REP. WALKER (93RD): Good afternoon everybody, good afternoon. I’d like to call the Appropriations Human Services Committee to order, we reconvene. We will have from 1:00 to 1:30, Rehabilitation Services and from 1:30 to 3:00, the Department of Social Services. So with that, I would like to call Commissioner Amy Porter. Good afternoon Commissioner. Do me a favor, just make sure that the microphone is on and when you go to speak, please make sure you identify yourself and if you, young lady speak, then make sure that you identify yourself. Okay. Good afternoon.

AMY PORTER: Good afternoon, Representative Walker, Representative Abercrombie, Senator Osten, Representative Case, and distinguished members of the Human Services Committee. My name is Amy Porter, and I’m the Commissioner for the Department of Rehabilitation Services, and I am joined here with Michelle Provost, who is our fiscal manager for the department.

I want to thank you for the opportunity to testify in support of the Governor’s proposed biennial budget for Fiscal Years 2020 and 2021. I would like to start by saying that we’re very grateful for
Governor Lamont’s support for the important work that our department does with older adults and with people with disabilities.

As many of you know, DORS continues to transfer to meet the needs of Connecticut citizens with disabilities and with a recent addition of aging services; we’re building a strong continuum of aging and disability services. We have a new mission which is “To maximize opportunities for the independence and well-being of people with disabilities and older adults in Connecticut” and all of our core programs are really designed to support this mission.

We have a diverse set of services that generally fall into five categories: employment, education, independent living, and advocacy. We deliver these services with an incredible staff of approximately 450 dedicated professionals. We operate with a budget of approximately $95 million, almost three-quarters of which comes from the Federal Government. On a state level, we receive funding from the General Fund, the Workers’ Compensation Fund and the Insurance Fund, and on a federal level, we receive funding from the U.S. Department of Education, The U.S. Department of Health and Human Services and the Social Security Administration.

The Governor’s proposed budget for our department in Fiscal Years 2020 and 2021 larger mirrors the budget for Fiscal years 2018 and 2019. I do want to describe the one proposed changed that goes beyond the baseline adjustments that are comment to all executive branch agencies.

The Department had one holdback in fiscal 2019 and this holdback has been annualized in the proposed
budget for 2020 and 2021; this in the area of elderly nutrition.

To provide some background on this program, department’s Elderly Nutrition Program provides congregate meals which are meals delivered in a community setting to adults aged 60 and over, their spouses regardless of their age, and individuals with disabilities who reside in elderly housing complexes that happen to have a congregate café on site. The program also provides home developed meals to adults age 60 and older who homebound or otherwise isolated and the program is supported by both state and federal funds. This program doesn’t have income or asset restrictions and it is not designed as an entitlement program. It’s really targeted to older adults with the greatest economic and social needs. Individuals who are Connecticut Home Care Program for Elders aren’t eligible for meals through the Elderly Nutrition Program, although we often do serve people who are waiting for an eligibility determination for that program. Our department contracts with Connecticut five area Agencies on Aging, or the Triple A’s who in turn contract with elderly nutrition providers based on a competitive bid process. This program has been able to maintain stable service levels within available appropriations. In Fiscal year 2018, the program provided 1,868,817 home delivered meals and congregate meals combined to 21,509 individuals, and those numbers are pretty similar to the numbers for Fiscal Year 2017.

Our contracts are designed to be flexible enough to adapt these changes in the local areas. We’re proud of this program and we’re grateful to our partners at the area agencies on aging and the Elderly
Nutrition Programs for delivering this critical service. That’s all I have.

In conclusion, I want to thank you again for the opportunity to testify in support of Governor Lamont’s recommended biennial budget and I’d be happy to answer any questions that you have.

REP. WALKER (93RD): Good afternoon and thank you very much for your testimony and thank you for being our Commissioner. I have one quick question before I open it up. You talk about the fact that DORS operates a budget of about $95 million? Well, we only have a third of that on our paper. So, where’s the rest?

AMY PORTER: Right, [laughing] [background laughing] Well, we have -- we do have -- a majority of our funding comes from federal funds. We get money through the U.S. Department of Education, through the Rehabilitation Services Administration for our Vocational Rehabilitation programs that are designed to help people with disabilities go to work. We get funding from the administration on community living for programs like Assisted Technology and Independent living, and some of our programs for -- that are delivered through the Older American’s Act. And we get money from the Social Security Administration to run their disability determination program. We have state employees who work with the Social Security Administration to evaluate an individual’s claim for social security disability benefits and they are the ones who look at all the medical evidence, send folks out for consultative exams, and make a determination of whether somebody is eligible for their services or not. So we provide a whole host of services both on the
disability side and the aging side that are federally funded.

REP. WALKER (93RD): Okay. Well, I am going to make a request from OFA because this just sort stuck out that we get a listing from all agencies on their federal dollars, so you don’t have to do anything, Office of Fiscal Analysis is going to provide us with that information. [laughing] I love it. Because I, I -- we also learned about some federal dollars that weren’t listed in another agency today, so we really need to see what federal dollars we are getting from and how. So thank you very much. And Representative Johnson, followed by Representative Abercrombie and followed by Senator Osten, followed by Representative Case. And the beat goes on. Okay, you get two chances. Thank you. Representative Johnson.

REP. JOHNSON (49TH): Thank you so Madam Chair. And thank you for your testimony and your work. I just have a quick question that you could probably provide to us during our committee meeting, or maybe you can answer, I’m not sure, but a lot of the times, for the last several years, maybe 30 years or more, there’s been an encouragement by the Social Security Administration when someone goes on a disability program to have them work. And one of the problems with the whole situation because many people with disabilities want to work, but they need to have the supplement for their income as well, as that -- their hours may not be regular and they run into overtime issues where they are reporting but then the administration of Social Security Administration, not your office, has trouble with making the adjustments appropriately. I wondered if you run into this, if anybody has complained to your
office about it. I know I get calls about it quite frequently. And I just wondered is there a way we can address it may be better, or maybe there’s something that my constituents are missing.

AMY PORTER: Thank you for the question. This is actually an issue that we are faced with all the time; people with disabilities who want to work and who are receiving benefits through either the supplemental security program or the Social Security Disability Insurance program. There’s different rules for both programs and those rules also interact with some other federal programs and other state programs. And so what we’ve done because it is such a huge issues, we run employment programs for people with disabilities. So, when you’re looking at employment and you’re trying to figure out so how do I help this person find their own path that makes the most sense, they need to understand what’s going to happen to their benefits and start to plan for that and we do have a benefits counseling program as one of our services that helps people understand the impact of work on their state and federal benefits, and we walk people through that impact from a very personalized perspective for them. So thank you so much for that question.

REP. JOHNSON (49TH): Well, thank you for your work, and I wouldn’t mind having some of that information and maybe turning it -- we do email blasts and we also send out information for people so the folks in my district will be able to get that information and make it more readily available maybe to some of the local agencies as well, like my town administrators and that sort of thing.
AMY PORTER: We’d be happy to share. We have great staff working on that program and we also have a number of publications. We have a Myth Busters publication that talks about -- sometimes it’s just I believe what my neighbor told me about the benefits and I don’t really understand what’s happening, and so we did develop a Myth Busters. We work with other partner agencies on those as well. So we will get that to you.

REP. JOHNSON (49TH): Thank you very much. Thank you, Madam Chair.

REP. WALKER (93RD): Thank you. Representative Abercrombie.

REP. ABERCROMBIE (83RD): Thank you, Madam Chair. Good afternoon Commissioner. Thank you for being here. So I just want a red flag that I’m really disappointed to see the cut to the Meals on Wheels. [laughing] You know, we’ve been trying to work on this. We both know that we’ve already heard of one program that has decided to no longer serve this population; they can’t afford to do it. I’m really concerned how this is going to impact the people in the community, so I just want a red flag that I’m really disappointed that that $2 million dollar cut is in there. So, you don’t have to comment at this point, I understand. But I think there will be followup conversations about that. Thank you, Madam Chair.

REP. WALKER (93RD): Thank you. Senator Osten.

SENATOR OSTEN (19TH): Thank you very much, and I just have -- do you know why the Elderly Nutrition Dollars did not go out the door in the current fiscal year, or have they gone out most recently?
AMY PORTER: I believe the current dollars are allocated.

SENATOR OSTEN (19TH): But have they left the -- have they been sent out to the -- my understanding is they have not been sent out to the -- yeah.

AMY PORTER: I am not aware that for our Elderly Nutrition Program that those -- that that funding was held back.

SENATOR OSTEN (19TH): If you could check into that. My understanding it’s stuck and not being sent out to the providers, and I would like to know about that.

AMY PORTER: Okay. So current year contract funding.

SENATOR OSTEN (19TH): Correct.

AMY PORTER: We’ll double check on that.

SENATOR OSTEN (19TH): All right. And then the other thing is, is how many of your positions, you have a 136 position, positions -- are those all funded in your personnel services line item?

AMY PORTER: We have, we have 15 vacancies that are funded.

SENATOR OSTEN (19TH): Thank you. How many people do you have right now?

