*Testimony before the Human Services Committee*
*Roderick L. Bremby, Commissioner*
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Good morning, Senator Markley, Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick L. Bremby, and I am the Commissioner of the Department of Social Services.

I am pleased to appear before you to offer remarks on several of the bills on today's agenda.

**H.B. No. 5256 (RAISED) AN ACT REQUIRING THE DEPARTMENT OF SOCIAL SERVICES TO COLLECT AND MAINTAIN DATA CONCERNING THE TRANSPORTATION NEEDS OF MEDICAID RECIPIENTS.**

This legislation requires the Department of Social Services to collect and maintain data regarding the non-emergency medical transportation (NEMT) program for Medicaid members.

As the single state agency in Connecticut designated to administer the Medicaid program, DSS oversees the NEMT program. NEMT is an important benefit for Medicaid members who need to get to and from Medicaid-covered medical services, but have no other means of transportation.

The ultimate goal of NEMT in Connecticut is person-centered, medically necessary, timely, and high quality access to medical services provided by a reliable, flexible, and innovative NEMT system. A person-centered health care delivery system only succeeds when a Medicaid member can effectively schedule and access Medicaid medical, behavioral health, and dental services. NEMT services provide a necessary bridge to ensure Medicaid members can manage their health conditions, live independently, and achieve their own health goals.

Effective January 1, 2018 the Department entered into an NEMT contract with Veyo, a Total Transit Company ("Veyo"). The contract restructured the NEMT program to provide Veyo with greater flexibility and capacity to engage a range of transportation through the state in order to best serve Medicaid members. A copy of the NEMT contract is available at www.ct.gov/dss/nemt. This new structure allows Veyo to implement an innovative NEMT approach, including, but not limited to, a technology platform and model that enhances members' access to NEMT and Medicaid-covered health services, ensures high quality for members and providers, achieve efficiencies, and appropriately administer utilization. This model also improves capacity to collect, analyze and report patterns in service delivery.

As drafted, HB 5256 requires the Department to collect and maintain certain data sets regarding NEMT. However, many of the data sets detailed throughout this legislation are already collected or required for maintenance under the current contract between DSS and Veyo. Specifically, Section XI of the contract, which was also included in the Request for Proposals, includes

language which requires the NEMT vendor to provide the Department with information similar to what is described in this bill.

The Department would like to take this opportunity to identify each requirement within this legislation and explain the status of such data within the current NEMT structure.
HB 5256 requires the Department to collect and maintain:

- *The number and location of Medicaid recipients in need of such transportation (lines 4-5)*
  The NEMT contract already requires the collection and maintenance of pickup and drop off location for Medicaid members requesting a trip. In addition, the NEMT vendor also collects the member's address and has access to the Department's member files, which also collects the member's address.

- *The number of such recipients with medical conditions or disabilities that require regular, multiple visits to medical providers, the regular schedule for such visits and the locations of such providers (lines 5-8)*
  Ongoing trips (also referred to as "standing order trips") are tracked by the current NEMT vendor, pursuant to the terms of the NEMT contract. This data is not currently collected by medical diagnosis or disability; however, medical diagnosis and member disabilities are captured in the member files.

- *Whether such recipients require special vehicles, medical equipment or escorts in order to be safely transported to nonemergency medical appointments (lines 9-11)*
  Mode of transportation is already recorded with each trip and is based on medical necessity and availability of the service being requested. Specific to escorts and medical equipment, the NEMT vendor has a separate form to capture both needs and records such accommodations within the member's record.

- *The department shall maintain a database of the information required to be collected pursuant to subsection (a) of this section and shall require any contractor with whom the department contracts to provide nonemergency medical transportation to Medicaid recipients to share such information with the department (lines 12-16)*
  The Department already collects encounter data through claims submission and payment. These records are stored in our data warehouse and include the Medicaid member's information, the date of the trip, the service provided (through the procedure code), the provider that provided the service and the amount paid for such service.

