

H.B. No. 5806 (RAISED) AN ACT INCREASING THE MINIMUM AMOUNT OF ASSETS THAT MAY BE RETAINED BY THE SPOUSE OF AN INSTITUTIONALIZED PERSON

This bill proposes to allow the spouse of an institutionalized person who is applying for Medicaid (referred to hereafter as the “community spouse”) to retain marital assets of at least \$50,000. This represents an increase in the amount the community spouse is currently allowed to keep. Under current statute, 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 \$119,220. If the total of the assets are under \$23,844, the minimum allowed by federal law, the community spouse may keep all of the assets. The couple’s home and one car are excluded from the assessment of spousal assets. The federal amounts are adjusted annually based on increases in the Consumer Price Index.

This bill requires a report of the fiscal impact of the minimum community spouse protected amount (CSPA) no later than July 1, 2016. The report is to contain data regarding the number of community spouses allowed to keep additional assets based on the increase in the minimum CSPA and the cost to the state of increasing said amount. This will require the Department’s eligibility workers to manually track this data at a time when it is imperative that the agency focus its resources on meeting the timely processing requirements mandated under the Shafer v. Bremby settlement agreement.

The Department continues to maintain that the current policy, which has been in place since 1989 (with the exception of FY 2011), is fair and reasonable and supports the original intent of the 1988 Medicare Catastrophic Coverage Act, which sought to prevent the impoverishment of spouses of those applying for Medicaid coverage for long-term care. Furthermore, the department’s current policy is in line with most other states.

We have opposed increases in the amount of assets protected for community spouses in past years due to our belief it will result in a significant fiscal impact to the state. Today, we cannot support increasing the minimum CSPA as it will have a negative fiscal impact on the Medicaid account in a challenging budget environment. For these reasons, we are unable to support HB 5806.

S.B. No. 280 (RAISED) AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES

This bill requires the Department to conduct a study of DSS programs to include: (1) the responsiveness of department programs to recipients of services, (2) identification of problems, if any, that exist within such programs, and (3) whether staff is allocated in a manner to meet the need for services within such programs.

The Department of Social Services supports the basic needs of children, families, elders and older adults, including persons with disabilities, through economic aid, health services, social work services, child support, energy aid, elderly protective services and many others. We currently service almost 950,000 state residents through the several dozen programs administered by the agency.

In June of 2013 the Department formally launched a Balanced Scorecard initiative to guide all divisions within the agency to use the same framework to develop plans and to provide a quantifiable way of measuring success and determining when changes need to be made. Over the last year, the Balanced Scorecard has proved to be an effective planning and performance management tool to align business activities with the vision and strategy of the organization.

In general, the Balanced Scorecard suggests that we view an organization from four perspectives: Customer, Learning & Growing, Stewardship and Internal Processes. All functional areas of the Department have completed at least an initial draft Balanced Scorecard and are beginning to work in teams on improving their selection and implementation of performance measures via a formal training and coaching.

The Balanced Scorecard is a large-scale and long-term organization change process that is actively supporting us in aligning all aspects of the Department with our mission and goals.

In addition to the Balanced Scorecard initiative, the Department continues to internally evaluate program efficiency and staffing, while also maintaining significant oversight from external entities.

The Department would like to illustrate a more specific example of this process by focusing on the perspective of our Medicaid program.

Connecticut Medicaid and CHIP are already accountable to both internally generated and externally required performance metrics that relate to beneficiary health outcomes and care satisfaction, access to care, provider satisfaction, and financial performance. The Division of Health Services (DHS) stewards oversight of performance-based contracts with the four Administrative Services Organizations (ASOs) that respectively manage Medicaid medical, behavioral health, dental and non-emergency medical transportation benefits, as well as the contract with HP that encompasses provider enrollment and engagement, claims processing and reporting of claims data. The Department withholds an identified percentage of administrative payments from each of the ASOs pending evaluation of whether benchmarks on identified health, satisfaction and financial outcomes have been achieved. Simply put, the ASOs must earn back these withholds through successful performance. The ASOs also report to DHS on a wide range of health measures (HEDIS and other indicators), conduct mystery shopper surveys to test beneficiary experience in accessing services, conduct geo-access analyses of provider availability, and evaluate special projects (e.g. the Person-Centered Medical Home initiative) based on a range of additional metrics.

Further, the DSS Division of Finance regularly analyzes and reports upon both point in time and trends in expenditures. This financial information is reported to the Centers for Medicare and

Medicaid Services, DSS leadership, leadership of the committees of cognizance and the Medical Assistance Program Oversight Council (MAPOC). DHS also presents detailed monthly reports on all aspects of program performance to MAPOC, and its associated committees regularly engage with the Department for review and comment on proposed policy changes, as well as current program operations.

