



*Written Testimony before the Human Services Committee
March 8, 2016*

Good afternoon Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. The Department of Social Services offers the following written testimony on several bills that impact the agency and our programs.

S.B. No. 110 (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 serve over one million individuals (28% of the population of Connecticut) through the several dozen programs administered by the agency.

The Department is proud to present as an agency that is technology and data driven. We strive toward timely access to services through eligibility process improvements, integration with Access Health CT, and our Eligibility Management System replacement.

The Department is also pleased with the current data regarding timeliness and accuracy of the programs we administer. For FFY 2015, the Supplemental Nutrition Assistance Program (SNAP) had a timeliness rate of 94.55%. This means almost 95% of applications submitted for SNAP were processed within the required timeframe. Medicaid timeliness (non-long term services and supports) reached 96.4% in September of 2015.

The Bureau of Child Support Enforcement established paternity for almost 14,000 children in FFY 2015 and collected a total of \$298,698,326 in child support collections. In FFY 2015 the Bureau of Child Support brought approximately \$4.8 million in estimated federal performance incentive dollars into the General Fund.

Customer service is one of the highest priorities for the Department. As we continually work toward the goal of providing the highest quality of services to the public, the Department would like to highlight a few of our activities. In January of 2016, our field offices saw over 39,000 people. Our benefit centers answered over 50,000 calls with an average wait time of 13 minutes. Our service centers received over 380,000 documents and processed over 370,000 work items.

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.

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.

For these reasons the Department believes this bill is unnecessary and would divert resources the Department needs to focus on the provision of services.

S.B. No. 111 (RAISED) AN ACT CONCERNING NURSING HOMES & H.B. No. 5248 (RAISED) AN ACT CONCERNING LONG-TERM CARE

DSS commends the Human Services 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. 111 and H.B. 5248 are not needed and would divert resources the Department needs to focus on the provision of services.

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 recently released in January of 2016.

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 and the Department plans to release new supply and demand projections in August 2016.

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. 113 (RAISED) AN ACT CONCERNING FEDERAL MEDICAID WAIVERS

The bill requires DSS to conduct a study to determine the need for any state waivers from federal Medicaid requirements or changes in the Medicaid state plan for the period of 7/1/16 through 6/30/2022.

This bill would require DSS to study existing waivers, innovative waivers in other states, and whether Medicaid State Plan Amendments are necessary to provide permanent services consistent with successful waivers.

First, the timeframe for this study is too far into the future to provide meaningful recommendations, as there are too many unknowns in the landscape of health care in general and Medicaid waivers in particular, as well as state budget changes, to predict several years into the

future. It is particularly challenging to anticipate which waiver programs might potentially make sense as permanent programs through amendments to the Medicaid State Plan, particularly because federal requirements and guidance changes over time.

The Department is always investigating Medicaid programs in other states to determine potential new innovations, including through organizations such as the National Association of Medicaid Directors, National Association of Medicaid Directors, and the National Governor's Association.

Federal regulations regarding Medicaid State Plan Amendments already provide that amendments to the Medicaid State Plan must be submitted "whenever necessary to reflect--(i) Changes in Federal law, regulations, policy interpretations, or court decisions; or (ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program...." 42 C.F.R. § 430.12(c)(1). Therefore, federal requirements already require amendments to the Medicaid State Plan in each of those circumstances, which makes this study unnecessary.

Finally, the Department regularly engages with legislators and other stakeholders to discuss existing programs and potential changes within the Medicaid program, including through a variety of councils and committees, especially the Medical Assistance Program Oversight Council (MAPOC).

For these reasons the Department believes this legislation is unnecessary and unworkable in its current form.

H.B. No. 5251 (RAISED) AN ACT CONCERNING MEDICAID

This bill requires the Commissioner of DSS to conduct a study of Medicaid programs 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 <https://www.cga.ct.gov/med/mh-meetings.asp?sYear=2016>) 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 HB 5251.

Consistent with 2013 legislation, MAPOC 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 bill, we respectfully suggest that the legislation is duplicative and unnecessary and would divert resources the Department needs to focus on the provision of services.