As most of the data detailed in this legislation is already captured and maintained, the Department believes this legislation is unnecessary. The Department appreciates the intent of the bill and is willing to work with the Committee and stakeholders to ensure specific data is discussed and shared when available.

**S.B. No. 270 (RAISED) AN ACT CONCERNING WORK AND COMMUNITY SERVICE REQUIREMENTS FOR RECIPIENTS OF CERTAIN PUBLIC ASSISTANCE PROGRAMS**

This proposal implements a work and community service requirement for adult recipients under the Medicaid program and the Supplemental Nutritional Assistance Program (SNAP).

Medicaid

The Department is proud to administer a comprehensive Medicaid program for the estimated 800,000 individuals in Connecticut that utilize Medicaid to access necessary medical, behavioral health, pharmacy and dental services.

CT Medicaid has achieved significant improvements in health outcomes, while controlling Medicaid costs. In FY 2017, Medicaid expenditures in DSS grew by only 1.1percent, while per member per month costs have remained remarkably steady over time.

In January 2018, the Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Director (SMD) letter outlining a new option for states under which it will "support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries in demonstration projects authorized under section 1115 of the Social Security Act (the Act)." Section 1115 is a research and demonstration waiver. States may seek waiver approval from CMS to elect to adopt "community engagement" standards, consistent with CMS guidance. Currently three states (AR, IN, KY) have been approved for 1115 waivers for work requirements with another seven states (AR, KS, ME, MS, NH, UT and WI) pending approval. Specifically, the state of Kentucky received waiver approval and is now subject to a federal lawsuit (Stewart v. Hargan) that argues that imposing this requirement is inconsistent with the program's purpose and exceeds the discretionary authority of the Secretary of Health and Human Services to waive federal law.

The Department agrees that participation in Medicaid based on work status is inconsistent with the purpose of Medicaid. The federal Social Security Act outlines that the purpose of Medicaid is to provide funds to states so that they can furnish 1) medical assistance to those whose income and resources are insufficient to meet the costs of necessary medical services, and 2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

For the following additional reasons, the Department does not support pursuing approval from CMS for an 1115 research and demonstration waiver to establish work or community service requirements as a condition of participation in CT Medicaid.

- Overall, our data shows that the large majority of CT Medicaid enrollees are either employed or are not in the federal government's work-requirement option group because they are children/teenagers, pregnant women, individuals with a disability or 65 and older. In fact, nearly 72% - or almost three out of every four individuals receiving Medicaid - are children under 19, adults over 65, persons with disabilities, or employed. It is also worth noting that

more than 5,000 CT Medicaid enrollees in our Med-Connect program have disabilities and are employed.

- Most Medicaid participants – and the groups that use the vast majority of funding – are older adults, people with disabilities and families with children.
    - Specifically, HUSKY C clients (Medicaid for the elderly or persons with disabilities) make up approximately 11 percent of the enrollees in CT Medicaid but comprise approximately 46 percent of expenses.
    - September 2016 data shows that over 31 percent of the HUSKY D population is considered an older adult, or between the age of 50 and 64.

- Imposing work requirements would be administratively complex and costly. Pursuant to the drafted legislation, the Department would be required to:
    - develop means of tracking and documenting compliance or exemption from the requirements for over 800,000 people who are currently participating in CT Medicaid;
    - greatly expand processes for noticing people and providing due process protections, including hearings, to those determined ineligible based on a failure to meet work requirements;
    - develop an additional process for reinstating people determined ineligible to receive coverage, upon demonstration that they meet requirements;
    - make system modifications in support of the same, and hire significant additional staff; and
    - with no budget to do so, meet the federal requirement that is identified in the CMS guidance of assisting members in overcoming barriers (e.g. childcare, transportation, education, and training) to work.

