



*Testimony before the Human Services Committee
Roderick L. Bremby, Commissioner
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Good afternoon, Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services. I appear before you to testify on **HB 6846, AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES PROGRAMS**. As I will be providing additional detailed testimony on the Governor's proposed budget to the Appropriations committee tomorrow, we will be using this opportunity today to do a general overview of the proposal while highlighting a few sections of particular interest.

The Department of Social Services provides a wide range of services to children, families, elders, persons with disabilities, and other individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living. Services include medical coverage, food and nutrition assistance, energy assistance, independent living, social work and protective services, child support, and financial subsistence. The Department currently supports over 950,000 Connecticut residents. This includes health care coverage for over 730,000 individuals through our HUSKY Health and medical assistance programs.

The Governor's budget recommendation includes \$3.159 billion for DSS in SFY 2016, representing an increase of \$45 million, or 1.4% above SFY 2015 estimates. For SFY 2017, the Governor's recommendation includes \$3.224 billion, an increase of \$65 million or 2.1% above SFY 2016 levels. Below are a few points of attention that the Department would like to explain further.

Sections 3 – 8 of the Governor's recommended bill seeks to transition coverage for HUSKY A adults with incomes above 138% of the federal poverty level, to health insurance plans purchased through Access Health CT, the state's health insurance marketplace. Adults transitioning to a qualified health plan through Access Health CT would also have the opportunity to qualify for federal subsidies. These subsidies would lower the costs associated with obtaining and maintaining health insurance coverage. These federal subsidies include advanced premium tax credits to reduce the monthly cost of health insurance premiums as well as additional cost sharing reductions to lower the out-of-pocket, point-of-service costs for obtaining medical care and/or prescription drugs.

Currently, coverage is provided to parents or caretaker relatives for children up to age 19 with household income at or below 201% of the federal poverty level, and for pregnant women with household income up to 263% of the federal poverty level. This proposal would transition coverage for an estimated 34,200 HUSKY A adults (including pregnant women), with income

over 138% of the federal poverty level to qualified health plans sold through Access Health CT. The department's shared system with Access Health CT now allows adults who do not meet the newly proposed income limit to seamlessly transition into a qualified health plan, ensuring continuous coverage.

The Department recognizes the value of continued access to health care for children. It is important to note that coverage for children enrolled in HUSKY A will not be impacted.

This transition of HUSKY A adults to the qualified health plans will result in a savings to the state of \$44.6 million in FY 16 and \$82.1 million in FY 17 (\$89.2 million in FY 16 and \$164.2 million in FY 17 after factoring in the federal share). The proposed changes in income limits are also supported by federal law as the Affordable Care Act authorizes the availability of health care coverage options through the state exchange for those impacted by the change.

In addition, this bill will eliminate HUSKY B Band 3, which serves children whose families' incomes are over 323% of the federal poverty level and is unsubsidized. Enrollment under HUSKY B Band 3 has been steadily declining, with Band 3 now serving only 227 children as of February 1, 2015. Given the availability of affordable health care through Access Health CT, there is no need to continue administering this component.

*Additional note- The Department requests a technical correction: Section 8 of the bill, which amends section 17b-303, should be deleted and section 28 of the bill amended to include the repeal of section 17b-303, as the provisions of section 17b-303 are obsolete.

Sections 9 and 10 eliminates the cost of living adjustments for recipients of Temporary Family Assistance, State Administered General Assistance, and Aid to the Aged Blind and Disabled that is administered annually on July 1. Anticipated savings estimated at \$2.4 million in FY 16 and \$4.7 million in FY 17.

Section 10 also proposes to apply annual Social Security increases to offset costs under the Aid to Aged, Blind and Disabled. Anticipated savings estimated at \$1.0 million in FY 16 and \$1.9 million in FY 17.

Sections 11 and 12 propose the elimination of inflationary adjustments for long term care facilities, including nursing homes and intermediate care facilities. Anticipated savings estimated at \$6.9 million in FY 16 and \$17.8 million in FY 17.

Sections 13 and 14 would remove rate increases for boarding homes. Currently, the Department reviews and determines boarding home rates annually, based on cost reports submitted by the facilities. Anticipated savings estimated at \$2.4 million in FY 16 and \$5.1 million in FY 17.

Section 15 proposes to reduce the reimbursement for brand name drugs from the average wholesale price (AWP)-16% to AWP-18% for an anticipated savings estimated at \$5.4 million in FY16 and \$5.9 million in FY 17.

Section 15 also reduces the dispensing fee for prescriptions from \$1.70 to \$1.40 for a savings of \$0.8 and \$0.9 million in FY 16 and FY 17 respectively.

Section 16 proposes to remove the low-cost hospital supplemental pool, resulting in a savings of \$5.1 million in each year of the biennium. In the past the legislature added funding beginning in FY 14 to increase the Medicaid base discharge rate for hospitals with a higher than average combined Medicare and Medicaid payer mix and less than average Medicaid expense per case.

Section 17 removes the exemption that allows ambulance services to receive higher than Medicaid allowable rates for services that are provided to individuals with dual Medicare/Medicaid coverage. Anticipated savings is estimated at \$4.3 million in FY 16 and \$5.1 million in FY 17.

Section 18 proposes to restructure the Department's state-funded Connecticut Home Care Program with two recommended provisions.

The first change recommends freezing intake on Category 1. The Department currently has just over 1,000 state funded Category 1 clients. These clients are at the lowest level of need under the current program. They are at risk of nursing home placement but are not yet at the nursing facility level of care. The Department also has a 1915i state plan option for individuals who are functionally the same as Category 1 clients; however they are also Medicaid recipients with income below 150% of the federal poverty level. Since the 1915i is a state plan service, the Department can continue to serve this population under the Home Care Program while receiving federal match on the services. On average over the last year the Department enrolled 33 new clients per month in Category 1 and closed 11. This change is estimated to save \$1.8 and \$5.6 million in FY 16 and FY 17 respectively.