AMY PORTER: For state funded positions, because remember, we have -- because we’re so heavily federally funded, a lot of our positions are actual federal funding, so we have about 450 positions in the Department, but for the --

SENATOR OSTEN (19TH): Are they all state employees?
AMY PORTER: They’re all state employees but some are 100% federally funded and they wouldn’t show up in that, in that number.

SENATOR Osten (19TH): They would show up in your fringe. They would show -- somebody’s gotta be paying there.

REP. WALKER (93RD): You need to -- first of all you need to identify yourself and speak into the microphone please.

MICHELLE PROVOST: Michelle Provost. The federal programs pay for the fringe benefit cost associated with any personal services charge to their programs.

SENATOR Osten (19TH): I can barely hear you, but.

REP. WALKER (93RD): Please -- no just come closer to the microphone. There you go.

MICHELLE PROVOST: So the federal program pays for 100% of the fringe benefit costs that are charged to the federal programs.

SENATOR Osten (19TH): Right, but they don’t pay when someone goes into the -- when they retire. That’s state provided.

MICHELLE PROVOST: Correct, state funds pay for retirement.

SENATOR Osten (19TH): So can you get for me, the number of employees that you actually have, the number of employees that are funded in your personnel services, and the number of vacancies that you have that are, that are unfilled. All right. That’s what I would like. Thank you very much, Madam Chair.
REP. WALKER (93RD): Thank you. Representative Case.

REP. CASE (63RD): Thank you, Madam Chair. Good afternoon. Just a couple quick questions, maybe four or five. We have the Elderly Nutrition, I know everybody has talked about this. The $2 million dollar holdback, is that -- that’s not your full allocation of dollars?

AMY PORTER: No, we have federal funding and state funding and we have been able to maintain those dollars for the last couple of years. The $2 million was a holdback a couple of years ago and has been sustained.

REP. CASE (63RD): It’s just brought light to a ton of people that -- not just legislators who understand holdbacks, but other people that see this budget that $2 million, they think it just a cut, but it’s a holdback of dollars that could be used, but it’s held back.

AMY PORTER: Right. Correct.

REP. CASE (63RD): And just a -- I don’t know, a question I’ve had that I’ve had with other agencies. So, OFE will probably come up later and tell me. But when you’re talking about -- in most budgets, they have a leap year dollar figure. Do you pay extra for agencies to have people who have beds or who are staying in facilities -- is there a cost for you guys?

AMY PORTER: We don’t, we don’t have facilities or beds, so our -- I think our --

REP. CASE (63RD): So your independent living centers, its day program?
AMY PORTER: They’re actually -- yeah, they have a set of core services that they provide.

REP. CASE (63RD): So you have no extra costs for the extra day of leap year.

AMY PORTER: I do not believe so.

REP. CASE (63RD): Thank you, Madam Chair.

REP. WALKER (93RD): Thank you, and what I did find out about the leap year, is that it’s on a Saturday and because some agencies provide services on a Saturday, then they’re budget is going to reflect leap year. The ones that do not have Saturday facilities are the one -- I mean Saturday programs are not going to have leap year funding. Yes, yeah. Senator Osten again, for the second time. Anybody else have questions? Good.

SENATOR OSTEN (19TH): Thank you. I just have one other question. You talked about federal dollars that help out with vocational and rehabilitation programs to get people to work, and we have a Bill in Labor that talks about making the minimum wage applicable to people in the IDDD world. And my understanding is some people are concerned about some of the family members -- some of the family members are concerned that should we raise the minimum wage to the -- so it’s not the sub-minimum wage that some of the IDDD community is being paid that -- that that will impact their payments in other services, and that’s a federal dollar issue. Do you have any insight on that?

AMY PORTER: I do think we have, through our Vocational Rehabilitation Program which is authorized under the Workforce Innovation and
Opportunity Act or WIOA, there is an entire section on sub-minimum wage and the idea is that in or -- in order for somebody to go into a sub-minimum wage job, they have to be offered all of the opportunities that are available to them, educated on those opportunities and that has to happen on at least an annual basis because what was happening is people were going into sub-minimum wage positions and not moving out of those. So that’s our federal mandate is to work with the DD community and the IDD Community and our sister agency at DDS to be able to implement our provisions of the law, but the -- we don’t -- we don’t place people in sub-minimum wage jobs. Ours is to make sure people have the opportunity to get the information they need and have the access to our Vocational Rehabilitation Program for competitive employment.

SENATOR OSTEN (19TH): And I’m still getting a complaint from many of the deaf and hard of hearing community on interpreters and getting them to doctor’s appointments or any other place where they may need some assistance and do you have any insight on that?

AMY PORTER: There is a -- by statute, there was created an Advisory Board for individuals who are deaf and hard of hearing. And that is one of the major issues that the board has really focused on this year legislatively as well as just in terms of sharing information, trying to understand what the current reality really is, so there is, there is some legislation out there in a couple of areas, but there is also a lot of work going on in the deaf community, the interpreting community to really figure out what are those issues, and I now DAS, who holds the master contract for all state agencies and
then the legislature can use that as well -- they are holding a series of focus groups with folks from the deaf community with interpreters and with the current contractors to really think about what’s working, what’s not working, and what can we do in the next procurement as a way to start to fix some of the issues.

SENATOR OSTEN (19TH): Thank you. Thank you very much, Madam Chair.

REP. WALKER (93RD): Thank you. I’m sorry. Representative Abercrombie followed by Representative Case.

REP. ABERCROMBIE (83RD): I just wanted to follow up for the Senator around the interpreters. So, I sat in on a lot of the advisory meetings and they came up with proposals. We are having a public hearing in Human Services this Thursday, the 7th, I think it is around this issue. There’s different pieces of it. I will say that a couple of the proposals did go to other committees and they were not raised there. So, the, the deaf community is very upset, but I can just speak for Human Services that’s raising some of those issues that came out of the work groups. So anybody is more than welcome to either watch it on TV or attend.

REP. WALKER (93RD): Representative Case.

REP. CASE (63RD): Thank you, Madam Chair. Just to followup on Senator Osten’s questioning, not on the interpreters, but on the sub-minimum wage, because my concern is as hers, I am getting a lot of calls on this. I’m not sure what the sub-minimum wage is right now. What is the average sub-minimum wage that you’re seeing?
AMY PORTER: I don’t have that information.

REP. CASE (63RD): It can vary. But, so if the minimum wage goes up, are people who are on state benefits still have to fall under the, the $1600 a month within their savings or checking?

AMY PORTER: I think those are probably questions related to Medicaid and Medicaid Programs, which we don’t operate, so.

REP. CASE (63RD): What I’m getting at, if you have people who are moved -- being moved from sub-minimum to minimum wage, they have the possibility of losing some of their benefits. Because if the sub-minimum wage was to help people to stay on, and I’m just afraid -- I guess we gotta watch it and see what happens but if everybody goes to the full wage, or the subminimum wage goes up, it could affect programs that people are or their eligibility for some of those programs. Do you not agree with that, or?

AMY PORTER: I’m just thinking those are -- those are Medicaid Programs, so probably a question for DSS.

REP. CASE (63RD): We’ve got them next, so, thank you. Thank you, Madam Chair.

REP. WALKER (93RD): Thank you. Are there any other questions. Oh, I was also corrected by OSA that it’s not Saturday rate, it’s per diem rates that are affected. Sorry. Are there any other questions? If not, thank you very much. That was easy. Okay. Thank you.

Next, we have the Department of Social Services. I don’t want to touch that one at all. You don’t want
to know. Good afternoon Commissioner, good afternoon, it’s great to see you.

ROD BREMBY: Thank you. Good afternoon Senator Osten, Representative Walker, distinguished members of the Appropriates Committee. My name is Rod Bremby, and I’m the Commissioner of the Department of Social Services. With me this afternoon, is Mike Gilbert, he’s our Chief Fiscal Officer and also Director of our Division of Financial Services. Behind us, I think three rows deep are the subject matter experts within the agency. I believe you have a slide deck. We’ll try to be very brief in going through that.

REP. WALKER (93RD): I was going to say, you’re going to just [makes a noise], go right through quickly?

ROD BREMBY: Hit the high points.

REP. WALKER (93RD): Yeah, because we’ve got a lot of questions. [laughing]

ROD BREMBY: Okay. So we’ve got something like 30 somethings slides, I’m only going to take 10 minutes to go through it, and hit the high points.

REP. WALKER (93RD): You’re good.

ROD BREMBY: But as we go through the deck, I’ll just call out the number at the base so that you can follow along. On slide two, we just want to highlight the fact that we are serving over million Connecticut residents, some 28% of the population through a wide variety of services across all 169 towns. We are technology and data driven, we use data as best we can to drive our policy and our programmatic service. We are accomplishing more
with less, and that’s to be clear. Our administrative costs for the agency are 3.2%. Our overall staffing is 1623 currently, and over 50% of the agency’s expenditures are federally reimbursed.

If you go to slide three, we highlight our vision, and our mission and our values. I just want to call your attention to the mission. This is fairly new, but we, along with our partners, and we’re emphasizing partners, provide person-centered programs and services to enhance the well-being of individual families and communities.

Moving over to slide four, we break out the type of assistance. As you can see, the Medicaid Program is the marque program in terms of the number of people or lives touched. The food program has seen a decrease over the last three years, and we expect that to continue to go down as the economy improves.