- Medicaid coverage enables job readiness, reduces absenteeism and supports maintenance of employment. CT Medicaid covers a broad array of preventative medical, behavioral health and dental services that enable members to address and manage their health conditions. Further, CT Medicaid provides supports to people in coordinating their care. Finally, CT Medicaid has the capacity in its provider network, including the best access to dental services of any program in the country, to serve people in a timely manner and in locations that are convenient to them. Timely, proximate access to preventative services enables people to be work ready and reduces their need to be absent from, or leave a job, due to their own, or their family members', unmanaged health conditions.

- Medicaid supports economic security. Diverse sources, including Oregon Health Insurance Experiment (OHIE) and Connecticut's experience with its expansion group (HUSKY D), document that gaining Medicaid virtually eliminates catastrophic out-of-pocket medical spending among previously uninsured adults and reduces financial hardship.

SNAP

SNAP is a federal nutrition program that helps eligible individuals and families afford the cost of food. In Connecticut SNAP assists approximately 400,000 residents or 200,000 households.

Federal legislation mandates that states require able-bodied adults without dependents (ABAWDs) from age 18 up to 50 to meet work requirements to be eligible for SNAP for more than three months during a 36-month period. Pursuant to the federal Food and Nutrition Act of 2008, states are provided the option to apply for a federal waiver to waive the applicability of the 3-month ABAWD time limit for any group of individuals in the state if the state can provide documentation that the area in which the individuals reside has an unemployment rate of over 10 percent, or does not have a sufficient number of jobs to provide employment for the individuals.

To this end, for the 2018 calendar year, the Department applied and subsequently received approval by the federal government to waive ABAWD work requirements from 114 towns and cities based on the region's combined average unemployment rate that was 20 percent above the national average for the 24-month period of April 2015 through March 2017 using the Bureau of Labor Statistics Local Area Unemployment Data. The national average unemployment rate for this 24-month period was 5.0 percent; 20 percent above this was 5.9 percent. The region's average unemployment rate for this period is 5.9 percent.

Also noted in federal regulations, ABAWD waivers are approved for a one year period. If the state wishes to continue utilizing this waiver it must re-apply yearly using the most recent 24-month period available. As a result, the number of towns eligible for exemption varies from year to year based on the period's unemployment rate.

As drafted Senate Bill 270 would prohibit the Department from applying for or implementing this waiver under SNAP. The Department does not support this legislation for numerous reasons.

- The federal ABAWD waiver specifically exempts work requirements for towns that do not have sufficient jobs to provide employment for individuals. Prohibiting the state of Connecticut from applying for this waiver, would reinstitute work requirements for residents in towns with the highest unemployment rates and where jobs are simply not available.

- Connecticut is not unique in utilizing the federal ABAWD wavier. Currently, 33 states, in addition to DC, Guam, and the US Virgin Islands, have waivers in place to exempt either part of, or the whole state/territory/district from the ABAWD time limit. Specifically, all states in the New England region participate in the ABAWD waiver, with the exception of Maine.

- SNAP benefits are 100% federally funded. The United States Department of Agriculture cites that every $5 in new SNAP benefits generates as much as $9 of economic activity. In 2017, approximately $687 million in direct federal funding came into Connecticut's food economy through SNAP, generating as much as $1.23 billion in economic activity. Limiting residents' ability to access federally funded SNAP benefits directly reduces the amount of federal dollars into the state at a time of significant economic insecurity and sluggish economic growth. In addition, SNAP benefits are used quickly and stimulate local businesses, including but not limited to, grocers, farmers markets, and neighborhood stores. Limiting SNAP would directly affect local economies across the state.
    - If the state of Connecticut was prohibited from applying for and implementing the ABAWD waiver, as this legislation suggests, the Department's data projects an estimated annual loss in federal revenue of $54 million, potentially affecting close

to 24,000 SNAP recipients. Even more staggering, this figure would represent a loss of approximately $97 million in economic activity.

