Testimony before the Human Services Committee
Kathleen M. Brennan, Deputy Commissioner
February 14, 2017

Good afternoon Senator Moore, Senator Markley, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Kathleen M. Brennan, and I am the Deputy Commissioner of the Department of Social Services (DSS).

I am pleased to appear before you today and respectfully request your support of the following two agency bills –

S.B. No. 804 (RAISED) AN ACT CONCERNING A SOCIAL WORK IN-HOME SUPPORT PROGRAM

This bill prohibits an individual who is receiving services from any Medicaid home and community-based services programs, administered by the Division of Health Services at DSS, from also being eligible for the Community Based Services Program, administered through the Social Work Unit at DSS.

This change is necessary to ensure resources are preserved to allow eligible individuals, at risk of institutionalization, to remain in the community longer. The bill also creates a safeguard, to make sure the Department is not paying for duplicative home care services.

In addition, this bill also includes a technical modification that renames the "Community Based Services Program," the "Social Work In-Home Support Program". This clarification will eliminate confusion with the similarly named, Medicaid home and community-based services programs.

Currently, this statute only restricts individuals eligible for the Personal Care Assistance program from receiving concurrent services from the Social Work In-Home Support Program. The Personal Care Assistance program is one of the programs offered under the array of Medicaid home and community-based services.

When this statute passed in the year 2000, the Personal Care Assistance program was one of the only home-based programs offered. However, with the passage of the Affordable Care Act, states have been provided the financial opportunity to expand home care programs in Medicaid. In addition, through the support of Governor Malloy, Connecticut has made rebalancing long-term services and supports, to keep individuals in the community longer, a priority under Medicaid.

This state and national support has provided DSS with the opportunity to expand the home-based service array under the Medicaid home and community-based services structure. Programs available include, but are not limited to, the Connecticut Home Care Program for Elders waiver,

the Acquired Brain Injury I and Acquired Brain Injury II waivers, the Personal Care Assistance waiver and the Community First Choice state plan option. All such programs provide medical and non-medical in-home supports that allow eligible individuals, who are at risk of institutionalization, to remain in the community. Approximately 27,000 individuals are currently active on waiver services, while an additional 460 are receiving Community First Choice services (outside of a waiver program).

The Social Work In-Home Support Program is a separate program administered through the Social Work unit at DSS. The program provides non-medical home care services to adults age 18 through 64, with physical or mental disabilities. Annual funding for this program has stayed relatively constant at $3.94 million and is supported through the federal Social Services Block Grant. With this appropriation, the program limits the monthly expenditure of services for each participant at $650. The service array available for participants under this maximum expenditure is much less than those offered through our Medicaid waivers and Community First Choice. For these reasons, the Social Work In-Home Support Program can be viewed as a safety net for those individuals that may not be financially or functionally eligible for the Medicaid home and community-based services programs, but are still at risk of institutionalization, and need home care supports to stay in the community.

It is vitally important that the limited funds available for the Social Work In-Home Support Program are preserved to serve as many individuals as possible that are at risk of institutionalization, but not eligible for Medicaid home and community-based services. As the Social Work In-Home Support Program allows individuals to remain in the community, the cost shift to the state to pay for more expensive institutionalized care is delayed. Currently, there are approximately 1,110 individuals that receive services under the Social Work In-Home Support Program. However, the program does have a waiting list. The Department believes that by prohibiting individuals that already receive services from Medicaid home and community-based services programs from being eligible for services through the Social-Work In-Home Support Program, the state may be able to serve additional individuals and consequently delay costly institutionalization.

For these reasons, the Department asks for your support of this bill.

H.B. No. 7037 (RAISED) AN ACT CONCERNING IMPROVEMENTS TO INCOME WITHHOLDING FOR CHILD SUPPORT

This bill requires employers to include a copy of the income withholding order for child support to a workers' compensation carrier, when an employee, who is subject to the income withholding for child support, makes a claim for workers' compensation benefits.

Currently, employers are mandated to "promptly notify" the Judicial Branch's Support Enforcement Services* when an employee with an income withholding order makes a claim for workers' compensation benefits. However, there are no means to enforce this requirement if an employer fails to follow through. Without notification of an employee's change in employment status, the income withholding order often does not carry to the workers' compensation benefit. In many cases, Support Enforcement Services will only find out about the change once the

withholding payments through the employer have ceased. From there, Support Enforcement Services has to initiate a manual process with the workers' compensation carrier to re-establish the withholding order. This process can result in a possible four to six week delay in child support payments to the custodial family.

