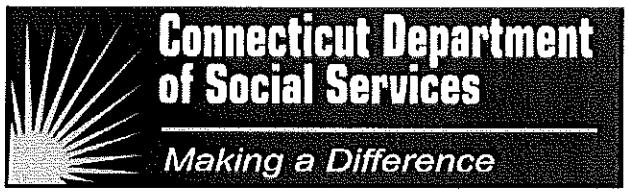

Testimony before the Human Services Committee

Commissioner Roderick L. Bremby

March 13, 2012

Good afternoon, 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.

S.B. No. 391 (RAISED) AN ACT EXPANDING ACCESS BY VETERANS TO PUBLIC ASSISTANCE PROGRAMS.

This bill proposes that Veterans' Aid and Attendance be excluded from determining eligibility for DSS programs and services. We believe that the impact would be minimal due to the small number of clients that would be affected and could easily be implemented by the department on behalf of veterans. Therefore, based on the information we have at this time, we support this proposal.

S.B. No. 392 (RAISED) AN ACT CONCERNING PHARMACY MEDICAID REIMBURSEMENT.

The purpose of this bill is to establish various reimbursement rates for different types of pharmacies. Reimbursement would be based on whether a retail pharmacy is a chain versus an independent pharmacy. The language in this bill distinguishes independent pharmacies from chain pharmacies based on ownership (privately owned versus publicly traded) and by the number of in-state stores.

The CT Pharmacy Association has for years advocated for the department to establish differential reimbursement for independent pharmacies and chain pharmacies. Due to the volume of transactions, chain pharmacies have enhanced negotiating power and are able to purchase pharmaceuticals at a much more discounted rate than independent pharmacies.

While this proposal is well-intended, 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. 394 (RAISED) AN ACT CONCERNING MEDICAID ELIGIBILITY AND THE IDENTIFICATION AND RECOVERY OF ASSETS.

Section 1 of this bill would not allow institutionalized individuals to be denied Medicaid solely on the basis of a "disqualifying asset." The bill defines a disqualifying asset as a single asset that causes an institutionalized individual's total assets to exceed the Medicaid limit. The Department would be required to grant Medicaid when institutionalized individuals have not liquidated a disqualifying asset within 45 days of notification of the need to do so, provided the State of Connecticut is able to place a lien against the asset.

Section 2 would permit the Department to make Medicaid payments to nursing facilities upon their request on behalf of individuals who have improperly transferred assets to qualify for assistance. Nursing facilities would first need to make every practical effort to recover such funds. The Department's payments would create a debt owed to the Department by the transferor or transferee. The Department is given the authority to pursue recovery of twice the actual amount of the debt.

This bill would create a significant administrative burden for the Department and would significantly increase Medicaid expenditures. If an individual, for example, has four bank accounts, each with a $500 balance, each account could be regarded as a single disqualifying asset as each account, if excluded, would allow the individual to qualify for Medicaid. The bill also authorizes the Department to lien these assets, which creates a significant administrative burden as we currently only place liens on real property such as homes and real estate.

The exclusion of a disqualifying asset would effectively allow institutionalized individuals to have assets in excess of the Medicaid asset limit, yet qualify for assistance. This would remove any incentive for individuals or their representatives to reduce their assets in a timely manner by paying nursing facilities, which would increase Medicaid expenditures. The amount that we could effectively recover in many instances would be far less than the amount of our Medicaid payments.

Finally, this bill would permit the Department to make payments to nursing facilities during penalty periods resulting from improper asset transfers made by individuals. These payments would not qualify for federal Medicaid reimbursement and would create unbudgeted expenses that would likely not be offset by our ability to pursue recovery from the ensuing debt.

While the Department opposes this bill, we understand that nursing facilities need timely payments for the vital services that they provide. We are willing to work with nursing facility representatives in an effort to develop mutually-agreeable measures that facilitate payment to them for their services.

S.B. No. 395 (RAISED) AN ACT INCREASING THE PERSONAL NEEDS ALLOWANCE FOR CERTAIN LONG-TERM CARE FACILITY RESIDENTS.