For these reasons, the Department opposes Senate Bill 270.

**H.B. No. 5461 (RAISED) AN ACT CONCERNING FUNDING FOR NUTRITION PROGRAMS FOR ELDERLY PERSONS**

This bill would require DSS to increase the fee schedule for Medicaid reimbursement to Meals on Wheels by no less than ten 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 revised reimbursement guidelines for the delivery of meals under its programs, effective October 1, 2016. The revision allows providers to receive reimbursement for multiple meal deliveries 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.

Unfortunately, the Department is unable to support a provision that requires a Medicaid rate increase at this time. Furthermore, the Department is concerned that this bill selects and provides a rate increase to one specific service provider in contrast to the hundreds of different service providers that provide vital home and community based services to Medicaid participants.

As drafted, a 10 percent rate increase to Meals on Wheels services would result in an increased state cost of approximately $560,000 in SFY 2019.

In this difficult economic time, the Department must oppose section 1 of this bill.

Section 2 of this bill also requires the Department of Rehabilitation Services (DORS), in consultation with the DSS and providers of Meals on Wheels services to study the benefits of: (1) consolidating all meals on wheels services under DORS, (2) contracting with Areas on Aging to issue Requests for Proposals to providers of Meals on Wheels; and (3) allocating a portion of copayments made by participants in Meals on Wheels programs to increase provider rates. Under DSS, Meals on Wheels is a service offered to eligible participants of the CT Home Care Program and Community First Choice. It is important to clarify that the Department is required by federal law to reimburse any qualified, willing provider under Medicaid. This includes both meal providers that receive Older Americans Act "Meals-on-Wheels" funding, and others that have not historically done so. Any change to this structure has the potential to jeopardize federal reimbursement for such services. The Department is open to consulting with DORS on this report as a mechanism to provide clarification on meals on wheels services provided through each agency; however the Department would respectfully request that the date the report is due to the legislature is extended to December 1, 2018.

**S.B. No. 440 (RAISED) AN ACT CONCERNING COVERAGE OF PHARMACOGENOMICS TESTING UNDER THE HUSKY HEALTH PROGRAMS**

This proposal requires Medicaid coverage without prior authorization (PA) for certain pharmacogenomic tests when determined medically necessary.

The Department of Social Services already covers a variety (over 200 types) of genetic tests under Medicaid, including pharmacogenomic tests. Specifically, if the test is done as part of an inpatient hospital service then the test would be paid through the diagnosis-related group (DRG) system in CT Medicaid. This means the payment for such test would already be included in part of the bundled DRG structure. If the test is to be done through a laboratory provider, DSS will pay according to our current laboratory fee schedule. In addition, any test that is considered medically necessary and not already covered through the above means, the Department will manually price. It is important to clarify however, that certain genetic testing is required to go through a PA process to determine medical necessity. This process protects the safety of HUSKY members by certifying the test is appropriate for each person's medical conditions. The PA process also ensures that the Department continues to be responsible stewards of state and federal funding by confirming that Medicaid is only paying for tests when they are medically necessary.

As drafted, SB 440 requires DSS to cover pharmacogenomic tests when medically necessary, and without PA for certain conditions. The Department has significant concerns with this language. Prohibiting the Department from implementing PA eliminates the ability for the Department to be responsible stewards of Medicaid funding and most importantly impairs the Department's ability to adapt to changing circumstances and clinical practice. It is also important to note that a person's genes do not change. Removing the ability for the Department to prior authorize will allow unnecessary testing and subsequent reimbursement for the same test outcome. In addition, the science of genetic testing is changing rapidly and new tests and diagnostic methodologies come on line almost daily. To etch one diagnostic modality into statute threatens to prevent HUSKY members from being able to access newer and potentially better and more accurate modalities in the future. The statutory definition of medical necessity allows, and in fact requires HUSKY coverage to grow and evolve as medical science, grows and evolves.