Requiring employers to attach the income withholding order when sending a referral to a worker's compensation carrier will result in the seamless withholding of the child support obligation from the workers' compensation benefit. This process will remove any potential for delayed payments to the custodial family. This requirement may also improve Connecticut's IV-D program (the state's child support program) performance and increase the associated federal incentive funding.

Income withholding is the most effective means of enforcing court-ordered child support. In SFY 2016, the IV-D program, through the Office of Child Support Services, collected approximately $301.7 million in child support payments. Out of that amount, 65% of those funds were collected through income withholding from employers and other payers of income. Income withholding as a method of child support collection has not only proven to be effective and efficient but also allows for expedient and consistent payments to families.

We ask for your support of this bill.

* Support Enforcement Services of the Judicial Branch is responsible for enforcement of child support orders under cooperative agreement with the Department of Social Services, Office of Child Support Services.

***

In addition, I will also offer remarks on several other bills on the agenda.

S.B. No. 775 (RAISED) AN ACT CONCERNING CONVEYANCES OF PROPERTY BY RECIPIENTS OF PUBLIC ASSISTANCE

A recipient of financial and/or medical assistance, or their legal liable relatives, is required to obtain consent from DSS before the transfer, sale or disposal of property. This bill proposes to limit the requirement for recipients of assistance to obtain such consent.

DSS is concerned that the language in this bill would open the Department to increased litigation, compromise the Department's ability to accurately determine eligibility for assistance and limit the state's ability to recoup on improperly disposed property; all resulting in significant financial loss to the state.

The proposed language, *"provided the commissioner shall not (1) unreasonably withhold consent"* inserts an ambiguous and undefined term into the statute – "unreasonably". As this term is not defined in statute, the Department is unclear what this provision actually means. The current statute does not prevent a client from challenging in court a decision by the Commissioner to withhold consent on the grounds that it was made without a valid basis,

arbitrarily or for an impermissible basis. However, the ambiguity inherent in an "unreasonableness" standard will substantially increase litigation, resulting in a financial expense to the state.

Next, the proposed language *"(2) treat as inferior to the state's interest in property any prior recorded sale, assignment, transfer or encumbrance for which consent was sought pursuant to this section*" is equally ambiguous and appears to cancel out the prohibition of selling, transferring, etc. property without the commissioner's consent. The word "prior" is ambiguous – prior to what?

The provision also seems to be contradictory to the present statutory requirement that a public assistance recipient obtain the Commissioner's approval before selling, transferring, assigning or encumbering property. The proposed language seems to imply that if consent is sought, but not given, the recipient can go ahead and sell, transfer, assign or encumber the property anyway. This change is problematic as it would remove any incentive for individuals and their legally liable relatives to inform the Department of changes that may affect eligibility. This limits the Department's recourse on eligibility when an asset is disposed of improperly. By requiring the consent of the DSS Commissioner the Department of Administrative Services has the ability to recoup the improperly disposed of property and reduce the amount of assistance paid out.

The Department opposes this bill.

S.B. No. 801 (RAISED) AN ACT REQUIRING CLIENT-SPECIFIC EMPLOYEE TRAINING AND EMPLOYEE TRANSITION PLANNING FOR HOME AND COMMUNITY-BASED CARE PROVIDERS

This bill instructs the Department to adopt regulations to require home health agencies to provide client-specific employee training and staff transition planning, in order to receive Medicaid reimbursement for live-in care provided to recipients of home and community-based services.

Currently, homemaker, companion and PCA providers participate in an orientation before providing services to a Medicaid waiver recipient. However, the Department understands and agrees that it is of the utmost importance that caregivers are trained properly. To ensure such training is available, the Department is currently working with the trade association to develop a detailed training curriculum focused on skill building. The goal of the training is to ensure the PCA's skills and the client's needs are a match. The training will be mandatory for all PCA providers. As the Department is already engaged in the development of this training with stakeholders, we respectfully request that the Department be allowed to move forward with these discussions, without legislation.