Additionally, the Department has also begun a partnership with an IT consulting firm, Teracore, to review, analyze and recommend improvements for our Benefits Center process. Key areas of focus include core business processes, collection and analysis of metrics, identification of 'pain points,' and conducting other activities to identify 'quick wins.' As of January 28, 2015, Teracore has completed site visits to the Bridgeport and New Britain Benefit Center offices, with an additional site visit scheduled for our Waterbury location. Teracore has tentatively announced a March release of their initial report for the Department, with additional recommendations to follow after full analysis is completed.

Further, the Department analyzes and produces monthly reports on the Benefit Center Activities through the ConneCT Public Dashboard located on the Department's website at <http://ct.gov/dss/lib/dss/connect/connectdashboard.pdf>

Speaking specifically to this bill, the Department has a number of concerns. First, the scope of the study is not defined. It is unclear if the intent of the bill is for the Department to study all programs administered by the agency, which would be extensive, or if there are specific programs in particular that the report should focus on. This bill also requires the Department to report on "How responsive such department programs are to recipients . . .", however this may be difficult to ascertain. First, the definition of "responsive" is going to differ depending on who is interpreting the language. Second, a follow-up study of this magnitude would most likely have to be contracted out as we do not have the resources to dedicate to this.

Lastly, it is important to reiterate that the Department of Social Services is already actively involved in an array of internal program evaluation activities and are currently accountable to many external entities that support continuing program review and integrity maintenance.

S.B. No. 281 (RAISED) AN ACT CONCERNING NURSING HOMES & S.B. No. 282 (RAISED) AN ACT CONCERNING LONG-TERM CARE

The Department of Social Services commends the Committee for its attention to the need for strategic planning for Medicaid long-term care services. This is a critical need given the strong preferences of older adults and individuals with disabilities to live in home and community-based settings, the state's interest in controlling escalating costs, and support for town-level tailoring of strategies to meet local needs. DSS respectfully suggests to the Committee, however, that the studies that are being proposed by S.B. 281 and S.B. 282 are not needed. In keeping with the legislation enacted by the General Assembly, Governor Malloy, the Office of Policy and Management, and DSS released the Strategic Plan to Rebalance Long-Term Services and Supports, which already captures the data and planning strategies that are contemplated by these bills. Also, section 17b-337, CGS, requires the Connecticut Long-Term Care Planning

Committee to prepare a long-term care plan every three years based on the fundamental principle that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting. The most recent plan, entitled Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut, was released in January 2013.

In support of the RFP for nursing facility diversification, the Department contracted with Mercer to make town-level projections of need for nursing home beds and associated workforce for all cities and towns in Connecticut. Mercer recently released updated projections for 2014.

The plans can be accessed at www.ct.gov/dss/rebal and http://www.ct.gov/opm/lib/opm/hhs/ltc_planning_committee/ltc_plan_-_2013.pdf

S.B. No. 283 (RAISED) AN ACT CONCERNING MEDICAID

This proposal requires the Commissioner of the Department of Social Services to conduct a study in Medicaid to assess factors pertinent to quality of care, gaps in care, and necessary actions to comply with the Affordable Care Act (ACA).

The DSS Division of Health Services is already charged with these functions on a standing basis, regularly reporting to the Commissioner on quality of care (through such means as annual reports on HEDIS measures, measures of the effectiveness of Intensive Care Management, and consumer and provider satisfaction), access (through such means as geo-access analysis and mystery shopper surveys) and necessary actions to comply with the ACA. The Department maintained an ACA compliance tracking tool and has fulfilled 100% of ACA provisions mandated to date.

The Department also provides detailed monthly reports (see this link for our posted materials <http://www.cga.ct.gov/med/mh-meetings.asp?sYear=2014>) to the Medical Assistance Program Oversight Council (MAPOC), which is charged under statute with a broad range of oversight activities that encompass the goals of SB 283 (see C.G.S. Section 17b-28).

Consistent with 2013 legislation, MAPOC last year convened an ad hoc Medicaid Network Access Committee that ultimately produced a detailed report, incorporating DSS material, on access to care as well as other factors relevant to provider participation (ACA Ordering, Prescribing and Referring requirement) - see this link for the posted report: http://www.cga.ct.gov/med/council/2014/0314/20140312ATTACH_Network%20Adequacy%20Report.pdf.

2014 legislation (Public Act 14-206) also expanded MAPOC membership and created a new standing committee to focus on "evidence-based best practices concerning Medicaid cost savings."

While the Department does not oppose the general concept of this proposal, we respectfully suggest that the legislation is duplicative and unnecessary.

S.B. No. 284 (RAISED) AN ACT CONCERNING MEDICAID COVERAGE OF CHIROPRACTIC SERVICES

This proposal requires the Department to add chiropractic services to the Medicaid State Plan as an optional service. Given the fiscal climate it is not anticipated that there will be funds included in the Governor's recommended budget to support this addition; therefore, the department must oppose it.