This proposal would increase the monthly personal needs allowance (PNA) for Medicaid clients residing in nursing facilities from $60 to $69. The bill also requires that the PNA be increased to reflect the annual inflation adjustment in Social Security income. Medicaid law requires that a state provide a minimum PNA of $30. States, on average, range from $30 to $70, putting Connecticut at the higher end of the scale.

The department is sensitive to the needs of this population and appreciates the difference that even nine dollars can make. However, increasing the amount that Medicaid clients can keep each month for their personal needs by just nine dollars would result in approximately $1.9 million in additional, unbudgeted Medicaid payments for nursing facilities annually. Furthermore, the annual inflation adjustment will result in an ongoing cost of approximately $400,000 per year.

Given the unbudgeted costs and the fact that Connecticut's current PNA is already on the high end – more than three-quarters of the states have a PNA that is less than $60 – we cannot support the bill.

S.B. No. 396 (RAISED) AN ACT CONCERNING THE ESTABLISHMENT OF COMMUNITY-BASED SOCIAL SERVICES.

This bill would require the department to develop and implement a pilot program providing for community-based delivery of social services in urban cities of sixty thousand or more residents.

We have several significant concerns with this bill. First, it is not clear what programs/services the proponents are intending to have administered by the municipality. As you are aware, the department is the Single State Agency for Medicaid and other federally funded programs which limits our ability to delegate authority to other entities for program administration.

Second, the bill contemplates a statewide pilot program to be administered within available appropriations. The department does not have any additional resources to fund such a pilot.

Third, a pilot program is typically operated on a limited basis in order to determine the feasibility of implementing on a broader scope. This bill would require implementation in all urban municipalities across Connecticut with 60,000 or more residents. This is simply not feasible as the department does not currently have the resources or capacity to administer a pilot program on a statewide basis, particularly one that has not been tested on a smaller scale.

Additional Concerns:

- The term "community based social services" is not defined.
- This appears to be a major duplication of efforts already being performed by the department.
- This proposed model does not fit with the service delivery model that the department is in the process of implementing. Our caseload dissemination and workflow design do not support the area-specific model being proposed.

We understand that behind this bill is a desire to offer alternate "doors" through which clients may enter the system and receive social services. However, as written and conceived at this time, this bill would not result in better service to our clients, but rather will result in duplication and fragmentation of service delivery, and conflict with modernization efforts currently underway, and therefore cannot be supported by the department.

S.B. No. 397 (RAISED) AN ACT AMENDING THE MEDICAID STATE PLAN TO INCLUDE CHIROPRACTIC TREATMENT AS AN OPTIONAL SERVICE.

The proposed legislation would require that section 17b-28e of the general statutes be amended to include chiropractic services as an optional service under the Medicaid program. Currently, chiropractic services are covered only for individuals under 21 years of age.

Medically necessary care of back complaints may be addressed with equal efficacy by other practitioners currently covered by Medicaid, such as physical therapists. Funding is not included in the budget to support the additional costs associated with expanding coverage for chiropractic services. Therefore, the department cannot support this increase.

H.B. No. 5450 (RAISED) AN ACT ESTABLISHING A BASIC HEALTH PROGRAM.

This bill would create a Basic Health Program (BHP) in accordance with the federal Affordable Care Act for all individuals under age sixty-five who are not eligible for Medicaid and whose income does not exceed 200% of the federal poverty level.

While the proposal to develop a BHP has a positive upside, we simply do not know enough to be supportive or to recommend that the state initiate development of a BHP. The financial risks of developing a BHP without additional basic information such as the risk profile of the population, the impact on the exchange, the cost of the essential health plan offered in the exchange and the CMS definition of allowable BHP costs, are great. The department remains interested in working to pursue additional information so that an informed decision can be made about whether to pursue a BHP and under what set of

assumptions. It is simply premature to create such a plan, when there are so many critical unknowns.

H.B. No. 5451 (RAISED) AN ACT CONCERNING TRANSPARENCY IN NURSING HOME COST REPORTS.