Section 2 of this bill extends the training requirements to PCAs hired under the Community First Choice (CFC) program. In CFC, the recipient of services is the employer. The employer (participant) is responsible for defining the qualifications of his or her staff. If the employer feels that training for his or her staff is required, the employer may use his or her CFC funds to pay for

the training. This includes training related to the employer's medical condition or personal care needs.

In addition, qualifications for staff and training are part of the CFC service plan and are reviewed and approved by DSS. If the qualifications and training are not appropriate, given the needs of the employer/participant, then the plan is not approved. The Department is responsible for assurances related to health and safety, but the state is not the employer of the PCAs.

The Department understands and agrees with the intent of this bill. However, as training is already being developed for PCA providers of waiver services, and training is already an option under CFC, the Department believes this bill is unnecessary.

S.B. No. 802 (RAISED) AN ACT CONCERNING WORKERS' COMPENSATION COVERAGE FOR INJURIES SUSTAINED BY PERSONAL CARE ATTENDANTS EMPLOYED DIRECTLY BY CONSUMERS IN THE COMMUNITY FIRST CHOICE PROGRAM

PCA services, other than agency-based Personal Care Attendant services, are now covered under DSS' Community First Choice (CFC) program. CFC is a 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 health and safety, 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 workers' 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. This includes providing workers' compensation if a PCA is employed full-time.

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 also require DSS to increase the budget allotment per participant to cover any additional costs for benefits. In this difficult economic climate, the Department is unable to support such an increase in Medicaid expenditures.

For these reasons, the Department cannot support this bill.

S.B. No. 803 (RAISED) AN ACT CONCERNING PRESUMPTIVE MEDICAID ELIGIBILITY FOR HOME CARE

This bill would provide presumptive eligibility for applicants for the Connecticut Home Care Program for Elders (CHCPE).

While the Department is committed to working on initiatives that ensure timely services to those in need of home care services, as evidenced by the initiation of a "FastTrack" program in July 2015 for applicants of the Home Care waiver, the Department is unable to support this proposal.

The Fast Track initiative determines potential eligibility for new applicants of CHCPE, within two or three business days of identifying them as Fast Track eligible. The Fast Track process reviews a client's application and determines if they meet the criteria for Fast Track. This is done through questions related to the applicant's assets and income. If Fast Track eligibility is approved, and the applicant has completed a functional assessment confirming functional eligibility, the applicant may begin to receive state-funded home care services.

It is important to note that Fast Track applicants are still required to comply with all standard Medicaid waiver application procedures to determine eligibility for the Medicaid-funded component or to validate eligibility for the state-funded component of the program. Also, when Fast Track eligibility is granted, clients are notified that if they subsequently are found ineligible for Medicaid they will be responsible for their share of the state-funded benefit. At that time, the applicant may reject Fast Track services and wait until the application is reviewed for complete Medicaid coverage, which may take up to 90 days.

Since July 2015, the Department has successfully screened a total of 565 applications (averaging between 20 and 50 applications a month) through Fast Track. These applicants received state-funded home care program services in an expedited manner. This averages out to an estimated 7 percent of all CHCPE applications received through the Department. A few reasons why CHCPE applicants may have been found ineligible for Fast Track services include, but are not limited to: incomplete applications, over assets, and over income.

Although the percentage of CHCPE applicants found eligible for Fast Track services may seem low, the Department is committed to ensuring timely services to those in need of home care services. For those eligible for Fast Track, this means state-funded services in two to three business days. For this reason, the Department has implemented Fast Track as an ongoing program initiative.

While the Department shares the desire for individuals to obtain prompt access to home care services, this proposal cannot be operationalized given the current allocation of resources and processes for determining eligibility. Furthermore, this bill will require additional financial, administrative, and staff resources from the Department. In this fiscal climate, the Department does not have access to such additional resources.

H.B. No. 7038 (RAISED) AN ACT CONCERNING A MEDICAID STATE PLAN AMENDMENT TO COMBINE RATES FOR HOMEMAKER AND COMPANION SERVICES

This bill requires DSS to submit a State Plan Amendment (SPA) to pay a provider the same rate for companion services as homemaker services, when both services are provided to the same client in the same day.