On slide five, we want to make sure that it is clear that we are grateful that this budget will allow us to achieve our true mission and provide us with resources to provide the support for folks who benefit from our services. We especially look forward to working with the General Assembly as we work with you over the next couple months in creating -- fashioning a budget that we will implement throughout the next year.

On table six shows the DSS budget at a glance. It identifies the major programs up in the upper left, staff and cost about $116 million dollars. OE expenses $139 million dollars, administrative costs, again 3.2%. Over to the far right, we show you that the total budget proposed is $4.4 billion net or $8.3 billion gross and for 2021, $4.5 billion net, and $ 8.4 billion gross. Just dropping down to the
last box on the far right corner it shows the federal reimbursement as a percentage or proportion of the programs for state fiscal year 2019.

Moving to slide seven, I just want to show you that the total funding increases for the next two years, $74 million and $102 million dollars respectively. The overall change in the General Fund budget is an increase of 1.7% and for 2021, 2.3%.

Slide number eight, just again, lists out the overview of the DSS budget.

Slide nine highlights the pie for the budget by core programs, as well as the recommended budget by core programs.

DSS overview on page ten shows you that our largest spend is 28%, Medicaid followed by nursing homes with LTC, long-term services and supports over 50% of our budget. It is really hospitals and nursing homes.

On slide 11, we begin to go through the baseline changes. I’m going to ask if you’ll slip over to slide 21 for me.

REP. WALKER (93RD): You can slow down a little bit. [laughing] [background laughing] Just a little bit.

ROD BREMBY: All right. You’ve got to remember, you’re talking --

REP. WALKER (93RD): By the time I get to the page, you said now go to next slide. I was like okay. I’m a little slower than that. [laughing]

ROD BREMBY: When you say slow and you’re talking to a boy from Alabama, I can go real slow.
REP. WALKER (93RD): Okay, we’re going middle. [laughing]

ROD BREMBY: All right. On slide 21, we wanted to slip over the details.

REP. WALKER (93RD): Slide 21, or slide 11?

ROD BREMBY: Slide 21. We wanted to skip slides 11-20 to just highlight some components that we probably wouldn’t get to in the interest of time.

REP. WALKER (93RD): Oh no, let’s go right back to slide 11 and talk about the budget.

ROD BREMBY: I’ll get back to it. I just wanna.

REP. WALKER (93RD): Oh, okay, all right, slide 21.

ROD BREMBY: Yeah, slide 21 starts with some achievements, and I’m not going to belabor the point, but I do want to show you that the agency is and has been doing more with less in a very real and constructive way. In terms of the SNAP achievements, we want to highlight for you that the SNAP application processing timeliness ranks number one in the northeast. For the last two years, we’ve ranked third in the nation with an application processing timeliness rate of 97.95%. You might recall in 2011 we were in the 58 percentile or percent range, and also moving to the right side of that slide, the Quality Control rates have also decreased over the years, and we’re very proud of that as well.

Moving to slide 22, the SNAP program not only is performing extremely well in terms of timeliness, but we’ve also been earning bonuses, high performance bonuses, $1.6 million dollars in both
the last two years. $1.6 million last year and this requires that we process within the standard of promptness, that’s seven days for applications that are emergencies and 30 days for regular applications. Last year, we also received $767,000 in high performance bonus for program access. So that means, along with our partners, have been very diligent in identifying and bringing on board people who are eligible for the program, but that exposure or that penetration rate for the program is over 92% and that’s the highest that the agency has experienced in its history.

Slide 23 brings us to front and center with an issue that I know that has been on your minds and in front of all of us. Over the last we had some operational challenges with our wait times in our benefit centers. Last year, last fall, around the November/December timeframe, we sent out over a million notices to individuals who then saw those notices and needed to call, and most of them were concerned about the MSP program, and the reductions there that disrupted our ability to operate efficiently. But as you can see, over the last several months, we’ve been able to bring that back into alignment with what we believe is the appropriate approach for responsiveness. And what isn’t shown on this slide is that we have secured, and are in the process of procuring technology to help sustain these over time. This has all been done with process improvement. So, we think that with additional technology, we can continue to maintain these.

On page 24, you can see our Medicaid application processing timeliness. I spoke about SNAP as being the best or -- best in the northeast and third in
the country. In terms of Medicaid, we also are number three in the country.

If you go to slide 25, we’ll just show you how impressive that is. If you look at the far left set of columns or bars, Connecticut’s same-day application for Medicaid, MAGI and CHIP processing is third in the nation, about 90%. You can see what the New England rate is, about 47% and the U.S. rate is hovering below 30%. So same-day application, 90%. When you move to the right, 1-7 days, you’ll see that Connecticut continues to outpace the nation and New England. When you get to over 45 days, and unfortunately, this is where we were five, six, seven years ago. There’s very few, minimal applications that are over 45 days. Nationally, you’re looking at somewhere in the 18% to 19% range. Doing more with less.

On slide 26, talking about the outcomes in Health Services. We’ve expanded the provider networks and opportunities for client access. We are increasing the preventative or routine care for clients. We’re reducing utilization of hospital inpatient stays, reducing the use of ED visits, and we’ve stabilized the costs of our Medicaid Program.

Slide 27 just shows you the provider network continuing to grow, the primary care physicians have increased by 2.59 -- I’m sorry, primary care providers, not all are physicians. And total specialty providers 3.6% increase, and so when people are saying that we can’t find physicians or doctors or providers in the Medicaid program, this slide and this data suggests the alternative.

On slide 28, Physician Services, utilization changes. You can see across that mix, we’ve
continued to increase our routine care or preventative.

Slide 29, Impatient Metrics, hospital utilizations is decreasing across all metrics admission, admissions per 1,000, readmission rate, days/1000 or the average length of stay, they’re all decreasing.

Slide 30, Emergency Department utilization is also decreasing.

Slide 31, we’re showing you that there is a decrease across the categories of services for expenditures. Primarily, Pharma drives medical costs, as you can see. Over the last four years, our Pharma costs have been net positive. In terms of that, we’ve been able to actually save money on Pharma from the previous year, largely by rebates. We’re increasing our cost of waivers. You’re seeing a slight decrease in the rates for nursing homes. But again, major cost categories are being held constant.

Slide 32, quarterly medical expenditure trends, as you can see, that too is remaining relatively steady over the last eight quarters. Our per member, per month trend over 2017/2018, have also remained steady over the last eight quarters.

Slide 34, shows the Medicaid growth trends. On the far left, you see the U.S. Medicaid spends rate combined with the DSS expenditures, DSS enrollment and then if you look to the far right, the PMPM or per member per month reductions. Again, Medicaid growth trends are being controlled.

Slide 37 shows you the state share of Medicaid, that’s the green bar on the far right side of those bars. That’s the state’s share of Medicaid. As you
can see, the overall costs have increased but the state’s share has been minimal at best, 2.4% since 2013.

And a couple other slides to wrap up and get back over to the budget issues. Slide 36 shows you the proportion of Medicaid of the state budget, the overall state budget. Medicaid continues to lead New England and many of our peer states with the smallest share of the state budget.

Moving to the next slide, not only is that favorable, but that has been increasing from a 2% to a 5% Medicaid expense as a percentage of the overall budget. So we have been able to keep the Medicaid budget in line.

And going back to the baseline changes for the upcoming 2021 budget, starting with slide 11. We walk through these very quickly. There is an adjustment that reflects the --

REP. WALKER (93RD): Commissioner, let’s let everybody get to page 11. [laughing] Okay, I think we’re good.

ROD BREMBY: I just remember what 10 minutes used to be like. [background laughing] I’m just grateful for the time. So slide 11.

REP. WALKER (93RD): We set aside 2 hours for you, so you’ve got plenty of time. [laughing] Go ahead.

ROD BREMBY: Thank you. So on slide 11, again, we just want to reflect, or the budget reflects the decreases in the federal support for the HUSKY D program from 94% of the cost of the program in this current year, to 93% in 2019, and then 90% in 2020. HUSKY B has also seen a reduction or will see a
reduction from 88% to 76.5% and then finally the 65% in federal fiscal year 2021. This means an increase of $59.5 million in year 2020 and $100 million dollars in state fiscal year 2021. We also provide additional funding to meet program requirements for a number of services. An increase of $28.2 million dollars or $126 million in the out year of the biennium. We’ve annualized staff 30 in Medicaid, 10 in Child Support, 17 in Shared Services, 33 in quality assurance efforts and 8 for MFP. All of these annualized costs are subject to federal reimbursement ranging from 50% to 90%. These will drive up the cost 7.5% in the first year, and the second year of the biennium.

