



STATE OF CONNECTICUT  
OFFICE OF POLICY AND MANAGEMENT

**TESTIMONY PRESENTED TO THE HUMAN SERVICES COMMITTEE  
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Testimony Supporting Senate Bill No. 17

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES

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Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee, thank you for the opportunity to offer testimony on Senate Bill No. 17, An Act Implementing the Governor's Budget Recommendations for Human Services.

This bill makes the following changes:

**Section 1. Establish Intellectual Disabilities Partnership.** Building upon the success of the Behavioral Health Partnership in improving health and cost outcomes for children and adults in need of publicly-provided and funded behavioral health services, the Governor is proposing a similar model by establishing an Intellectual Disabilities (ID) Partnership. Together, the Department of Developmental Services (DDS), the Department of Social Services (DSS) and the Office of Policy and Management will be tasked with, among other things, developing a continuum of services between in-home supports and group home placement that would allow DDS to provide the right service (based on acuity) at the right time and cost, exploring options for private pay and other third party payments, developing supportive housing models tailored to persons with ID, exploring the potential for management of ID services by an administrative services or managed care organization and developing strategies to address and fund the DDS waiting list. As happened with the Behavioral Health Partnership, it is anticipated that these changes will bring greater focus and attention to this important area and ultimately result in the development of a broader array of services that will assist in downsizing public facilities and addressing the waiting list.

**Section 2. Tighten Requirements Regarding Changes of Ownership of Community Living Arrangements (CLAs).** CLAs operated by DDS private providers are currently funded by both DDS and DSS – DDS covers service costs and DSS funds room and board. The service costs are Medicaid reimbursable, while room and board costs are not. Land and building costs are reimbursed through rates set and payments made by DSS over a 30-year useful life. This bill will prevent DDS providers from selling CLAs

that are either fully or significantly paid off and profiting from the sale while another DDS provider receives a new 30-year rate for the same property at the new market value. This practice essentially results in the state paying twice for the same property. The language specifies that useful life and value will not be reset because of a sale or transition of an existing property from one provider to another. It also requires both DDS and DSS to approve changes in ownership. In addition, the bill stipulates that if a provider were to sell a property that the provider owned outright, or has a mortgage on, the amount of the value at the time of the sale would be adjusted in the next development of that provider in order to recoup profit that the provider might have received for a property that was funded through DSS room and board payments.

**Sections 3 - 16.** Transfer Lead Agency Responsibilities for Autism. Effective January 1, 2015, Medicaid state plan coverage under DSS was expanded to include medically necessary services for members under age 21 with autism spectrum disorder. In addition, the enacted budget for the current biennium included the transfer of the Birth to Three program from the Department of Developmental Services to DSS, which received the Medicaid portion of the funding, and the Office of Early Childhood. This bill further consolidates autism services under DSS by transferring lead agency responsibilities (and the supporting resources) from DDS to DSS.

**Section 17.** Define "Autism Spectrum Disorder". This bill adds language to define autism spectrum disorder as having the same meaning as is set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders." This definition is consistent with section 38a-488b, CGS, which details the requirements for health insurers' coverage for autism spectrum disorder therapies. This bill will add clarity as to who may be eligible for services under the state's programs serving individuals with autism spectrum disorder.

**Section 18.** Transition Health Insurance Coverage for Former Industry Clients. This section eliminates the mandate for the state to provide health insurance coverage to persons who were employed at the workshops provided under the former Board of Education and Services for the Blind's Industries Program, which closed in 2003. Currently, there are 19 individuals taking advantage of this coverage. Due to the availability of health insurance coverage under the Affordable Care Act or other sources, as applicable, it is anticipated that these individuals will receive coverage elsewhere, resulting in a savings of approximately \$183,000 in FY 2017. The Department of Rehabilitation Services will be reaching out to both Access Health CT and DSS to assist with the transition.

**Section 19.** Limit Orthodontia Coverage. Medicaid coverage of orthodontic services is currently limited to children under 21 years of age who have a score of 26 or higher on the Salzmann Handicapping Malocclusion Index, a scoring tool used to determine the level of misalignment of an individual's teeth. This bill increases the minimum qualifying score on the Salzmann index to 29. As a result of this change, DSS will no longer cover cases that might otherwise be considered "cosmetic" under other state Medicaid

programs. In addition, this change will make Connecticut's criteria more comparable with the levels used in surrounding states, which rely on the more stringent Handicapping Labio-lingual Deviation (HLD) scale, another commonly used scale to evaluate and quantify the severity of malocclusion (the imperfect positioning of the teeth when the jaw is closed). (Massachusetts, New York and Rhode Island all require a minimum qualifying score of 28 under the HLD scale.) It is important to note that, with prior authorization, orthodontic services will continue to be approved for individuals with a score below 29 if such services are medically necessary. Savings of \$3.2 million in FY 2017 (\$6.4 million after factoring in the federal share) are anticipated.