This bill would require each for-profit chronic and convalescent nursing home (CCNH) to include in the annual cost report filings, profit and loss statements for each related party that pays ten thousand dollars or more per year for goods, fees, and services and a profit loss statement for each nursing home transaction with such party. A related party could include companies connected to nursing facilities through family associations, common ownership, control or business association with any of the owners, operators or officials of the facility.

First, the bill requires what the department believes to be excessive reporting. It is not necessary for the Department to have all of this information on file for every year for every provider. We believe it is more reasonable and appropriate that facilities be required to provide detailed financial information upon request.

Second, this bill only requires for-profit chronic and convalescent nursing home (CCNH) provide this information to the department and therefore excludes not-for-profit facilities and facilities only having the rest home with nursing supervision (RHNS) level of care. We believe that all facilities should also be required to provide this level of detailed information upon request.

The Department would recommend that the bill language be struck and replaced with the following:

> Any licensed nursing facility which receives state funding pursuant to this section shall, upon request by the Department of Social Services, provide financial related party information including, but not limited to, audited financial statements, goods and services purchased, a profit and loss statement for each nursing home transaction with such party and any other information that the department may deem relevant. For purposes of this subsection, a "related party" includes, but is not limited to, companies related to such nursing homes through family associations, common ownership, control or business association with any of the owners, operators or officials of the facility. The statement shall include the actual cost of the goods and services, including a detailed account of the goods and services purchased and fees paid, and the mark-up, profit or administrative charges related to such purchase.

H.B. No. 5452 (RAISED) AN ACT CONCERNING THE DELIVERY OF SOCIAL SERVICES.

The bill proposes to mandate the Department to enroll Adult Day Care Providers as participating providers in the CT Home Care program within 30 days of obtaining certification by the Adult Day Care Association.

The Department opposes this bill for a number of reasons. First, this bill attempts to circumvent the Medicaid enrollment process by requiring that the Department "register" a provider after completing only a portion of the process. Enrolling providers who have not met all federal Medicaid requirements **would jeopardize the state's federal match.**

Furthermore, the Department is responsible for the provision of home and community based services for over 15,000 frail elders who are among our state's most vulnerable citizens. It is imperative that the Department ensure that the service providers that serve these frail elders are quality providers who are financially stable so as to protect the population from an untimely closing or termination of services. To that end, the Department has developed guidelines that are included as part of its contract with the Access Agencies who assist in the enrollment of providers. Our guidelines include:

- that the provider clearly understand the provider standards and requirements,
- possess all applicable licensing, registration or certifications, and
- have been in business for at least one year in performing the functions for which they wish to contract.

Exceptions can be made to this requirement in the event the provider fills an unmet need in the community. Additionally, the provider must produce documentation of financial stability so as not to put our clients at risk. In the past, we have had situations where providers have closed their doors leaving care managers scrambling to try and find alternative services for our clients with little or no notice.

This proposed legislation directly conflicts with assurances made to the Centers for Medicare and Medicaid Services in our Medicaid waiver and requirements in our contracts that are directed at protecting its program participants.

This bill does not recognize the provider enrollment process that the Department must perform in order to be compliant with federal requirements for enrolling Medicaid providers and ensuring federal match on claims. Adult Day Care Centers are not licensed by DPH but must be certified by the Connecticut Association of Adult Day Centers (CAADC).
Enrollment as a Home Care provider consists of:

- Obtaining certification from CAADC (this is the certification referenced in the proposal).

- Submitting an enrollment packet, including all supporting documentation to the Access Agency. Additional components of a provider enrollment packet include: knowledge of eldercare issues, written policies and procedures, submission of references, evidence of financial stability, bonding and liability insurance.
- Recommendation by the Access Agency for enrollment.
- DSS Quality Assurance review.
- HP enrollment procedure.

The bill does not contemplate the entirety of this process, which could result in the loss of federal matching funds.

Section 2 of the bill appears to suggest that the provider, even if providing other types of covered services such as homemaker/companion, only register once with DSS. This is unacceptable because, depending upon the type of service being provided, there are different enrollment/licensure/registration policies and procedures involving different state agencies including the Department of Public Health and the Department of Consumer Protection. It seems that this bill would entirely circumvent those processes which exist to protect the health and safety of the consumer.