Slide 12 speaks to the annualized rate increases for nursing homes, intermediate care facilities, and individuals with intellectual disabilities waiver services and certain home health services. That’s a 10.9% increase over the two years -- across each year of the two years. We’ve adjusted the departments OE expenses for several issues, impact support costs, expiring federal administrative support for the PCMH Plus Program, federally required roll out of the electronic visit verification. We are also doing that with our partners at DDS. Agency training costs that we had on the Impact Project at 90% reimbursement, goes back to the General Fund at 90%. And acuity based nursing home rate system change, increases of $11.3 million and $4.8 million out in the -- our year of biennium. Funding associated with the PCA collective bargaining agreement increases the annualized 2019 wage increase to $3.9 million in 2020, and $5.9 million in state fiscal year 2021.
On slide 13, the next slide, finding for DDS community residential services, and this is to recognized age out placements; 77 age out placement in 2020, and 67 age out placements in 2021, as well as transitions under the Money Follows the Person program, and other initiatives, that 65 in the first year, 53 in the second year, for an increase of $10.9 million or $27.5 million in the out year. We’ve also annualized private provider wage adjustments for DDS’ community residential services. Funding for private provider costs associated with conversion, or closure of 10 DDS public group homes, savings of $8.2 million is reflected under the DDS budget, for a net savings of $0.5 million across both agency budgets.

Slide 14, the removal of the inflationary rate adjustments for nursing homes and intermediate care facilities for individuals with IDD, that’s $15.2 million in the first year, and $32.3 million in the second year. This middle bullet calls out a specific program and policy change that institutes an asset waiver for the MSP program at the federal minimum levels. What’s important to note is the vehicle, the house, those are excluded from the asset provision or test. What we have here is an increase of $2.8 million in state fiscal year 2020, and a reduction of $8.7 million in the second year, revenue gain of $16 million in the second year. There are some staffing and systems support costs in both years of the budget for this effort. The last bullet strengthens utilization management including changes in our prepayment edits. As our Medicaid program currently operates, if we get a clean claim, we pay that. And then we audit and we try to recoup any over payments. This will begin to set up for
edits so that those claims are slowed down a little bit, so that we may not pay as quickly, but we’ll pay as accurately if not more accurately. So, this unit UM is also an opportunity for us to see a capture of additional revenue, but there’s a reduction of $1.4 million in the first year and $9.8 million in the second year.

Slide 15, first bullet, we are looking at more program integrity efforts including additional audit and third-party liability. Medicaid should be the program of last resort in terms of payment. Revenue and federal compliance activities are also bundled in this initiative. We’re looking at funding for staff of $1.3 million included in this effort, but a reduction of costs $5.1 million in the first year and $5.9 million in the second year. We expect to strengthen our rebalancing efforts under the Money Follows the Person program. We’ve currently transitioned some 5100 people from long-term care facilities, back into the community for living. This reflects an additional 800 transitions beyond what’s in our baseline for the second year of the biennium. Funding for staff and support services for $1.5 million and $1.2 million in the respective years is included, but we also expect to see a reduction of $3.5 million in the out year of the biennium. We will also seek to explore enhancing our Pharma purchasing power by expanding on what we are currently doing. We are part of an eight-state consortium where we pool our purchases and are receiving a tremendous support through rebates, but we’re going to see if we can’t do a little bit better than that. I look to bring in or reduce our costs by another $3.5 million.
Slide 16, we seek to institute a value-based component for certain hospital payments by reducing payments by 15% for readmission within 30 days of discharge for a related diagnosis. Our neighbor to the north does not pay for any readmission for Medicaid. We think 15% is just enough to help change the process so that we focus on those dismissals that may need a little bit more care and attention. We’re looking at a reduction of $2.0 million in the first year, and $2.4 million in the second year. We want to reduce excess nursing home capacity through rebasing nursing home rates. We believe we are over bedded in the nursing facility sector and we also will eliminate stop/loss provisions for home with low census or very low federal quality measures scores. So on one hand, we’re increasing the quality of the beds. On the other hand, this is an attempt to take out those lower performing facilities or those beds and service. Reduction of $2.4 million in the first year, $2.9 million in the second year. The implementation of a 1915(i) waiver for home and community-based services, including supportive housing for approximately 850 Medicaid recipients who have experienced homelessness, and whose average Medicaid costs exceed $40,000 a year. This is an opportunity to try to be creative in addressing some of the needs of high costs, high utilization members and those who may need a house, or a home, or a residence. We seek to try to acquire that through this 1915(i) waiver. Reduction of $0.6 million in the first year, $3.1 million in the second year.

Slide 17, we’re going to step up the expansion of step therapy for additional drug classes. This helps to make sure that we’re using the right
pharmacological intervention for the treatment. Oftentimes, there are tried and true referrals or prescriptions. We want to make sure the right prescription for the right patient is in place for these drug classes -- for these treatments in particular. We can expand this as we find more success. Reduction of $0.5 million in the right year. $1.8 million in the second year.

Subjecting diabetic test strips and lancets to a special type of preferred drug list, reducing supplemental -- generating supplemental rebates to the state is another approach we want to test out. A $0.2 million increase in the first year, reduction of $1 million in the second year.

The last bullet on page 17 seeks to implement a diabetes prevention program, utilizing innovative health network administrator supplies -- or suppliers of diabetes prevention programs through our medical ASO. I think we’re going to tag onto the evidenced-based community -- CDC program that has been put out nationally, and we believe that we can get some benefit out of that program through our medical ASO and other providers.

Slide 18, hospital user fee will continue at the existing state fiscal year 2019 level of $900 million dollars, the Governor’s recommended budget also includes hospital supplemental payments of $453.3 million, $40 million under the state fiscal year 2019 expenditure amount of $43.3 million, and this is to ensure that the state does not exceed the federally allowable upper payment limit; meaning that the Medicaid payment stays below the Medicare payment. Of the total for hospital supplemental payments $15 million in 2020, and $45 million in
2021 will be set aside for quality based payments. This is an area that we still need to do some developmental formulation, but we believe that this will help to increase the quality of services that are provided through the hospital sector. Funding for adjustments to the 3M grouper reduction to DRG-based payments is included at the state’s share cost of $59.1 million and $61.8 million in the 2 years of the biennium. Those -- that would be $171 million and $177 million gross to include the federal share.

Slide 19 funds to support the development of a plan to get -- address the state’s gaps in substance use disorder using possibly 1115 waiver is included in the Governor’s recommended budget, an increase of $0.5 million and $0.25 million in the second year to begin to develop this plan to address those gaps that might exist within our treatment plan. And then funds to support the expansion of the Person Center Medical Home Plus model to address duals. You might recall several years ago we attempted to negotiate an arrangement with CMS where we would partner to better support the dual eligible within our Medicaid program. The duals represents 11% of our population but they drive close to 50% of our costs and so we believe that we might be able to tackle this through the PCMH+ program. We hope to implement this program no later than January 1, 2023, but there is some setup work to do. We have $0.75 million included in the 2021 budget to begin to do that planning effort.

On the very last slide that walks through the budget changes that we noted, the budget also moves rate increases for boarding homes under our state supplement assistance programs by $1.7 million in the first year, $3.7 million in the second year. We
continue to fund protective services for the elderly under the Social Services Block Grant, that’s a $0.6 million reduction in both years for the -- and then removes the cost of living adjustment for public assistance recipients under TFA and SAGA, and State Supplement to $2.6 million the first year, $4.8 million in the second year. The next to last bullet annualizes the holdbacks for this current year under the Community Services and Family Program, TANF accounts and that equates to a $0.4 million reduction in both years and funding State police in DSS field offices has also been removed under this budget in both years, and that’s $0.4 million we will seek to partner with the town police officers for those services and where not possible, we’ll look for security guard services.

Again, we want to thank you for the opportunity to present the Governor’s budget for the Department of Social Services. We look forward to working with you over the coming month to get to a budget that we will implement and we will implement successfully over the next two years of the biennium. With that, I’ll pause and stand for questions.

REP. WALKER (93RD): Do you want a swig of water or something? [laughing] Thank you, thank you for your presentation. I’m just going to jump in real quick and go to my favorite one, the hospitals. So, the one -- first of all, the one thing that I -- I mean going back to page 18 on your slide, I understand the user -- the first two bullets. The second one is this hospital supplement payments of $15 million and $45 million, it’s a quality-based payment. Can you explain that to me please?
ROD BREMBY: Sure. So, hypothetical, if we identify with partners that there are --

REP. WALKER (93RD): Do me a favor, bring the microphone near you. Thanks.

ROD BREMBY: Sure. Let’s just say that -- let me just use the - what the Medicare currently does. Medicare has a quality-based program for hospitals across the United States. They reimburse based upon hospital acquired infections, or readmission rates. We want to look for opportunities where we can gain share with hospitals to look at areas where quality may not be as high, and so as to use those supplements as a way to incentivize better outcomes across a level -- a set of services within the hospital.

REP. WALKER (93RD): So you mentioned readmissions. That was one of the things that I did see that was over to the side, and I saw the -- you were planning on a reduction in that cost area, correct?

ROD BREMBY: What is in the Governor’s recommended budget is a 15% reduction for readmission within 30 days. We’ve also included in that, that features that you cannot also readmit in an observation status.

REP. WALKER (93RD): What does that mean?

ROD BREMBY: Under the Medicare program, where they look at quality outcomes, from time-to-time, some facilities will readmit a patient, not as an inpatient but in an observation status so as not to be seen or penalized for a hospital readmission. We would like to begin this conversation with a 15% reduction for readmission within a 30 day space, but
also include readmissions and being readmitted to an observation status.

REP. WALKER (93RD): So you want to reduce the observation status by 15% along with readmission, or are you excluding it? Am I missing that?