The Department would like to begin by clarifying that any such rate adjustment to homemaker services would require a Medicaid waiver amendment, not a SPA, as such services are provided under home and community-based services waivers.

The Department understands that the language in this bill specifies that the homemaker and companion rates would only be aligned in situations when the services are provided to the same client on the same day. However, differentiating rates for services provided on the same day to the same client, versus across a spectrum of days to different clients, is not permissible under federal law.

Currently, homemaker services are reimbursed at $4.12 per 15 minute increment ($16.48 per hour) and companion services are reimbursed at $3.67 per 15 minute increment. To align reimbursement rates for all homemaker and companion services, the Department would be faced with a $4.67 million increase to the state share of Medicaid expenditures. In this difficult fiscal environment, the Department is unable to support such expenditure increases.

For this reason, the Department is unable to support this bill.

H.B. No. 7039 (RAISED) AN ACT REDUCING STATE CONSERVATORSHIP EXPENSES

This bill proposes numerous amendments to executive branch statutes to ensure payment of expenses related to conservatorships.

The Department is currently engaged in conversations with Probate Court regarding the changes requested in this proposal. The Department appreciates these constructive conversations and hopes to continue the positive exchange. However, in the bill's current form, the Department is unable to support this language due to the negative fiscal impact such language will have on the budget.

Specific to section 1 of this bill, a state Medicaid agency is required to reduce costs to the state by using available beneficiary income for payment of institutional services. A Medicaid beneficiary's available income is reduced by all allowable deductions defined by the post eligibility treatment of income rules. Currently, allowable deductions consist of medical expenses, maintenance needs of the individual's spouse or family and a personal needs allowance that is established by state law. This bill proposes to add conservator expenses,

including conservator compensation, probate court filing fees and expenses and premiums for any probate court bonds as additional allowable deductions. The Department is unable to implement such additions without approval from the Centers for Medicare & Medicaid Services (CMS). If approved, this provision would increase the percentage of costs the state would be liable to pay for institutional services provided to a Medicaid beneficiary.

Sections 2 through 5 effectively give conservators priority over the state's claims for reimbursement, including reimbursement for public assistance. In most cases the conservator will file their liens upon being appointed conservator and prior to filing a Medicaid application, giving the conservator priority over subsequently filed liens. DAS currently files claims/liens for the full amount of public assistance (cash/medical) owed, state humane cost of care, as well as cost of incarceration. Adding additional liability to the state's claim will decrease any collection efforts.

Additionally, the remaining sections are a wide expansion for the payment and recovery of conservator fees, and appear to provide reimbursement to the Probate Court Administration fund. It would seem that the payment proposals are wholly incompatible with, and do not belong in, C.G.S. sections. 17b-93, 17b-94 and 17b-95 (unless there is to be priority for a conservator's lien in a decedent estate of a public assistance beneficiary). The proposal seems to equate conservator fees and the reimbursement to the Probate Court Administration fund with any claim of the State for reimbursement. This proposal will absolutely reduce recoveries to the state. Also, the provisions of 17b-94(a) is not presently within the jurisdiction of the Probate Court. This provision however, would permit Probate Court to set any conservator fee amount and then allow priority statutory lien status on the claim.

In summary, sections 2 through 5 intrude on the State's recovery for assistance and other recoveries authorized by statute, and will have a significant negative fiscal impact on the budget. The Department must oppose this bill.

H.B. No. 7041 (RAISED) AN ACT INCREASING THE RATE OF REIMBURSEMENT FOR MEALS ON WHEELS

This bill would require DSS to increase the Medicaid reimbursement rate to Meals on Wheels providers by 10 percent.

The Department appreciates the valued service Meals on Wheels provides to recipients of our Medicaid home and community-based services.

To address concerns expressed by meal delivery providers, the Department recently revised reimbursement guidelines for the delivery of meals under waiver programs, effective October 1, 2016. The revision now allows for providers to receive reimbursement for multiple meal delivery in a single day as appropriate (maximum of 7 units/days of meals per delivery). Providers can now be reimbursed for a full multiple meal delivery as long as the client is present to accept the full delivery.

A 10 percent rate increase for Meals on Wheels providers would result in an increased state cost of $554,126 in SFY 2018 and $564,011 in SFY 2019. In this difficult economic time, the Department must oppose this bill.