H.B. No. 5586 (RAISED) AN ACT CONCERNING WORKERS' COMPENSATION COVERAGE FOR INJURIES SUSTAINED BY PERSONAL CARE ATTENDANTS EMPLOYED DIRECTLY BY CONSUMERS IN STATE-FUNDED PROGRAMS

This bill will make personal care attendants (PCAs) employed directly by consumers state employees for the purposes of workers' compensation.

PCA services, other than agency based Personal Care Attendant Services, are now covered under DSS' Community First Choice (CFC) program. CFC is a new program offered to active Medicaid participants that allows such individuals to receive supports and services in their home. Such services include; help preparing meals, doing household chores and assistance with activities of daily living. Under CFC participants have both 'budget authority' and 'employer authority'. Employer authority allows the participants to hire and manage their own staff. The Medicaid participant is the employer. Budget authority allows such participants to have control over how they spend their 'budget' within guidelines established by the Department.

A Medicaid participant receiving services under CFC must demonstrate that the funds being spent are aligned with his or her stated goals and in a manner that addresses safety and health including any identified risks. The budget is based on an assessment which results in a funding level associated with the estimate of need. Participants may spend their funding to purchase worker's compensation. Participants also have access to a fiscal intermediary. The fiscal intermediary acts on behalf of the participant by paying bills and managing payroll as directed by the participant. Participants are employers and therefore must follow any applicable laws of the state governing employers, including any laws associated with workers' compensation.

The Department thanks the Committee for bringing attention to this concern; however participants/employers of PCAs through DSS already have the option to purchase workers compensation for their PCAs.

This bill would place additional restrictions on the ability of Medicaid participants to self-direct and manage their own budget. As this is not consistent with the principles of CFC and the Department firmly believes in allowing participants the highest degree of choice and control we are unable to support this language.

Additionally, requiring PCAs employed directly by consumers, to be deemed state employees, would require additional appropriations.

For these reasons, we are unable to support this bill.

H.B. No. 5587 (RAISED) AN ACT ESTABLISHING A COUNCIL TO MAKE RECOMMENDATIONS CONCERNING SERVICES FOR CHILDREN AND YOUNG ADULTS WITH DEVELOPMENTAL DISABILITIES

This bill establishes a council to make recommendations concerning services for children and young adults with developmental disabilities.

The Department thanks the Committee for its attention on this important topic. The administration also agrees that specific focus in this area is needed. An oversight group similar to the Behavioral Health Oversight Council is already being contemplated to oversee the activities of the Intellectual Disability (ID) Partnership, proposed in Section 1 of the Governor's bill, Senate Bill 17. This new Council could add some key aspects of this bill to its focus.

In addition to the consideration of this new oversight council, two other groups focused on serving individuals with developmental disabilities exist: the Connecticut Council on Developmental Disabilities, which was reconvened by the Governor through Executive Order #19 and the Autism Spectrum Disorder Advisory Council in section 17a-215d of the general statutes. DSS is working with both the Office of Policy and Management (OPM) and the Department of Developmental Services (DDS) to ensure that any additional groups created by statute do not duplicate current efforts, and will continue ongoing discussions with the proponents of this bill to try to develop language that can be supported.

H.B. No. 5588 (RAISED) AN ACT CONCERNING THE TIMING OF PAYMENTS FROM SUPPLEMENTAL INPATIENT PAYMENT POOLS FOR SHORT-TERM GENERAL HOSPITALS

This bill places several requirements on the Department of Social Services regarding the payment process to hospitals from the supplemental inpatient payment pools.

By making the establishment of the inpatient and small hospital supplemental pools mandatory rather than discretionary, it reduces the State's ability to adjust hospital funding in the state budget. This bill also requires that the supplemental pool be for all hospitals, rather than certain hospitals, which could potentially increase expenditures by adding other types of hospitals not currently being paid supplemental payments, such as chronic disease hospitals.

Although the term “pool” is used in federal correspondence to describe the total amount of available funding appropriated in the state budget for hospital supplemental payments, there is no separate “pool” of funding, as all of these funds are appropriated through the General Fund. Accordingly, it would interfere with the budget process by establishing a separate interest-earning fund and would expose the state to unbudgeted increased expenditures both by preventing transfers within state funds and also by requiring that any interest from the pool of funds be credited to those funds.