Section 3 of the bill would require that the department include the provider on a list of eligible Medicaid providers within 30 days of receiving the name from the Access Agency. Once again, this provision completely circumvents the Medicaid enrollment process performed by the department. Therefore, we are opposed to this bill.

H.B. No. 5475 (RAISED) AN ACT CONCERNING NURSING HOMES.

This bill would require a study of nursing homes by the Commissioner of Social Services to assess quality of care and whether enough nursing home beds exist to meet the need for services. The Commissioner would need to submit the report not later than July 1, 2013.

The Department of Public Health is the licensing agency for skilled nursing facilities in Connecticut and oversees the quality of care within those facilities. The DSS Office of Certificate-of-Need and Rate-Setting has and continues to survey all nursing homes for occupancy levels, including empty beds, every six weeks to assess bed needs. Additionally, the Money Follows the Person program funded a large study by W.M. Mercer to research quality and access as part of the department's rebalancing initiative. The final report has been released and is available on the DSS website. This bill, therefore, is not necessary as it would duplicate efforts already made.

H.B. No. 5476 (RAISED) AN ACT EXPANDING CONSUMER CHOICE FOR SKILLED NURSING CARE AT HOME.

The bill would establish a pilot program under a Section 1115 Medicaid waiver to allow individuals receiving continuous skilled nursing services in their home to have the option of directly hiring registered and licensed practical nurses rather than the state paying for the services through a home health agency. The Department would be required to create a methodology and fee to certify nurses to provide such skilled care. Certification requirements would include, but not be limited to, nurses who (1) have a current affiliation with an accredited hospital or other nursing facility; (2) have a current Medicaid provider number; (3) have at least one year of experience providing such care; (4) certify, in writing, that they shall not terminate care without providing a two-week written notice to the consumer, except in cases of documented severe illness, injury or death; (5) agree to implement a physician-approved plan of care; (6) submit to a criminal background check and demonstrate no convictions and (7) certify in writing, that they shall assist the consumer in obtaining replacement care in the event the nurse is unable to work for any reason. The Department would also be required to survey Medicaid recipients living at home with continuous skilled nursing services to determine whether they have experienced interruptions of service and the reasons for such interruptions, and to determine the staffing levels of home health agencies and the salaries these agencies pay their nursing staff.

The Department funds nursing services provided to individuals in their homes by enrolling and paying home health care agencies as providers. Home health care agencies employ registered nurses, licensed practical nurses and home health aides, in addition to physical and occupational therapists. Home health care agencies are licensed by the Department of Public Health pursuant to state statute (§§19a-490 and 19a-491) and state regulations (§§ 19-13-D66 to -D79 and §§ 17b-262-724 to -735, inclusive).

Under federal law, nursing services performed as a component of home health services must be provided "on a part-time or intermittent basis by a home health agency . . . or if there is no agency in the area, a registered nurse" who is licensed to practice in the state and who meets other specific requirements outlined in the law (42 C.F.R. § 440.70(b)(1)).

While federal law permits states to cover private duty nursing without the use of licensed home health care agencies, the Department currently limits coverage to services provided by home health care agencies because such agencies are well regulated and afford the most protection for clients. For example, in the event that a nurse or other caregiver is unable to cover a shift one day, the home health care agency is responsible for arranging for coverage. Furthermore, if the home health care agency chooses to discontinue providing services to a client, they may do so only with proper notice and must continue service until another provider is identified.

The Department has opposed legislation similar to this bill in the past because it removes the protections clients have if their regular nurse cannot provide service, or if the agency wishes to discontinue services. In both cases, the agency is required to maintain services

until another care provider is identified. Few clients, under the best of circumstances, have the resources to recruit and hire their own nurses. Similarly, the Department does not have the resources to recruit, certify and maintain a list of nurses interested in providing such services, nor does it have the resources to police the employment policies of home health agencies, a role more appropriate to the Department of Public Health. The language of Section 1(b) suggests that nurses employed by hospitals and nursing facilities could be enlisted to certify for the pilot, however, since these employers struggle themselves to maintain their cadres of nursing staff, it is doubtful that they would either welcome or cooperate with this pilot.