Furthermore, lines 14 through 18 of this bill allow the Department to give preference to any Medicaid-enrolled laboratory provider that offers a discount to such tests. As stated earlier in this testimony, the Department already has a set reimbursement process and fee schedule for genetic tests. Carving out one specific test gives special status to one particular service out of thousands of categories of covered services.

For these reasons, the Department must oppose this bill.

**S.B. No. 438 (RAISED) AN ACT CONCERNING A STUDY OF MEDICAID-FUNDED PROGRAMS AND THE CONNECTICUT ENERGY ASSISTANCE PROGRAM**

Section 1 of 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.

CT Medicaid has achieved significant improvements in health outcomes, while controlling Medicaid costs. In FY 2017, total Medicaid expenditures in DSS, including both federal and state shares of the program, grew by only 1.1%. This is a remarkable result when compared with performance against the national average. Further, the state share of CT Medicaid costs has increased by only $34 million (1.2%) over the five year period from SFY 2012 through 2017. Over that same time period, the Department has reduced per member per month costs under the Medicaid account by 3.4%.

To ensure ongoing cost efficiencies, the DSS Division of Health Services and the Division of Financial Services are already charged with monitoring program outcomes and financials associated with the Medicaid program. The Division of Health Services regularly reports to the Commissioner on:

- quality of care, as measured by a comprehensive set of HEDIS measures and consumer experience of care survey results;
- access, as measured by geo-access analyses and mystery shopper surveys; and
- financial trends, to ensure that program goals are achieved through the most efficient means.

The Department provides detailed monthly Medicaid financial reports to the leadership of the committees of cognizance of the legislature and to the Office of Fiscal Analysis. These reports include overall expenditures, enrollment data, per member per month cost, and detailed spending by service type. Additionally, the Department reports annually on Medicaid financial trends to the Medical Assistance Program Oversight Council (MAPOC). The latest of these reports is available at this link: https://www.cga.ct.gov/med/council/2018/0209/20180209ATTACH_HUSKY%20Financial%20Trends%20Presentation.pdf . MAPOC is charged under statute [Connecticut General Statutes Section 17b-28] with oversight activities that specifically address the stated goals of HB 438.

While the Department does not oppose the general concept of this section, we respectfully suggest that the legislation is duplicative and unnecessary and would divert resources the Department needs to focus on the provision of services.

Section 2 of this bill requires a payment plan that ensures payment to deliverable fuel vendors participating in the Connecticut Energy Assistance Program (CEAP) within ten business days after the date of the fuel delivery. In addition the bill requires the Department to make payments to fuel vendors if the Community Action Agency (CAA) is unable or fails to make such payment.

The deliverable fuel vendors, who participate in CEAP under the Department of Social Services, provide a vital benefit that ensures thousands of eligible residents stay warm during the winter season. The Department greatly appreciates the fuel vendors' commitment and dedication to CEAP throughout each heating season.

However, the proposed language in section 2 of SB 438 is in violation of current expectations identified for CEAP deliverable payments outlined in Part III, Section 15 of the annually-signed Supplier/Vendor Conditions of Participation Form in two important ways. First, any accurate count established to track payments to deliverable fuel vendors must begin on the date that a CAA receives a fuel slip or invoice for payment, not the date that a fuel delivery is made. Second, the standard that has been agreed to for many years by participating vendors is that CAAs will issue payments within 30 days of receipt of a fuel slip or invoice. Subsection (F) of section 2 would reduce this to ten days after the date of fuel delivery. CAAs process CEAP payments for approximately 60,000 to 64,000 deliveries annually between the heating season of November through mid-April. Requiring that all payments be made within ten days of delivery would create a significant burden on the already strained staff resources of the CAAs. In addition, there are many vendors that do not submit their invoices right after the delivery date and therefore the CAAs would not be able to process those payments for deliveries until receipt of an invoice.

