at levels that would make it possible for them to succeed even within the twenty-one month time limit plus two extensions contemplated in subsection (b).

Third, it might be difficult to identify sufficient participants during the fiscal year who meet the bill's criteria. The number of JFES participants without a high school diploma is only 30% of the approximately 8,000 monthly JFES cases. Furthermore, it is unknown how many of these individuals would test at levels that make participation in vocational education possible within the given time period even with the inclusion of adult basic

education. Given the limitations on recruiting a sufficient number JFES participants who meet the bill's criteria, it will be a significant challenge for the Department of Labor (DOL) and the Workforce Investment Boards to identify, recruit, screen and enroll 1,000 participants into appropriate training and education programs within the state fiscal year and within current resources.

Lastly, the Governor's recommended appropriation for TFA does not contemplate the impact of an expansion of the income limit for the people in the pilot who would need six month extensions.

Please note that the current TFA/JFES program already provides these options for some participants. TFA/JFES currently offers vocational educational activities. For example, in December 2011, 825 of the TFA/JFES-enrolled individuals were participating in vocational education. Many of these training opportunities included a basic skills component. Under federal law, however, vocational education as a countable work activity is limited to 12 months and no more than 30% of the people in countable activities can be in vocational education.

The JFES program also allows individuals to participate in basic education/English as a second language and GED (ABE/GED/ESL) classes. For these activities to count towards meeting federal work participation requirements, however, ABE/GED/ESL participation must be combined with 20 hours of approved work activities.

Under the TANF block grant guidelines, all states must meet a Work Participation Rate (WPR) of 50% for "All Families." Work participation rates measure the degree to which parents in TANF families are engaged in work activities that lead to self-sufficiency. Activities that can be counted toward the WPR are defined by the federal government and federal regulations significantly restrict states' abilities to include education as countable activities. Failure to meet the WPR could result in a significant financial penalty for the state. It is important to note that the WPR is calculated after the end of the reported federal fiscal year. It is impossible to predict with certainty how many TFA recipients may take part in activities that are not countable toward the work participation rate (such as educational activities) before jeopardizing the states ability to meet the participation rate.

S.B. No. 229 (RAISED) AN ACT CONCERNING MEDICAID LONG-TERM CARE COVERAGE FOR MARRIED COUPLES.

Under this proposed legislation, the 'community spouse' (meaning the spouse who remains in the community when the other spouse enters long-term care) would retain marital assets up to a maximum of $113,640, which is the maximum amount allowed under federal law. Currently, community spouses of long-term care Medicaid recipients are allowed to keep one-half of the couple's liquid assets, up to the federal maximum of $113,640, exclusive of the community spouse's home and one car. Pursuant to federal law, community spouses are allowed to keep a minimum of $22,728.

In the 2010 session, the legislature passed Public Act 10-73, which did exactly what this bill proposes, to allow the community spouse to retain up to the federal maximum. However, the fiscal 2012-2013 budget adopted by the legislature in 2011 reverted to the policy that was in place prior to 2010, due to the projected costs of over $31 million.

	Pre-2010	**2010**	**2011**	**2012 Proposed**
Community Spouse Protected Allowance allowed under CT law	Community spouse could retain one-half of the marital assets, up to federal maximum protected amount of $109,560 at the time.	PA 10-73 allowed the community spouse of an institutionalized individual to retain the full, maximum protected amount, as determined by federal law ($109,560).	PA 11-44 reversed PA 10-73; community spouse could retain one-half of the marital assets, up to the federal maximum protected amount of $109,560 at the time.	S.B. No. 229 would allow the community spouse of an institutionalized individual to receive the maximum protected amount, as determined by federal law (currently, $113,640).

To demonstrate the potential fiscal impact of this change, we offer the following two examples.

1. Mr. S entered a nursing home on October 1, 2011. The spousal assets as of that date were $80,000. They applied for Medicaid on October 1, 2011.