ROD BREMBY: We want to reduce the payment for the treatment by 15% if the person comes back to the hospital within 30 days, whether they’re admitted inpatient or that there’s an observational status for which they come back to the hospital. Either one, we’d like to code that as a readmission so that the payment is reduced by 15%.

REP. WALKER (93RD): And coding is the next term. The 3M. Okay, so the -- when we made the transition from the ICD-9 to ICD-10, that was definitely a challenge for the hospitals and for a lot of other people. We are looking at making whole the hospitals for that reduction, am I correct on that?

ROD BREMBY: Within the budget, there is an allocation that is identified for to restore -- let’s see, we have $59.1 million in the first year, and $61.8 million for the second year, that’s the state’s share. The application of the grouper with the modification of going from ICD-9 to ICD-10 created some noise in the system. It was not anticipated but the Governor’s budget does recognize a return of these dollars, $59.1, and $61.8 million to the state budget.

REP. WALKER (93RD): So in that, in that change going from ICD-9 to 10, we had a loss for the hospitals. So we’re trying to go back and provide them back with those Medicaid rates that they seem
to have lost funding for under the ICD-10. Are we considering going back to ICD-9, can we do that? No?

ROD BREMBY: No, there is a conversation underway and the mechanics of which we would step into that is ongoing. So, ICD-10 is the most accurate way to charge for services. If I were to just use a layman’s description of the difference between ICD-9 and ICD-10, the older code used to perhaps look at an extremity as a site for a procedure. ICD-10 may tell you which extremity and which area of the extremity that procedure is taking place. So we really want to get the best description of the services that are provided. Loading that 10 into the base was something that 3M did and we were unaware and so I think that this is -- there’s a conversation currently underway with the Hospital Association and the administration to try to get some common ground.

REP. WALKER (93RD): I will tell you that I had to go for a physical and I was talking with my doctor. And as we were going, I noticed she had the coding number over there. And so as we talked, she talks in a little bit and then she goes over and does another code, then we talk a little bit, then she goes and she types -- so finally at the end of it, I sort of monitored how long we spent. I said how long do you spend in doing coding? She says for every hour I give you, I probably spend about 2 hours in doing coding. I don’t want my doctors to do that. [laughing] I want them to talk to me. So, I want us to figure out how -- and I’m -- I understand we have to manage healthcare without question, we have to manage the cost because we do have the ebbs and flows of, of funding. But I worry
that my doctor is becoming an accountant more so than being the administrator of my health care. So in looking forward -- and I also read that the transition to the ICD-10 is nationally a problem.

RED BREMBY: Yes. It’s a national experience.

REP. WALKER (93RD): Yes, I, I, I know [laughing] and so I -- in looking at some of the things that I’ve talked about in doing this whole process are -- is CMS leading the conversation about addressing this transition or is does it -- is it going to fall on each state to make that determination and adjustment? Because I mean I think that -- I tried talking to NCSL, National Council of State Legislators and to find out a little bit more about it, and they said all states are going back to CMS and complaining, but that doesn’t help our hospitals nor does it help us in the -- so do you have any suggestion on how we can go forward with this to try and address this problem? Because until we figure it out, it’s going to continue to be a problem.

ROD BREMBY: So with the exception of the example that you shared which is provider transition to technologist. I think that is grouper issue, the adjustment from 9 to 10 is a short-term issue. Longer term we may forecast what happens when and if there’s an ICD-11. It took a long number of years to go from 9 to 10. I mean, people pushed back against that a lot. But, I think doctors of our state would agree that we have to find a way to integrate the best information with the technology without turning providers into technologists. It is -- it’s causing disruption in the, in the system. A lot of people who came to the field to want to help people, to treat people, find that they spend more
time trying to figure out how to get paid for that services. And so --

REP. WALKER (93RD): So -- but -- I mean, does the fault lie with 3M, does the fault lie with CMS, does the fault lie with us for using 3M? I’m trying to figure -- I know everybody uses 3M, I know that, but --

ROD BREMBY: So today, I’ll just put on my policy hat for a second and I think the fault lies in the system that we have nationally to pay for health care. So we do the best we can, all states, with finding the most expedient and efficient route to make payments, but if this is a business, then we have to figure out how people are going to get compensation. So the challenge is how do we make this whole system better?

REP. WALKER (93RD): I agree, and I hope this conversation really does continue because it’s really, it’s important for a variety of reasons. I don’t want to go into all the litany of the different things that are impacting. So I’m going to leave it at that. Representative Abercrombie.

REP. ABERCROMBIE (83RD): Thank you, Madam Chair. Good afternoon, Commissioner and to your staff for being here. On, on page 8 of the budget packet we’re looking at, strengthening the rebalancing efforts under MFP. How many currently -- how many individuals currently are we authorized to have under this program, and how many do you want to increase to with the support of seven new positions?

ROD BREMBY: So, the -- the enhancement seeks to bring on another 800 transitions above the baseline of what is imbedded in the program. We would like
to -- I don’t know what the universe of possibility is, but we know that 800 is a good movement above the base. Dawn is here, I think, and can tell you what that universe is. But we are stifled at some point from moving more people because of the lack of available housing and space in community. We believe 800 is reasonable for this next biennial.

REP. ABERCROMBIE (83RD): And how many do we currently have on the program right now, about?

ROD BREMBY: We’ve 5100 out of long-term care facilities into community for lesser restrictive environments. We’re also looking for innovative ways to partner so that individuals can live together perhaps in the community and get services that are shared. So we’re looking at being very innovative in this approach.

REP. ABERCROMBIE (83RD): And then two questions, Madam? And then under the TFA, there’s a reduction in each year. I think it’s 12 -- where was it? There’s a reduction in here under the temporary family assistance. Yet in your -- this packet, right, on page 26 and 29, you talk about increases that you need for some of these programs, and you list the TFA. So on one hand you’re saying a reduction because of individuals coming off the program, but in the other hand, you’re saying you need more for increases. So I’m just trying to figure out where that lies.

MIKE GILBERT: Thank you. The particular change that you

REP. WALKER (93RD): And who might you be, sir?
MIKE GILBERT: Sorry, Mike Gilbert, Chief Financial Officer, DSS. The change that you see is an aggregate change across all programs. So when you see that increase, it’s, you know, driven by many different changes. Some in a positive direction -- on the net, in a positive direction, but some are decreasing. So, it’s a compilation of changes across all of the programs that are listed. The TFA program, as you know it, is a program that had a significant downward adjustment to reflect caseload trends. So while it’s in the mix, that increase would actually be a little bit higher if it weren’t for the TFA decrease. So we are seeing some significant reductions in our TFA caseloads, have been seeing them for many years. That trend continues. You know, we had over 14,000 clients on TFA back in July 2017, and in the month of January of this year, we recently broke the barrier and now into the 10,000 -- high 10,000 range. So, you know, that decrease in TFA is purely a caseload adjustment. It reflects the continued decline in caseloads, which you know, have been evident for many years now.

REP. ABERCROMBIE (83RD): So in the future, as you put this packet together, right? I wouldn’t include them in the definition of increases, but it gets very confusing when you’re trying to do apples-to-apples. Just FYI. Oh, that’s my two questions. Thank you. Put me on the list for round two.

REP. WALKER (93RD): Got it. [laughing] Senator Osten.

SENATOR OSTEN (19TH): Thank you very much, Madam Chair. Commissioner, can you tell me how many
positions, you have 1968 -- does that include your federally funded positions?

ROD BREMBY: Those are authorized state positions, they do not include all federally funded positions.

SENATOR OSTEN (19TH): Can you give me the -- can you -- to the working group, can you bring the number of federally funded positions there? The 1968, does that include -- are all of those positions in your personnel services line item?

ROD BREMBY: Our personnel line item funds all positions under the authorized position count.

SENATOR OSTEN (19TH): And is that number different than the 1968?

ROD BREMBY: Yes it is.

SENATOR OSTEN (19TH): And what is the authorized position count?

ROD BREMBY: Well, that number is the authorized position count, the real position count as of 02/28, is something like 1634.

SENATOR OSTEN (19TH): And of those 1630 -- say it again?

ROD BREMBY: 1623 is the number of positions that we have on board as of 02/28 this year.

SENATOR OSTEN (19TH): And do you have unfilled positions that you are filling?

ROD BREMBY: We have some 300 unfilled positions, and yes, we have some in process.
SENATOR OSTEN (19TH): So, [laughing] You have $131,193,200 in the personnel services line item. How many positions does that fund?

MIKE GILBERT: So at this point in time, we’re still working our way through some of the detail around the Governor’s recommended package, but we believe that that would somewhere --

SENATOR OSTEN (19TH): That’s in your package, but --

MIKE GILBERT: I’m sorry?

SENATOR OSTEN (19TH): No, the 1960 is the agency requested.

MIKE GILBERT: Yes, 1986 is our full authorized count. We anticipate --

SENATOR OSTEN (19TH): 68.

MIKE GILBERT: We anticipate that with the funding that’s given to us, we will be able to fund somewhere around 1800 positions, but we’re still looking at refining that estimate to get a more precise number.

SENATOR OSTEN (19TH): And so I -- what I would like at the working group is how many positions do you have that are federally funded that the people are working at. And how many positions do you have that are currently working, and how many positions do you have that are currently funded but unfilled. So those three numbers if I could get those.