The second change proposes to return cost sharing under the state-funded Connecticut Home Care Program to 15%. The current cost sharing requirement for state-funded CHCP recipients is 7% of the cost of care under the state-funded program (PA 11-6). This change is estimated to save \$2.8 and \$3 million on FY 16 and FY 17 respectively.

Section 19 proposes to reduce the funeral benefit paid for indigent individuals who pass away without the ability to pay for the cost of a funeral or burial. The current burial benefit in Connecticut is \$1,800. This funeral payment is substantially higher than neighboring New England states. For example, Massachusetts is \$1,100, Vermont is \$1,100 and Rhode Island is \$900. This proposal brings Connecticut's burial benefit in line with the surrounding states by reducing it to \$1,000. Anticipated estimated savings is \$1.7 million for FY 16 and FY 17.

Sections 20 and 21 proposes to reduce the personal needs allowance for residents of long-term care facilities from \$60 to \$50. Social Security and other unearned income received by residents of long-term care facilities is applied towards the cost of care except for a monthly personal needs allowance (PNA). Residents use their personal needs allowances for such items as gifts, clothing, cosmetics, grooming, personal phone, reading materials and entertainment outside of the facility. This reduction aligns Connecticut with the national average and is \$20 above the

federal minimum. It is also the same level as that of New York and Rhode Island. Savings of \$1.0 million in FY 16 and \$1.1 million in FY 17 are anticipated.

Section 22 eliminates payment of Medicare Part D copays for dually eligible clients who are not residents of nursing homes or participants of waivers. Anticipated savings estimated at \$80,000 for FY 16 and \$90,000 for FY 17.

Section 23 extends the state's current moratorium on the expansion of nursing home beds. This proposal permanently extends this moratorium. This proposal also provides greater flexibility by providing a mechanism to close a facility and transfer beds to another facility.

Section 24 clarifies that the Department has the discretion to revise the rate of a nursing facility that is closing down and includes factors that will be taken into consideration when determining the interim rate issued for the period during which a facility is closing down. By doing so, this bill will help contain costs when facilities close in the future and thus will result in cost avoidance.

Section 25 clarifies the second phase in the modernization of the inpatient hospital reimbursement. On January 1, 2015, the state moved from an antiquated case rate reimbursement system to a modern reimbursement methodology based on Diagnosis Related Groups or DRGs. The second phase of this transition will move reimbursement from hospital-specific base rates to peer group base rates. Peer groups will be established for at least three hospital classifications; children's hospitals, state hospitals, and all other general acute care hospitals. While utilized for the initial implementation, hospital-specific base rates are incongruous with a properly functioning DRG reimbursement methodology. The transition to peer group base rates is expected to take up to 5 years.

Section 26 strengthens the state's rebalancing efforts in accordance with Governor Malloy's Strategic Rebalancing Plan. By focusing on long-term services and supports, this proposal increases community options and supports consumers' informed choice. Details of the proposal include a requirement of notification when nursing facility residents are expected to become Medicaid eligible. Not only will this requirement better inform the resident of the choices available to them, it also provides them with the information necessary to make a better and more well-informed choice.

The Strategic Rebalancing Plan, initiated just 3 years ago, establishes the framework for change within the long-term services and supports system of the state. It addresses supply and demand trends for nursing home and community based services, ensuring that our investments in services and infrastructure are aligned with the preferences of the people we serve. The plan is guided by the principles of person-centeredness protecting the values of dignity, autonomy and choice for those who seek long-term services and supports. Several federally funded grants including Money Follows the Person, serve as foundational initiatives within the plan.

One primary goal of the plan is to improve access to information regarding services. The Long-Term Care Needs Assessment published by the UConn Center on Aging in 2007, revised in

2010, found that lack of knowledge about community based services is the second greatest obstacle to accessing the services. Without comprehensive information about existing community-based services and transition supports to return to the community, people may see remaining in the nursing home as their only option. The long-term care benefit under Medicaid covers nursing home care and also covers community-based services in lieu of the nursing home. The Department is dedicated to making sure our residents are aware of such options. It is imperative that the population we serve is well informed about the benefit so that they can make a knowledgeable choice about where they receive long-term services and supports. Section 26 is responsive to this goal. Other states such as Washington State have led the United States regarding access to information for elders and people with disabilities by passing similar legislation.

Options for community services are increasing rapidly within the Medicaid program and the Department anticipates that this level of change will continue. To address this rapidly changing environment, the Department's Money Follows the Person program has trained a special team of experts knowledgeable about new services and skilled in transitional case management. By utilizing this specialized team of experts, Section 26 ensures access to information regarding Medicaid benefits, along with transitional support to make certain that the people we serve have the ability to make an informed choice about where they would like to receive long-term services.

Section 27 and 28 eliminates the Family Support Grant with an anticipating a savings of \$57,161 in each year.

In addition this proposal eliminates funding for Healthy Start. Projected savings of \$1.4 million in each year.

This proposal also eliminates funding for adult chiropractic services. Legislation enacted in the 2012 General Assembly session included \$250,000 in each of the two years to fund chiropractic services for adults. The funding was a capped amount to limit excess utilization and expenditures and therefore was entirely state funded. Initial expenditures for the pilot were far below the funded amount in the first year as chiropractic utilization grew slowly. In contrast, services projected to cost the entirety of the available funding were authorized within the first four months of the second year of the pilot. This rapid increase in utilization strongly suggests that further coverage of chiropractic services would result in unsustainable levels of utilization and cost.