   Under the current rules, Mrs. S was allowed to keep one-half of the spousal assets ($40,000), plus the home and one car. The couple reduced their assets of $80,000 to $40,000 for Mrs. S and $1,600 (the Medicaid asset limit) for Mr. S in December 2011, and DSS granted Medicaid eligibility for Mr. S. They spend $11,000 of their money on Mr. S's nursing home care – approximately one month worth's of care. The rest of the money was spent on funeral contracts and home repairs.

   Under the proposed legislation, Mrs. S would automatically be allowed to retain assets up to $113,640 – the maximum amount allowed under federal law. Since their assets were below this amount when Mr. S was admitted to the nursing facility, Mr. S would have been immediately eligible for Medicaid, shifting cost of nursing home care for one month to the Medicaid program.

2. Mr. H entered a nursing home on August 1, 2011. The spousal assets as of that date were $150,000. They applied for Medicaid on November 1, 2011.

Under the current rules, Mrs. H is allowed to keep one-half of the spousal assets ($75,000) plus the home and one car. The couple reduced their assets of $150,000 to $75,000 for Mrs. H and $1,600 (the Medicaid asset limit) for Mr. H in December 2011, and DSS granted Medicaid eligibility for Mr. H. They spend $35,000 on home repairs for Mrs. H and $40,000 on Mr. H's nursing home care – approximately 3½ months of care.

Under the proposed legislation, Mrs. H would automatically be allowed to retain assets up to $113,640 – the maximum protection amount allowed under federal law. They would only need to spend $34,760 to be eligible ($150,000 - $113,640 for Mrs. H - $1,600 for Mr. H), which they can accomplish through the home repairs. They would not need to spend any money on Mr. H's care and would therefore shift the cost of care for 3 ½ months of care to Medicaid.

Funding was not included in the Governor's recommended budget adjustments to support this increase; therefore this proposal cannot be supported by the department.

S.B. No. 233 (RAISED) AN ACT CONCERNING ADVANCE PAYMENTS TO NURSING FACILITIES FOR UNCOMPENSATED CARE.

This legislation would require DSS to make an advance payment to a nursing facility whenever the facility is providing eligible, uncompensated services to one or more consumers whose application for long-term care medical assistance has been pending for more than 90 days or when payment has not been made to the facility within 30 days of an approved application. The bill would limit the advance payment to 90 percent of the estimated amount due. Additionally, the bill allows for recovery of advance payments within 30 days of the application being granted and payment being made to the facility by reducing the payment due to the facility.

This proposal would have an estimated cost of $50 million to $60 million. In addition, the state could not claim federal financial participation (FFP) for any payments made for individuals not yet determined eligible.

A long-term care eligibility determination is a highly complex and deeply involved process that requires the cooperation of all stakeholders to complete. Federal Medicaid law requires the imposition of penalties if applicants or their spouses transfer assets, for the purpose of qualifying for Medicaid, within five years of applying for long-term care Medicaid services. This requires that DSS eligibility workers review financial transactions for all assets during this five-year period. Merely obtaining all of the financial records, often from family members who are unwilling to share or unable to obtain the records, routinely takes more than 90 days. The subsequent review of the records once they are obtained is a painstaking process which essentially amounts to a forensic accounting by eligibility workers.

We are concerned that passage of this proposal will remove an incentive for the family and nursing facility to complete the application in its entirety. Not completing the application will result in a denial, which will then necessitate a recoupment of payments made to the facility in good faith. In fact, any advance payment made on behalf of an applicant who is later determined to be ineligible, due to asset transfers or failure to meet other Medicaid eligibility requirements, would have to be reimbursed to the department.

Second, the legislation would require advance payment if a nursing facility has not received Medicaid payment within 30 days of an approved application. Medicaid is the payer of last resort after other payment sources, such as Medicare and private insurance. The coordination of benefits can often exceed 30 days, resulting in advance payments to nursing facilities. Although other sources may ultimately pay, the administrative burden of issuing advance payment and then obtaining reimbursement would create a significant administrative burden for the department.