And then I have one question on protective services. The protective services elderly funding is lower in the Governor’s proposal, what would not be funded if
only -- with -- what is not going to be funded with that $557,000 decrease?

ROD BREMBY: We have identified a different funding source for that. That is CSGB. SSBG for protective services for the elderly. That accounts for the decrease in the Governor’s budget.

SENATOR OSTEN (19TH): And where does that show up in our budget?

MIKE GILBERT: So that would -- in the budget pages that you’re looking at now, the federal funds are not detailed, so that would traditionally be identified one, through our SSBG blocker which comes before the legislature in the summer. There is an additional document which can be accessed online where I believe there is some additional detail around federal funds that are delineated based upon the Governor’s recommended budget presentation. I haven’t looked at that closely, but it may be identified in that particular document.

SENATOR OSTEN (19TH): So to the working group, can you bring to us, if there has been a cut in a particular program, what -- are we actually seeing a cut, or is that being funded from another source, okay? Thank you. Thank you, Madam Chair.

REP. WALKER (93RD): Thank you. Representative Dillon.

REP. DILLON (92ND): Thank you, Madam Chair. Good afternoon and thank you very much. I just have two questions for this round, I think. The -- I’m not really sure where to go with this whole [inaudible - 01:11:25] but I asked the Secretary [inaudible - 01:11:28] to outline for us what the new Governor’s
policy is for access to mental health and addition services, and since then we’ve enjoyed last Friday going through pretty dramatic change, I think, to the delivery system for mental health and substance abuse, and a lot of cuts, and we also saw a million in new money for opioid treatment for people in prison. Now your budget has about a $1.5 million in consultant’s fees. I think $750,000 of it is for a consultant to work on opioid. I’m trying to look at this time all of the leads that we’ve gotten in the budgets where there are cuts to direct service, there are increases in treatment in prison, and now we’re looking at consultants, and try to divine what the Governor’s vision is of access to mental health and addictions. And I know that that’s a big question and we have a lot to do today, but, but, for your piece of the budget, I wonder if you could bring some information to the work group so that we could work through that particular issue and understand exactly why we’re looking at the changes we’re looking at.

ROD BREMBY: We’d be happy to bring back more information to the study group or the work group. What I can tell is that we have a multiagency task force that’s looking at the entire continuum on how to get our arms around this opioid epidemic all the way from what’s happening in our correctional facilities to make sure that treatment is available there so when people leave the facilities, they are graced by a provider so that there’s no drop off there. This group is actively [bless you], looking to see if we can’t identify the 1115 waiver to kind of sure up those gaps in the continuum services so that we can be more effective in preventing and also
treatment opioid addiction. We’d be happy to bring the information back for you.

REP DILLON (92ND): That would be really, really helpful. And for the past three years, we’ve had problems in -- with autopsies [laughing] because of unexpected deaths of young people from opioids. So that we’re feeling that everywhere, but we are looking at changes here, so that would be great. Thank you very much.

And for the next question, because I’m totally addled about this ICD-10 question. [laughing] If you could bring back some more information to walk us through. I was -- when I was reading the sheets when we first got them, besides remembering very clearly the roll out of ICD-9, and what it did to our lives, and that was a long time ago. The theory would be that, that the information here should be more granular. The, the theory should be that the, the model has always been that it allocates resources within the dollar amount that we set. It wouldn’t tell us how much we should spend in the aggregate, it -- but it might direct resources from one category to another for example, depending on what it sees. So when I saw the 16% drop, it was -- it didn’t look right to me because it wouldn’t seem to me that a third-party model should be telling us how much money to spend in the aggregate. It could be directing us to what’s going on in our state, if that’s coherent. So, I’m sorry, go ahead.

ROD BREMBY: No, I was just going to say we would be happy to bring back the information, how the framework is set up for the payment.

REP DILLON (92ND): Very much, because it looks like there’s a national model here that wasn’t adjusted
for Connecticut historic spending. And I don’t know if that’s what happened, but that’s the only thing I could think of looking at it. Thank you. And second round too. Yes Ma’am.


REP. CASE (63RD): Thank you Madam Chair. Good afternoon Commissioner. I have a bunch of questions but just -- you can bring it back to the working group. One of my big ones was, I know Representative Abercrombie, we worked a lot last year on the Lean Process. Where do we stand with that as far as savings in this budget? And you can bring that back if you want to, but we’ve spend a lot -- seven days putting agencies together and if we have anything that came out of it that can show in this budget for saving, because a lot of good things it showed in there.

My first question is, obviously, you can bring back to the working group is the Medicare savings program, and how we get there as far as -- we’re going to go off the federal asset test. I know we’ve been asking for asset tests, but I don’t know if we can draw up our own, and if that asset test that we’re doing, I know it take nine people according to your budget here to do that. Is that something that we’re going to be holding on to the database and making sure that we can just keep going forward and soon enough, it can be just standardized and we won’t need those positions to do?

And lastly what concerns me with the DSS field offices. You have -- which I didn’t realize until I thought back State police officers in there doing that. You’re talking about working with local
government. To bring local police officers? Have you had the conversation yet with the State police?

ROD BREMBY: We have not begun to have the conversation with anyone just yet about how to source or resource the security for the offices.

REP. CASE (63RD): Cause that’s what happened with Higher Ed, they went ahead and did it with the locals at the Community Colleges and a grievance went through and now the State police are back in there and the local towns are out, and we were going to save money with the local towns. But because they’re a state building and state employees, the State police officers had the right to protect. That’s what came out of it. It was a good working relationship with the local police officers because it’s a lot of the local people going into those offices, a lot of local people going into our Community Colleges, but because of the nature of whose buildings they are and who is in the buildings working I think that’s the way it happened. So I was just curious if there was a preempted conversation with the State police.

ROD BREMBY: No, we have had local police officers providing security in some of our offices in the past, so it wouldn’t probably be much of a transition to return to that. Many of our facilities are leased, so they’re not State buildings, but we’ve not had those conversations to answer your question.

REP. CASE (63RD): Okay, so it’s really -- it’s not a dedicated savings at this point of the $380,000, it’s hopeful that we’re going to get there.
ROD BREMBY: It’s in the budget, we anticipate making that savings.

REP. CASE (63RD): Okay. I look forward to talking to you in the working group. Thank you. Thank you, Madam Chair.

REP. WALKER (93RD): Thank you. Senator Somers.

SENATOR SOMERS (18TH): Yes, good afternoon Commissioner. Thank you for being here. And I have a lot of questions, so I probably will just ask you a couple and I’ll put them in writing so everyone can see your answers when you have time to get back to us. My first question, though, has to do with the funding to reflect decreased hospital payments due to the readmission rate. So right now, if you have a Medicaid patient and they have a multitude of comorbidities like chronic heart disease, and they get into the hospital, stabilized, and then they’re sent to the nursing home. With that type of disease, it’s very often the nursing home can’t handle it and they’ll send them back to the hospital. So the nursing home is gigged for sending them back, and then the hospital, if they get readmitted, which many times they do, what percentage payment of the original Medicare payment is the hospital getting right now on readmission?

ROD BREMBY: Um, I believe that varies by hospital. The Medicare penalty ranges from nothing to I think a maximum of 2% of all Medicare claims for that facility. So it’s not a per, per readmission issue. For us, we’re just looking at the distinct readmission, looking at 15%.

SENATOR SOMERS (18TH): So you’re looking at the total readmissions? Is that what you’re looking at?
ROD BREMBY: No, we’re looking at each individual readmission, 15% of those readmission that would be subject to this penalty.

SENATOR SOMERS (18TH): Okay, I might not be understanding your answer correctly. It’s my understanding that, you know, a patient is in the hospital and the hospital bills based on codes for Medicaid reimbursement. Then they are sent to -- I’m just making this up, a nursing home, and something related to what they were -- they had in the hospital causes them to have to go back to the hospital, and upon readmission, they are not -- the hospital, unless I’m wrong, is not reimbursed the same rate. Sometimes I’m told they’re not reimbursed at all for that readmission if it’s the same issue that they had, is that correct or incorrect?

ROD BREMBY: No, we’ve been reimbursing. Yes.

SENATOR SOMERS (18TH): Okay.

ROD BREMBY: We have reimbursing.

SENATOR SOMERS (18TH): Okay. So is it reimbursed at the same rate as it was originally billed for?

ROD BREMBY: I believe it’s whatever the condition is.

SENATOR SOMERS (18TH): Okay. And so you want to take 15% off of that char -- whatever that reimbursement is, depending on the hospital it’s different, off of that service.

ROD BREMBY: That is correct.

SENATOR SOMERS (18TH): Okay. I just wanted to make sure I understood that right. So you’re telling me
that when a hospital -- I just want to make sure because I’m not hearing that from the hospitals, that’s why I want to make sure I’m correct. So a patient comes in with chronic heart disease, they’re in there for three days, they go home to the nursing home, they find something wrong, they have to send them back, you are reimbursing them for readmission?

ROD BREMBY: We are paying the hospital. We are reimbursing the claim that’s submitted for treating people, whether they have been released once or twice, and come back for the same condition.

SENATOR SOMERS (18TH): Okay. That’s different than what I’ve been told many times. So I just want to make sure I’m correct. All right, so that was -- I’m glad you clarified that. And then my next question.