The bill places the state at risk for unbudgeted expenditures by requiring the state to make payments first and only later seeking reimbursement from the federal government for the federal share. That provision assumes that the federal share of payments is already included in the appropriation. However, only the state share of the funds are appropriated in the budget and the federal share of matching funds for supplemental payments can only be obtained from the federal government after the Centers for Medicare and Medicaid Services (CMS) approves each applicable Medicaid State Plan Amendment for the relevant supplemental payments. The State simply does not have those federal funds until such approvals are received.

In a time of increasing federal oversight and state budget constraints, this bill removes the flexibility necessary to ensure compliance with federal requirements and mid-year budget adjustments. The existing statutory language already enables the establishment of supplemental payments and provides the needed flexibility to adapt to federal requirements and changing circumstances. This bill would expose the state to significant unbudgeted liability if there were delays or denial of federal matching funds, especially because the state budget includes only the state share, not the federal share of expenditures. For these reasons, the Department opposes this bill.

H.B. No. 5589 (RAISED) AN ACT CONCERNING AN ACUITY-BASED SYSTEM FOR MEDICAID REIMBURSEMENT

This bill requires the Department to implement a prospective acuity based methodology for a portion of nursing facility reimbursements to be phased in over four years. Incorporated are additional state county cost differentials, a pay for performance rate adjustment add-on, and revisions to the rate property components. Additional rate add-on adjustments are proposed for cognitive conditions with complex care needs, ventilator dependence, developmental disabilities, behavioral health needs, and special care for obesity related conditions. These rate add-ons would come with additional costs outside of the prospective system already developed by the Center for Medicare and Medicaid Services (CMS).

A lengthy transition would need to occur for the nursing facilities to move to a prospective case-mix system. The absence of such a transition could potentially result in a major logistical issue. This bill stipulates that the design of the system would precede the actual legal implementation of the new reimbursement system. This would be problematic if the system did not coincide with statute and could create an immensely flawed reimbursement system.

There are also fiscal implications with this proposed bill. Estimated start-up costs are \$750,000, which includes approximately \$400,000 for consulting and development of an acuity based reimbursement system and \$350,000 for nursing facility training. Estimated annual costs are \$1,310,000, which includes approximately \$510,000 for on-going consultant costs, \$200,000 for nurse audit staff, and \$600,000 for additional nursing facility time.

The administrative costs for implementation of such a methodology would also need to be reviewed. Additional costs would include the development of a nurse audit program, training of nurse auditors, and the development and administrative costs of a pay-for-performance initiative.

The rate add-ons for pay-for-performance and for residents with specific care needs would also require additional appropriations. The up-coding of resident assessments by nursing facilities and improper payments due to insufficient documentation would also have a short term fiscal impact.

The Department would like to note however, that we are currently in the process of studying the possibility of an acuity based system for nursing facilities. The Department understands the importance of such a methodology and is actively reviewing process design. The Department has met with the industry and is working with Myers and Stauffer to begin steps toward development. At this time however, the Department is unable to support this legislation as the bill details not only have significant fiscal implications, but the Department has not had the opportunity to review the validity of the specific components of the model that are framed in the proposed legislation. For these reasons the Department is unable to support this bill.

H.B. No. 5590 (RAISED) AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS

This bill requires that certain bond and grant awards for capital projects to federally qualified health centers (FQHCs) and all related expenses not be considered administrative costs, and therefore not subject to the administrative cost cap.

The language is problematic in that it defines cost classifications for an unspecified action. Defining cost (accounting) classifications in this manner conflicts with cost principles that are defined in the Code of Federal Regulations, Title 2, Part 200 (formerly OMB Circular A-87).

In accordance with current federal law, FQHCs are not reimbursed based upon a cost-based system that utilizes cost reports. FQHCs are currently reimbursed utilizing a prospective payment system that receives an annual inflation factor. However, during the development of alternate payment methodologies (APMs) for FQHCs, FQHC Medicaid reimbursement would need to comply with the federal cost standards as outlined in 2 CFR 200. Alternative payment methodologies are utilized to reimburse FQHCs outside the current Medicaid encounter rate. These APMs can include supplemental payments based on volume and quality, additional payments under the State Innovation Model or a complete replacement of the current prospective payment system. This proposed language would conflict with federal regulations in that federal rules determine how costs are classified within cost reports that are used to support Medicaid rates and the claiming of federal revenue.

For these reasons the Department must oppose this bill.