CHAIRPERSON: Representative Catherine F. Abercrombie

SENATORS: Moore, Logan, Maroney, Haskell

REPRESENTATIVES: Abercrombie, Case, Pheanious, Butler, Cook, Dathan, Hughes, McGee, Santiago, Stallworth, Green, Mastrofrancesco, Sredzinski, Wood

REP. ABERCROMBIE (83RD): Public and you have three minutes. You'll hear a timer go off and we would appreciate you adhering to the three minutes because we have a lot of people that are here to testify today. So, will that, I'm gonna call up - oh, okay. So, I have to do something new. Okay. I've never done this before in 14 years. Yeah, I'm serious. Okay. So, just so people understand, I have to make the following announcement.

In the interest of safety, I would ask you to note the location and the access to the exits - I'm gonna be an airline stewardess - the two doors through which you entered the room, so the emergency exits are marked with exit signs. In the event of an emergency, please walk quickly to the nearest exit. After exiting the room, go straight and exit the building by the main entrance or follow the exit signs to one or the other exits. Please quickly exit the building and follow any instructions from the Capitol Police. Do not delay and do not return unless you - unless you are advised that the building is safe. In the event of a lockdown,
COMMISSIONER RODERICK BREMBY: Thank you. Good morning, Senator Moore, Representative Abercrombie, distinguished Members of the Human Services Committee. My name is Rod Bremby. I'm the Commissioner of the Department of Social Services. I'm here to testify before you on several bills before today's agenda. In the interest of time, what I'll do is not read the testimony, but I'll go through and hit the highlights and I'll stand for questions along with a distinguished panel of subject matter experts to my right and your left.

On S.B. 836, AN ACT HOLDING HARMLESS MEDICAID CLIENTS AND PROVIDERS AFFECTED BY AGENCY COMPUTER ERRORS. We're unclear about what the intent of the bill is in terms of any new computer system that would be modified, but the department is open to discussion with the proponents of this bill to better understand the specific issue that this bill is attempting to resolve. The department opposes Section 2 of the bill because it contradicts federal and state laws requiring the verification of eligibility prior to granting or issuing benefits. Applicants and recipients of benefits may appeal any department decision that aggrieves them including determination or denial of benefits. When appropriate, the department issues underpayments and provides retroactive medical coverage in the event that a hearing officer determines that the department has made an error that resulted in
incorrect termination or issuance of benefits. In light of these reasons, the department must oppose this bill.

For S.B. 837, AN ACT CONCERNING MEDICAID PAYMENT RATES FOR NURSE-MIDWIVES, DSS appreciates the intent of this legislation; however, we believe that the fee increase should be tied to improvements in clinical outcomes. The department's policy of paying nurse-midwives, nurse practitioners, and physician's assistants at 90 percent of the physician fee schedule dates back for as long as we have records of our fee schedules. What's interesting to note is despite the differences in training, experience, and debt between physicians and nurse-midwives, the department also recognizes the difference in comparison of clinical outcomes between nurse-midwives and obstetrical gynecologists.

Numerous studies show that when compared head-to-head, the outcome of women and infants served by a nurse-midwife are as good as if not superior to those served by an obstetrician. The Department of Social Services believes that equalizing fees paid to midwives, obstetricians, is an idea whose time clinically has come. The financial impact of this legislation, however, would be substantial, not only due to the extra payments to nurse-midwives, but also because nurse practitioners and physician's assistants will expect their fees to be increased as well. Because of these increased expenditures, the department cannot support this bill.

S.B. 898, AN ACT ESTABLISHING THE HISPANIC AND FELLOW COMMUNITIES OF COLOR NONPROFIT STABILIZATION AND GROWTH FUND. The department supports and
understands the value and importance of a strong and viable network of nonprofit providers. Without our nonprofit partners, we could not be able to support the various service needs of our communities; however, we do not agree that funds in the HRD Hispanics programs account should be diverted from direct clinical services, client services, to support economic development of a nonprofit provider. Specifically, Governor Lamont's budget for fiscal year 20-21 includes an allocation of $25 million dollars for nonprofit grant program administered through the Office of Policy and Management. The Department of Economic and Community Development is the state's lead agency for economic development and would be a more appropriate agency to assist with support for our nonprofit partners. To finalize, the Governor's budget does not include funds for this bill. We must oppose S.B. 898.