ROD BREMBY: Senator, just to be clear, Medicare and Medicaid will reimburse differently.

SENATOR SOMERS (18TH): Oh yeah, that --

ROD BREMBY: So the hospitals might be saying for Medicare.

SENATOR SOMERS (18TH): No with Medi -- I just wanted to make sure, that’s why I’m asking that. To make sure. I know Medicare is different, I just wanted to make sure I was clear on that. Okay, and then -- but -- and I kno -- I realize that each hospital is reimbursed differently, Medicaid rates are different based on a percentage of Medicare, I am assuming, right? So, I have a lot of questions, so I will just go to one more so we can have it here, which is. When you go -- when you talk about the diabetic supply program, you talked about going
out to a manufacturer and only bidding a manufacture that would agree to pay the state a rebate. Is that correct?

ROD BREMBY: Yes.

SENATOR SOMERS (18TH): Okay. So what happens to that rebate when it comes back into the state, where does that go or where does that end up? What fund does that go in?

ROD BREMBY: It comes back to the General Fund as a revenue account.

SENATOR SOMERS (18TH): Okay. Do you know how --

ROD BREMBY: Hang on a second.

MIKE GILBERT: I’m sorry, just a little bit more precise as that, it actually offsets a -- it’s posted as an offset to the Medicaid account expenditures. All rebates come in as offsets to Medicaid expenses as opposed to going directly to the General Fund.

SENATOR SOMERS (18TH): Okay. And then, I’m just writing that down. My last question and then I’ll stop, but I still have more, so it’s -- do you think that your department has taken advantage as much as possible for federal reimbursement through the Labor System that up -- that are available? Or do you think that you could do more through trying to capture more federal reimbursement?

MIKE GILBERT: Of the Waiver systems?

SENATOR SOMERS (18TH): Yeah, you have an ability to apply for certain waivers for Medicaid services for let’s say college students.
ROD BREMBY: So I believe that we have taken advantage of a large number of labors actually on the Medicaid side. We probably have more waivers than just about any other state, but yes, we have taken advantage of a lot of waivers.

SENATOR SOMERS (18TH): Are you familiar with other states, how they have applied for waivers for -- to be able to deliver Medicaid services to college students differently?

ROD BREMBY: We have explored that over the last several years, and we would be happy to continue to explore that. It has not been our experience -- we’ve not seen an experience that results in I think what was identified or hoped as an opportunity for Medicaid to provide services for college students. But we’d be open to assessing and continuing that dialogue.

SENATOR SOMERS (18TH): Okay, thank you. The rest of my questions, if we don’t have a second round, I’ll just put in writing and send. Okay. So I’ll ask them in my second round, thank you.

REP. WALKER (93RD): Commissioner, in the budget, the budget that we have, there’s a reduction in the number of nursing home beds, and have you all evaluated with the reductions with the nursing home beds that are in the budget, what the impact will be for the state? I know you made a comment that you said we were over bedded. So, do you have that information and can you provide that to us?

ROD BREMBY: We believe that we can provide that. We have assessed where the state is over bedded and we’re -- yes.
REP. WALKER (93RD): Is it -- right now, where are we with the number of beds that we have?

ROD BREMBY: My number is 3000.

REP. WALKER (93RD): Mm-hmm. And the reduction that you’re asking for in this budget is approximately 15% less? 10% less?

MIKE GILBERT: So if I could try to answer that. The reduction that we’re looking at here is an adjustment that we’re making to rates to take into consideration two things, one is if the home has a low census and one is if a home has the lowest quality rating. So, as part of an entire rebasing analysis, so we rebase rates periodically. So we’d be doing a rebasing analysis of the entire structure, so it’s very difficult to predict exactly how many homes -- to what degrees, home would be affected until that rebasing is complete. So, you know, somebody will be able to do that analysis over the next few months in detail to understand this better and how it relates to rebasing. But in particular, and the only other piece I would add to that, it’s difficult to then predict what the impact will be on a particular home, depending on here those rates fall out. So get a precise number of how many bed would be reduced is difficult to do. You know, we have tried to estimate that and it could be as much as half of that differential, you know, between the -- of the 3000 number that was put out there.

REP. WALKER (93RD): Okay, I’d like to see that in the work session. I’d really like to see exactly what you’re Con -- and what your ideas are and how you’re going to -- because of the impact, one it has on the availability for seniors, but we have a
variety of other people utilizing those services, but also for the number of people employed too. So we need to look at all of those. Okay. Representative Abercrombie for the second time. Go right ahead. Go ahead, I didn’t see your hand.

REP. MASTROFRANCESCO (80TH): That’s okay, thank you, Madam Chair. Very nice to see you again Commissioner. Thank you for coming. The asset test, and maybe could have asked this question and I might have missed it. Do you know exactly how many individuals would be affected by the asset test?

ROD BREMBY: So, we have and est -- we have estimated what the impact of the application of the asset test would be. Let me see if I can’t get to my information here. Roughly 10% of the MSP population.

REP. MASTROFRANCESCO (80TH): Do you have a number of how many that represents? Ten percent is how many people?

MIKE GILBERT: So we currently have approximately 180,000 people on the program at this point in time. So it would be 10 -- approximately 10%.

REP. MASTROFRANCESCO (80TH): 18,000 -- okay, so 10% of the -- okay. And the staff that you will need to -- for the system changes for that. Are those new -- new employees or are they existing employees doing additional work?

MIKE GILBERT: No, those would be new employees.

REP. MASTROFRANCESCO (80TH): And will they be working on just that or are there other programs that they can assist in as well?
ROD BREMBY: We expect that they would be working on this, although 50% of their cost is offset by federal reimbursement.

REP. MASTROFRANCESCO (80TH): Okay. Thank you.

REP. WALKER (93RD): Thank you. I just wanted to ask, the Hospital Association says that the, the difference on the rates is $230 million and yours says $170, do you know why there’s a difference?

ROD BREMBY: I think that’s trying to get resolved. But that’s the number that’s in the Governor’s recommended budget.

REP. WALKER (93RD): The $170?

ROD BREMBY: Yes.

REP. WALKER (93RD): Okay. All right, well we’ll work on that one too. Okay, so everybody from the -- no, Representative Johnson.

REP. JOHNSON (49TH): Thank you, Madam Chair. And thank you so much for your presentation and all the good work that you do. I do have a few questions. You may not be able to answer some of them. So hopefully you would be able to give me the information at our meeting. The first one is, you mentioned that you think approximately 18,000 people will be affected by the MSP asset test. Why those numbers for the asset test? As a general rule, when you have asset tests, they tend not to go to elderly people because they utilize some of their assets to maintain their lifestyle, and when you look at that, I was wondering if you were including 401K’s, pensions, those kinds of things when you take a look at the assets, particularly, I guess, 401Ks and Annuities would be something that people utilized as
their income, which would then bring them way down below the, the -- their income level as well, so you’re really going to have a bad impact on their ability to sustain themselves in the communities.

ROD BREMBY: So, what is in the budget is a plan to be consistent with federal rules. The resources that would be countable, would include money in a checking or savings account, stocks and bonds. As I mentioned earlier, the individual’s home, one car, burial plot and up to $1500 in a burial account and household and personal items.

REP. JOHNSON (49TH): I understand the Medicaid standard for, you know, asset exemptions. What I’m asking you is, how we arrived at the ones for the Medicare as a secondary payer program. So that was -- and they seem like they’re fairly low and then you have, of course, the Annuities. So, I mean maybe something in writing would be helpful for me to be analyze it, but I do have a huge problem with bouncing people off this program, particularly when it has a huge impact on their ability to stay in their homes or continue tax payment on their car. So it’s really going to have an impact on the lower income people.

And the final question I have about MSP is, what areas of the state do you think will be most impacted by the asset limitation? You don’t have to answer now, but it would be fine for that.

The next question I have is, state assisted general assistance, it looks like a huge reduction. So, what is going on with that reduction with SAGA?

MIKE GILBERT: So this is another case where the changes that you see there are representative of
changes in caseload trends. So, in the SAGA program as in the Temporary Family Assistance Program, you know, we are seeing decreasing caseloads and so the adjustment for funding there, not a policy change, just reflective of anticipated trends around case loading costs.

REP. JOHNSON (49TH): Thank you for that. Are you correlating the TANF and the SAGA costs with the increase in homelessness?

MIKE GILBERT: So we are not exactly making that relationship when we do these projections. We are actually just forecasting what we see in terms of trends in the accounts, you know, based upon the eligibility qualifications for the programs.

REP. JOHNSON (49TH): So what I’m seeing in my district is a huge increase in homelessness. So we have more homeless families. We have more people living on the river. We have people who are moved into areas behinds people’s homes. So we do have a problem with homelessness, and this has been taking affect over these periods of time where we have these decreases in TANF where we’ve gone to 21 months, now we have many more people who are homeless in my district and also with SAGA. SAGA used to be able to give a -- and in fact, I have a Bill in where SAGA was -- you were able to get a voucher, and get a place to live. Those programs are now $215 a month, isn’t much even to buy -- I don’t know what you buy with $215 a month. But, it could be that, you know, we’re having a real problem with creating and overflow of homelessness and we’re going to create more difficulties, as you probably are aware, senior housing is not really as readily available as it was, so going back to the problem
with Medicare savings program, if we bounce people out of their homes because they can’t pay the property tax anymore, then what’s going to happen is they’re going to be trying to find a place in senior housing, and we’re not building much of that. So you’ve got a hard job, I thank you so much for your work. Whatever you can do to fill me in on some of these details I would be most appreciative of. And I thank you so much, Madam Chair.