Section 2(e) of this bill also requires the Department to "allocate available state funding in a reserve account… to make payment not later than ten days after fuel delivery to such vendors is a community action agency is unable to or fails to make such a payment." All existing state dollars are already earmarked for other program expenditures. Reallocating such dollars for a reserve account would then require the Department to remove funding for its current purpose and have the potential to negatively affect current social service programs.

To ensure payment for CEAP vendors, all CEAP contracts with CAAs already require that CAAs pay vendors timely. Specifically CEAP contracts require:

- CAAs to adhere to the federal regulations applicable to CEAP, and all requirements relating to the receipt or use of federal funds.
- CAAs to indemnify defend and hold harmless the state from and against any and all claims, liabilities, damages, losses, costs and expenses arising directly or indirectly in connection with the contract or acts of commission or omission by the CAA.
- CAAs to maintain $1 million in professional liability insurance.

In addition, the contracts with CAAs also hold CAAs liable for any state or federal audit exceptions, and require CAAs to return to the Department all payments to which exception has been taken or which have been disallowed because of such an exception.

Unfortunately, as most are aware, the Department has been working through a recent situation with the Community Action Agency of New Haven (CAANH) where payments to 48 fuel vendors for their services in the FFY 2017 program did not occur (totaling approximately $190,000). It is important to clarify, that specific to this situation, the Department had already provided full payment, using the designated federal CEAP dollars, to the CAANH. However, these funds were not used by CAANH for their intended purpose of paying the fuel vendors that provided such services.

When the Department became aware of this situation we provided immediate and formal communication to the CAANH that these outstanding payments were a violation of contracting terms and outlined specific expectations and next steps. To ensure this does not happen again, the Department made the decision to remove the CAANH from being the pass through for fuel vendor payments for the FFY 2018 heating season and future heating seasons.

More recently, the Department identified state funds to pay the outstanding obligations to the fuel vendors. These funds have been paid out and the Department is in the process of working through a repayment agreement that requires CAANH to repay the misused funds to the Department.

The Department would also like to take this opportunity to detail the scale of this situation in relation to the full program in CT. In FFY 2017 a total of 382 vendors participated in the program and provided close to 64,000 deliveries statewide. CEAP expenditures for FFY 2017 totaled over $22 million. In contrast, during the same time period, the CAANH worked with 85 of these vendors and as noted above, had outstanding payments to 48 of such vendors, totaling approximately $190,000. This represents less than 1% of total payments under CEAP.

It is the Department's highest priority to ensure the CEAP vendors are paid for their services. Throughout this unfortunate situation the Department worked in partnership with the fuel vendors and regularly communicated to the Board of Directors about ongoing concerns with the CAA's progress toward resolution.

The Department also has numerous safeguards in place to facilitate payment to vendors, and is open to further discussions with the Committee and stakeholders to make certain that CEAP vendors are protected from this situation occurring again. To this end, the Department, in partnership with the Connecticut Association for Community Action (CAFCA), has also started to take steps toward engaging the full CAA network in a conversation around service integration and strategic restructuring to effectively meet the community service delivery needs of Connecticut residents and promote sustainability within the CAA network.

The Department believes that ongoing conversations with all stakeholders may more appropriately address the underlying concerns that this legislation is attempting to resolve.

**H.B. No. 5464 (RAISED) AN ACT CONCERNING NURSING HOME SERVICES**

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 study being proposed in HB 5464 is 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 CT Sustainability Plan: Home and Community-Based Services Strategies and Tactics was published January of 2016.

The plans can be accessed at www.ct.gov/dss/rebal and http://www.ct.gov/dss/lib/dss/CTSustainabilityPlan_AppendixA43015.pdf

In addition, the state has reconstituted the Nursing Home Financial Advisory Council (pursuant to CGS 17b-339) and is currently meeting on a quarterly basis to discuss issues concerning the financial solvency of and quality of care provided by nursing homes.