The pilot would also allow LPNs to practice without the supervision of an RN, which would require significant changes to Connecticut's Nurse Practice Act. A further review of this provision needs to be undertaken by the Department of Consumer Protection and the Department of Public Health.

Lastly, the bill requires a survey of Medicaid clients requiring continuous skilled nursing services in their homes to assess the frequency that their services are interrupted. The Department is not opposed to such a measure and will endeavor to conduct such a survey. This study can be conducted administratively, therefore legislation is not required.

It is our understanding that this legislation is being proposed to address the needs of one individual. However, this change to our services would require the department to seek a Medicaid waiver from the federal Centers for Medicare and Medicaid services, a long and arduous process which consumes limited resources. Moreover, if approved by CMS, this change would not apply to just this one individual but to all Medicaid recipients. Thus, we do not support the bill.

H.B. No. 5477 (RAISED) AN ACT CONCERNING MEDICAID.

This bill would require that the Commissioner of Social Services conduct a study of Medicaid programs including: (1) factors the Commissioner deems pertinent to quality of care, and (2) whether there are any gaps in access by eligible residents. This new requirement appears to duplicate in part the much broader access and quality reporting that is required of the Commissioner under existing statute that establishes the Medical Assistance Program Oversight Council (MAPOC). The Department does not support new reporting requirements that duplicate those that are required by the MAPOC or that fragment the oversight of access and quality performance monitoring.

H.B. No. 5480 (RAISED) AN ACT CONCERNING INCREASING HOME AND COMMUNITY-BASED CARE FOR ELDERLY MEDICAID RECIPIENTS.

Section 1 requires DSS to seek approval of a 1915(i) Medicaid state plan amendment to improve access for individuals who are eligible for the state-funded categories (Levels 1

& 2) of the Connecticut Home Care Program for Elders (CHCPE). The department is currently in the process of preparing a 1915(i) state plan amendment to cover these services under Medicaid when they are provided to recipients who are otherwise eligible for Medicaid. This option will allow the department to claim federal medical assistance percentage (FMAP) for services provided to these recipients.

The bill appears to propose an expansion in Medicaid eligibility under a 1915(i) which would result in substantial unbudgeted costs. For this reason, the department opposes section 1 of this bill.

Section 2 of the bill seeks to require DSS to submit an application for the State Balancing Incentive Payment Program (BIPP) and to implement the administrative changes required to meet threshold requirements for BIPP funding.

In relevant part, Section 110(b) of Public Act 11-44 authorized the Department "to implement policies and procedures necessary to implement optional initiatives authorized pursuant to the Patient Protection and Affordable Care Act, P. L. 111-148, and the Health Care and Education Reconciliation Act of 2010, relating to: . . . (G) the establishment of a balancing incentive payment program for home and community-based services."

Background: BIPP requires that states:

- in which 25% or greater of Medicaid spending is on HCBS (as opposed to institutionally-based LTC) commit to increase that percentage to a target of 50% by September 14, 2015; and
- within six month of applying, have implemented the following:
    - a "no-wrong door single entry point system" to facilitate consumer access to information on LTC services and to assess their financial and functional eligibility for available programs;
    - "conflict-free" case management (e.g. of the kind provided by the Access Agencies for the CHCPE; neutral in relationship to providers); and a core, statewide standardized assessment instrument.

MFP staff are leading the Department's efforts to prepare a BIPP application, with a target date for completion of March 30, 2012. This effort will also include staff of the ACU and of Aging Services Division, as well as others. The BIPP is also a revenue maximization opportunity and it supports the Department's re-balancing goals.

The department is currently in the process of preparing a BIPP application, with a target date for completion of March 30.2012. This section duplicates existing statute that establishes the Department's authority to implement the BIPP and is therefore unneccesary.

H.B. No. 5481 (RAISED) AN ACT CONCERNING AN INCREASE IN RATES FOR CERTAIN CHRONIC DISEASE HOSPITALS.