The department opposes the legislation as it is proposed here, but will continue to work with the industry to come up with a less costly solution.

S.B. No. 236 (RAISED) AN ACT CONCERNING REIMBURSEMENT OF EMERGENCY ROOM PHYSICIANS FOR TREATMENT OF MEDICAID RECIPIENTS.

This bill would require the department to pay emergency management physicians, who are not employed by the hospital, directly, rather than including this payment as a professional component of the payment made to the hospital, which is the department's current policy.

For patients who require emergency care, but who are not admitted to the hospital, the department reimburses the hospital separately for the visit and for a professional fee. If emergency management physicians were permitted to bill separately in lieu of the hospital's professional fee, there will be additional significant costs. The emergency management physicians would be able to bill for a combination of evaluation and management services and procedures that may well exceed the single professional fee currently charged by the hospital.

For patients who require emergency care and are admitted to the hospital, it is the department's policy to include the emergency department visit fee and the professional fee as part of the inpatient payment. This legislation would result in duplicate payment for costs already included in the hospital inpatient payment.

Finally, the legislation would permit emergency department physicians to bill for services rendered to patients who are seen in the emergency department for urgent, rather than emergent care. Hospitals are currently paid the outpatient clinic fee for urgent visits. This fee includes both the facility and professional reimbursement. Here as well, the

legislation would result in duplicate payment for costs already included in the hospital's reimbursement for the urgent visit.

We appreciate the interest emergency physicians have in obtaining reimbursement directly from the Department; however, we cannot support the legislation as written. We are certainly willing to work with the physicians with the hope of arriving at a mutually agreeable solution.

H.B. No. 5280 (RAISED) AN ACT ADJUSTING NURSING HOME RATES FOR PHYSICAL PLANT IMPROVEMENTS.

This bill reinstates fair rent reimbursement for nursing facilities that have incurred costs for physical plant improvements. Beginning July 1, 2012, facilities would receive rate adjustments that reflect costs related to physical plant improvements implemented between October 1, 2007, and June 30, 2012.

This bill also allows the inclusion of movable equipment depreciation into the fair rent calculation. Currently, moveable equipment depreciation expenses are recognized in the rates and reset during the base year recalculation (approximately every four years). While this change would provide a more direct annual funding mechanism for movable equipment, the department opposes this change until a full review of the rate-setting methodology can be completed. The department supports a more global review of the rate-setting methodology before the implementation of a significant change in reimbursement methodology.

We estimate an increase of $8.2 million in Medicaid expenditures annually for this change in reimbursement methodology, plus an increase of $8.2 million in Medicaid expenditures annually for pass-through of fair rent. These additional costs have not been budgeted.

H.B. No. 5281 (RAISED) AN ACT CONCERNING FRAUD DETECTION IN SOCIAL SERVICES PROGRAMS.

This bill would require the department to conduct random quarterly audits of 15% of enrolled providers and to consult with the Chief State's Attorney to identify staff and resources to dedicate to the prevention of fraud and abuse.

DSS currently has a robust fraud prevention and detection program. The Quality Assurance Audit Division completes approximately 125 audits per year with a staff of approximately 20 auditors. Within our Quality Assurance unit, we have a Special Investigations Unit specifically to develop fraud referrals, investigate complaints, and oversee the provider enrollment process and to perform data analysis on claims data. The

purpose of the data analysis is to identify questionable claim payments. This is accomplished using the following analytical tools:

- Peer Group Comparisons – as an example, this compares the payments of pediatric dentists to all pediatric dentists.
- Case Type Comparisons – this compares the billing of a specific procedure code by all providers who bill that code.
- Provider Exception Profile – this analyzes a provider's payments as compared to what is estimated to be paid based upon the number of patients treated.
- Data Warehouse – this provides 31 canned targeted queries to identify aberrant payments (for example, we can identify a dental extraction and a subsequent payment for a filing on the tooth that was extracted).
- Spike Reports – this identifies a sudden increase in payments to a provider.
- Ad Hoc Queries – these are the most frequently used queries where we can develop a query based upon any variety of factors.