REP. ABERCROMBIE (83RD): Thank you, Madam Chair. Talking a little bit about the step therapy, two questions. One, how did you come up with the illnesses for the step therapy. And then two, under the step therapy, I think we have dispenses as written, would that still be included under the particular illnesses?

ROD BREMBY: I think -- the second one I’m going to need to check in with Dr. Jervoski (sp?) on, but also the first set, those were chosen just by reviewing what other states may be trying to do, some that are manageable. But in terms of dispense as written, I believe that that is where we start, is that not right?

REP. WALKER (93RD): Maybe Dr. Jervoski (sp?) would like to come up here?

ROD BREMBY: Yes, it will be dispense as written. He also said that there are not a lot of choices with these medications, with these conditions. So this is our first entre into this area.
REP. ABERCROMBIE (83RD): Okay, yeah, I would be curious to see with the savings that you have, you know, listed there with those particular diseases. And then, I think that my colleague asked you about the MSPS asset test, and I apologize if she asked this, I wasn’t sure. Did she ask you about a look back in this program? Would this be something that we do, a look back on this? And what would be the benefit or not a benefit doing look back for MSP?

ROD BREMBY: She did not ask about a look back, and we’ll need to bring that information to the subcommittee work.

REP. ABERCROMBIE (83RD): Okay. That would be helpful. And that’s my two. Thank you, Madam Chair.

REP. WALKER (93RD): Thank you, I just wanted to ask, in the Governor’s budget, it, it seems that the Governor is calling for removal of public hearings for nursing home closures. Is that true?

ROD BREMBY: Certain closures, yes.

REP. WALKER (93RD): Certain closures?

ROD BREMBY: Not all closures, but certain closures. But for low occupancy, yes.

REP. WALKER (93RD): Okay, all right. Well, I think I’m a little concerned because one, we are supposedly going into a phase of transparency at a higher level and accountability, so I’m concerned about having anything done without having any public observation or opportunity to input, so I’m going to sort of weigh in very clearly on something like that because we need to know exactly why and how. I mean if it’s -- everything is clear and everything is
based on facts and everything, then there should be no reason to do it without any type of hearing. It’s got to be public and it’s got to be available for us to hear about it, because that’s what we expect from our government. So I’m not at all thrilled with the idea of that. Representative Dillon.

REP DILLON (92ND): Thank you very much, Madam Chair. Just brief questions. Going back, and I apologize, I did not hear all of Senator Somer’s questions so — and the response, so I guess I’m going to ask my own about the readmission. You cited Massachusetts. I guess my concern, and there is a question here [laughing] was that Massachusetts has an uncompensated care pool, yes? They adopted it the same year that we did. Ours was dismantled by litigation. Okay. Massachusetts also has a troubled hospital fund. You’re not eligible for aide if you’re for profit. So, that there is a net, and I supported the original uncompensated care pool, which of course was ripped up because, not so — just for the money, but because I believe that hospitals or doctors should not be punished based on their zip code. Because that very often drives your payer mix. There are some hospitals and some doctor’s offices, you’re not going to see shotgun wounds. You’re not — and I understand people are transferred around to different facilities, but if you’re looking at readmission, I need to be — I would really like to see how you’re doing it, because I would trust what they’re doing in that Massachusetts because I don’t believe that they’re going to punish in the city hospitals. I’m very worried given the history in Connecticut that the — even if that’s not the plan, that could be the
outcome, and there -- I would like to see the diagnoses that would be affected and make sure that certain populations of people would not be the issue. We have to think about that. And zip codes obviously would also affect my thinking about the nursing home closures. So, that’s the question. Please provide details about the impact on inner city or zip codes, it could be rural too -- when you do this 15% readmission penalty, given that we have no uncompensated care pool in Connecticut.

ROD BREMBY: Thank you.

REP. ABERCROMBIE (83RD): Senator Somers.

SENATOR SOMERS (18TH): Yes, thank you once again. I have a question on the removing the statutory rate increases or the elimination of the rate increases for the nursing home, and the intermediate care facilities and the boarding home. Can you tell me the last time that the nursing homes had a rate increase?

MIKE GILBERT: So the nursing homes received a 2% rate increase this year. I believe that was instituted in November.

SENATOR SOMERS (18TH): Okay. And what was the time previous to this one, if they have had one?

MIKE GILBERT: I’m sorry, I can’t answer that, but. So approximately two years previous, there was a wage adjustment for nursing homes.

SENATOR SOMERS (18TH): Okay, and do you know, how has that kept up with the cost to keep a patient in a nursing home? You know the, like the average cost of care per patient versus what they received in
reimbursement increase? I can ask that question in writing, sorry.

ROD BREMBY: We -- okay, that would be great. I’m sure we don’t have that.

SENATOR SOMERS (18TH): And then, also for the other facilities, but I’ll put that in writing. Then lastly, we’re talking about removing the [inaudible - 01:43:03] for the, you know, aid to the blind, aid to the disabled, etc. Could you tell me the last time that all of these listed accounts had a cost of living adjustment? Have they typically gotten one every year? Sorry.

MIKE GILBERT: If we could bring that to the work group, we’ll respond to your questions in writing. We can detail the history of that. It has been rarely -- it’s been very rare that have given increases of this nature.

SENATOR SOMERS (18TH): That would be great because then we could look at, you know, what the aid to the blind is now versus if it’s never had a cost of living adjustment, etc. That would be very helpful, but I will put all of this in writing to you afterwards. And I have additional questions, but I will hold them.

ROD BREMBY: Thank you.

REP. ABERCROMBIE (83RD): Senator, if you could send your questions to the OFA staff because they’ll do the list and send it over to DSS, this way we all have copies of that. Senator Osten.

SENATOR OSTEN (19TH): Thank you very much, Madam Chair. So, regarding the diabetic supply. Do you know why this was previously bifurcated by
ROD BREMBY: So, Herman Crance, who is our Pharmacy Lead says that under 21 was bifurcated because it was covered under EPTSD. It’s the different way to pay for it.

SENATOR OSTEN (19TH): And it’s not any longer covered that way, so we put it? So why has it changed now?

ROD BREMBY: Herman’s saying that instead of bifurcating making it all payable at a pharmacy. Ease of use, tracking against single manufacturer, multiple manufacturers, having the opportunity for rebates.

SENATOR OSTEN (19TH): So we have more money, we can get more imbursements by doing it this way, essentially?

ROD BREMBY: Yes, yes, pooling the purchase.

SENATOR OSTEN (19TH): And then, on the -- and this may have already been asked. The pharmacy purchasing pool work, does the current pool only cover certain kinds of medications?

ROD BREMBY: So it’s limited to only those drugs for which an agreement could be establish with the manufacturer for a rebate. But it is extensive in terms of the connections with manufacturers for rebates.

SENATOR OSTEN (19TH): And are you looking for other pools to for other medications to purchase?

ROD BREMBY: Potentially, yes.
SENATOR OSTEN (19TH): Is this something you just do on a normal basis, or is every year or every six months, or just on a revolving door. I’m not certain which.

ROD BREMBY: It has not been an ongoing review, but it is a strategic opportunity to take a look now. The state is performing extremely well in its amount of rebates, but we believe that there may be additional room to grow, new opportunities. We know that a large state to our west, far, far west, is looking to pool procurement or purchases across a number of venues, so maybe a relationship there might be beneficial, or a larger collective that is currently buying Pharma, so we’re just looking to explore to see if we can get an even better outcome on rebates.

SENATOR OSTEN (19TH): Okay. Thank you very much, Madam Chair.

REP. ABERCROMBIE (83RD): So, that’s all I have on the list right now for round two. Is there anyone that was not on the list for round two? Seeing none, do we go to round three, Madam Chair? Do we have more questions ladies and gentleman? Okay, anyone else?

REP. WALKER (93RD): That it’s. That was only an hour and a half, no. Oh, it was.

REP. ABERCROMBIE (83RD): But that’s all they have.

REP. WALKER (93RD): Oh, we only had an hour and -- oh, so we ran out of time. [laughing] [background laughing] Well thank you Commissioner, and I’m sure that we’ll be talking a lot.

ROD BREMBY: Thank you very much for your time.
REP. WALKER (93RD): Thank you, bye, bye. So, this concludes the agency portion of the Human Services Subcommittee meeting. We will re -- we will close and we will reconvene at 4:30, 4:30, 4:30, am I right? 4:30, we will reconvene at 4:30 for the public hearing portion of the -- of the day. Commissioner, we would love to have you if you’d like, come back and listen to some of the conversations that people are having. I’ve invited the Commission from DCF also to come back -- just to be part of the conversation and hear some of the things that people have to say, so thank you.

ROD BREMBY: Thank you for your invitation.

REP. WALKER (93RD): Thank you. [laughing] Good answer. Everybody have a good afternoon. [laughing]