This bill would provide an annual rate adjustment for freestanding chronic disease hospitals that receive more than 50% of inpatient-service revenue from Medicaid. This proposal would only affect the Hospital for Special Care. The Department is currently evaluating the adequacy of reimbursement for chronic disease hospitals. The Hospital for Special Care currently receives a rate that is significantly higher than the other free-standing chronic disease hospitals in the state.

Name of Hospital	Daily Medicaid Rate
Hospital for Special Care in New Britain	$1,112.35
Gaylord Hospital, Inc	$914.32
Mount Sinai in Hartford	$898.18
State of Connecticut Department of Veterans Affairs in Rocky Hill	$597.38

At this time, the department is unable to support this bill pending completion of our analysis of chronic disease hospital reimbursement. Implementing an unfunded annual rate increase for only one of the state's four freestanding chronic disease hospitals defeats the purpose of this comprehensive rate review.

H.B. No. 5482 (RAISED) AN ACT EXPANDING THE CONGREGATE MEALS PROGRAM FOR THE ELDERLY.

This bill would offer congregate meals under the elderly nutrition program for at least one additional day. The statewide Elderly Nutrition Program is funded by a variety of sources, including federal ($8,474,686), state ($2,495,942) and local funds as well as voluntary client contributions. Authorized under Title III-C of the federal Older Americans Act (OAA), the Program is operated through regional and local projects throughout the state by community organizations designated as Elderly Nutrition Providers (ENPs). The Agencies on Aging allot funds received through the Department of Social Services State Unit on Aging to service providers, based on an area assessment of need, to ensure provision of congregate and home delivered meals, nutrition screening and nutrition education to older persons throughout their designated regions. Meals are provided at congregate meal sites and by home delivery. Each meal must meet nutritional requirements and special dietary needs must be considered. Title III-C specifically provides guidelines and funding for nutrition services.

Under the provisions of the OAA, funding from all sources is combined to operate the Program as one statewide program. The OAA currently provides in 42 U.S.C. 3030e and 3030f that elderly nutrition projects provide at least one meal on five or more days per week in both the congregate and home delivered programs except in rural areas where such frequency is not feasible and a lesser frequency is approved by the state agency. This provision has not been interpreted to mean that every project must provide meal

service at least 5 days per week at every congregate site or to every home delivered client, but rather that provision of meal services is available five days per week. For example, some ENPs are contracted to only provide meals on the weekend. Other sites operate three days per week.

Other concerns include the following:

- It is not clear from the use of the language "program" or "programs" in this bill whether it is the intention to require a minimum of six days of meals (one more day than is currently required by the Older Americans Act) in both the congregate and home-delivered programs under the Act. Likewise, does the language require that every ENP provide a minimum of six days of meals at every congregate meal site or to every home delivered client?

- The Program served 1,233,154 home-delivered meals to 6,239 consumers and 832,916 congregate meals to 18,554 consumers in FY 2011. The cost of each of these meals was met through combining all the sources of funding. To fund one meal for one additional day would require not only an increase of at least 20% of state funding, but an amount to make up for the per meal cost funded by the other sources.

- The cost of a meal on a weekend doesn't necessarily equal the cost of a meal on a weekday. Providers may not find it feasible to operate on a weekend because they may be unable to get volunteers to serve on a weekend, may need to pay workers higher wages to produce the food or transport it, or be unable to use the same congregate meal sites (such as senior centers) on a weekend as a weekday.

This bill is well-intentioned but would result in an unbudgeted cost, and, therefore, the department cannot support the bill.

H.B. No. 5483 (RAISED) AN ACT CONCERNING COVERAGE OF TELEMEDICINE SERVICES UNDER MEDICAID.

Telemedicine is a modality used in remote and rural areas of the nation to serve populations who find it difficult to access health care. There are few such areas in Connecticut, therefore the need for and the ultimate cost of such services is unclear. It is also unclear what is intended by "interactive data communication" and its impact on the Medicaid population.

The Department recognizes the potential of telemedicine and would be happy to work with the authors of the bill to study the need for these service modalities, their cost-effectiveness, and the best ways to safely implement them.

I thank you for the opportunity to testify before you today and welcome any questions you may have.