In addition, as required by the Affordable Care Act, the department has recently contracted with Health Management Systems as its Recovery Audit Contractor or "RAC." The RAC will perform audits similar to the audits performed by the department, thereby increasing the scope of audit oversight.

To demonstrate the scope of what this bill would require, the department currently has 7,358 enrolled "billing" providers. The legislation would therefore require approximately 1,100 audits (15%) to be completed on a quarterly basis totally 4,400 audits per year. As stated above, the department currently conducts 125 audits per year with 20 auditors. This bill would necessitate the hiring of an additional 700 auditors which would significantly increase expenditures in the department's budget.

Additionally, the requirement that the department consult with the Chief State's Attorney to identify staff and resources to dedicate to the prevention of fraud and abuse is inappropriate. It is within the sole purview of the department to determine the use of our resources, not that of another branch agency. Furthermore, the department currently has a memorandum of understanding with the Office of the Chief State's Attorney's Medicaid Fraud Control Unit (MFCU). This MOU requires the department to refer all identified fraud for investigation. The department meets with the MFCU on a regular basis to discuss active and potential fraud referrals. The MFCU currently has five staff: one prosecutor and four investigators. We respect and appreciate the reciprocal arrangement on behalf of taxpayers between DSS and the Chief State's Attorney's Office.

Lastly, CGS §17b-99 only refers to vendors and providers and should not be expanded to cover audits of beneficiaries. The DSS Office of Quality Assurance does perform investigations of beneficiary fraud. These investigations are not audits and beneficiaries committing fraud against our programs are subject to criminal prosecution. If this

language was enacted, we would be required to perform audits of 15% of our 700,000 beneficiaries each quarter. This equates to 105,000 audits per quarter.

For the year ended December 31, 2012, Quality Assurance's Audit Division completed 124 audits. These audits identified $16.6 million in overpayments and produced $5.8 million in cost avoidance. Most audit targets are chosen based upon claims payment history and general knowledge of the provider community.

Given the reasons cited above, we are opposed to the bill.

H.B. No. 5285 (RAISED) AN ACT ADJUSTING COMMUNITY HEALTH CENTER RATES FOR CAPITAL INVESTMENTS.

This bill proposes to add a capital cost rate adjustment to a community health center's existing payment rate and establish a separate capital cost rate adjustment for each Medicaid service provided by a center. No adjustment would be given for any depreciation or interest expenses associated with capital costs that were disapproved by the federal Department of Health and Human Services, the Office of Health Care Access within the Department of Public Health, or another federal or state government agency with capital expenditure authority related to health care services. The Commissioner of Social Services may allow actual debt service in lieu of allowable depreciation and interest expenses associated with capital items funded with a debt obligation, provided debt service amounts are deemed reasonable in consideration of the interest rate and other loan terms.

Federally Qualified Health Centers (FQHCs) are reimbursed via medical, and/or dental and/or mental health federally approved prospective rates. Included in the rates is reimbursement for the center's historical interest and depreciation average costs reported in the base 1999 and 2000 Medicaid cost reports. The base rates established using this methodology effective January 1, 2001, are inflated annually by the Medicare Economic Index every October 1. Under this federally prescribed and approved prospective rate system, an FQHC may apply to DSS for a "scope of service" review and possible associated rate adjustments.

Since the implementation of the prospective payment system in January 2001, there have been numerous scope-of-service rate increases given for capital and operational improvements and expansions. While we do not oppose the bill, we would be seeking to limit the administrative impact through regulations.

Thank you for the opportunity to testify. I would be happy to answer questions you have.