**Sections 20 and 21. Reduce the Burial Benefit.** The burial benefit pays for burial, funeral or cremation expenses of indigent persons who pass away without the ability to pay for the cost of a funeral, burial or cremation. The current burial benefit in Connecticut is \$1,400. In comparison, surrounding states have a lower burial benefit. New York and Rhode Island both have a burial benefit of \$900 while Massachusetts and Vermont have burial benefits of \$1,100. This proposal brings Connecticut's burial benefit in line with the surrounding states by reducing it to \$1,000. Savings of \$1.1 million in FY 2017 are anticipated.

**Section 22. Maintain the Minimum Flat Rate for Boarding Homes.** The state's minimum flat rate is used by DSS for boarding homes that choose not to issue an annual cost report and by DDS for the room and board rate for community companion homes. Although legislative intent was to freeze all boarding home rates over the biennium, the implementer did not include the language needed to freeze the state's minimum flat rate. In the absence of language, DSS increased the rate for the impacted homes at a cost of \$86,000 in FY 2016. To avoid additional costs and to be consistent with legislative intent, the minimum flat rate is maintained at FY 2016 levels. Savings of \$90,000 in FY 2017 are anticipated.

**Sections 23 and 24. Clarify Hospital Reimbursement.** This bill clarifies existing policy and legislative intent with regards to rate revisions to ensure that increases are not later made beyond the levels contemplated and approved for each respective enacted budget. Specifically, references to "reasonable costs" are replaced with references to 42 U.S.C. § 1396a(a)(30)(A), which requires state Medicaid programs to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available ... at least to the extent that such care and services are available to the general population." The federal Centers for Medicare and Medicaid Services recently issued new federal regulations to ensure that Medicaid members have sufficient access to services as required by this federal statute. Therefore, going forward, access will be addressed through the detailed requirements in the new regulations. In addition, the bill updates language to reflect implementation of the payment system for inpatient services based on diagnosis-related groups (DRGs), as well as adding language to clarify that DSS may use a different payment methodology for some services where the DRG model is not appropriate (e.g., services such as psychiatric and rehabilitative services where the length of stay can vary widely).

**Sections 25 - 32. Repeal Waiver Requirements.** This bill repeals the provisions of section 17b-8, which require DSS to submit applications for federal waivers, waiver renewals, and certain proposed amendments to the Medicaid state plan to the committees of cognizance for review and approval before submission to the federal government. Repeal of this provision will allow the state to make more timely applications to the federal government for necessary changes in waiver programs that have critical fiscal and programmatic implications if not adopted. In addition, it will eliminate duplicative public notice requirements that are already required by federal law. CMS requires states to obtain public input during the development of a waiver by: providing at least a 30-day public notice and comment period; summarizing public comments received during the public input process; detailing the rationale behind any comments not adopted; and specifying any modifications made to the waiver as a result of the public comments. The additional state requirement of a subsequent public hearing and legislative review is unnecessary in light of the rigorous public notice and input process, and the ensuing CMS review, which is already afforded under the federal law. Finally, the removal of this requirement will enable DSS to redirect staff time and resources to provide critical core services to the public.

**Sections 32 and 33. Repeal Certain Statutory Language.** This section of the bill implements the following provisions included in the Governor's budget:

1. Repeal Community Care Teams (section 17a-484e). This language repeals a new grant program for acute care and behavioral health services which was established in Public Act 15-5, June special session. The Governor's proposed budget incorporates a \$3 million reduction due to the elimination of this program.
2. Repeal Waiver Requirements (section 17b-8). See write-up for Sections 25 - 32.
3. Repeal Obsolete Provisions Regarding Healthy Start (section 17b-277b). This bill removes language that is no longer relevant. The Governor's proposed budget transfers Healthy Start to the Office of Early Childhood. In addition, DSS examined the rules and regulations within Medicaid policy and determined that the Healthy Start program is not eligible for federal reimbursement under Medicaid.
4. Eliminate Commission on Health Equity under the Health Care Advocate (section 38a-1051). The language repeals the Commission on Health Equity as it duplicates responsibilities of the Department of Public Health.

In total, the initiatives in this bill will result in savings of \$7.6 million in FY 2017 (\$10.8 million after factoring in the federal share).

I respectfully request that the committee support this bill. I would like to again thank the committee for the opportunity to present this testimony, and I am happy to answer any questions you may have.