For S.B. 899, AN ACT CONCERNING CHILDREN WHO TRANSFER FROM HUSKY A TO HUSKY B HEALTH CARE COVERAGE. The department opposes this legislation. While children do move between Husky A and Husky B, the numbers are minimal. During a six-month period last year, only 1 percent of children newly enrolled in Husky A moved to Husky B, and among those, the transition confused children who experienced difficulty in receiving services and only a small number of providers experienced issues with receiving payments for services. This is due in part to providers having the capacity or capability to follow the eligibility changes through the automated eligibility verification system. This system allows providers to obtain real time online
access the eligibility information sought by this bill.

On H.B. 7121, AN ACT CONCERNING SEMI-MONTHLY TRANSFERS OF SUPPLEMENTAL NUTRITION BENEFITS. This bill requires the distribution of supplemental nutrition assistance benefits twice a month. As a threshold matter, the department notes that the federal law prohibits agencies from issuing SNAP benefits more than once per month. Currently, there is no other state in the nation that does it. When the state of Michigan attempted to do so about a decade ago, a survey of staff recipients found that 59 percent preferred continuing to receive benefits once per month with only 35 percent favoring a twice a month system. For these reasons, the department must oppose the bill. H.B. 7123, AN ACT CONCERNING TELEPHONE WAIT TIMES FOR PERSONS CONTACTING THE DEPARTMENT OF SOCIAL SERVICES. This bill would require the department to increase staffing, resources, telecommunications technology in an effort to ensure that wait times for calls to the department's benefit centers do not exceed 60 minutes.

This bill is probably predicated because of an attempt last year where we reduced the wait times from well in excess of 100 minutes down to something more manageable, 27 minutes. Then towards the November, December, January timeframe, that wait time reduction was not sustainable. We encountered about a million notices that we had to issue to all of our members, most of them related to the MSP changes that were going on. We were also completing the last stages of rolling out EMS replacement of impact, so those wait times went back up. They skyrocketed. We sat down in July of last year with
a lot of advocates, laid out our pathway with them. We told them what we would do to bring the wait times down and sustain those.

We're gonna need to do some technology fixes to sustain the wait times, but the process improvements that we've been able to make have resulted in wait times for the last month from - I think we're at about 10 minutes. Average wait time is 10 minutes this month. Last three days were something like seven, five, and three, so we keep an eye on this. We're monitoring this. We know that we have a big infrastructure delivery as well as software upgrades coming. We expect to have vendor bids and proposals back by the second quarter of 2019, but what you will hear is that there's been no improvement and what we can say categorically is that there has. Prior to our conversation with a lot of folks about dysfunctionality, people thought that we were talking about a call center, something that we contract with, with a lot of our other vendors, and we have wait times that are very reasonable for call centers because what you do is a light touch and transfer the call on.

The benefits center is just like a virtual physical office. It's a one-touch resolution from beginning to end, so I don't think that you'll hear many, if any, complaints about the resolution of matters that come through the benefits centers, but there have been challenges getting into the benefit centers to get resolved. Our auto-renewal process for applications, over 70 percent for MAGI population. For our MSP population, that's over 85 percent. Auto-renewal, where people don't have to call in, so we are committed to continuous improvement. We'd
love to be able to continue our conversation here, but we cannot support the bill in its present form.

H.B. 7165, AN ACT CONCERNING MEDICAID COVERAGE FOR DONOR BREAST MILK. We wish to offer our strongest endorsement of breastfeeding for all newborns. After loving parents, breastfeeding is one of the best ways to start a newborn on his life's journey, but breast milk is neither a nutritional supplement nor an artificial nutritional product to treat a medical condition. Breast milk is food. Federal law does not allow us to cover breast milk or any other type of food because food does not fall within the federal definition of medical assistance that may be covered by Medicaid. The Department of Social Services strongly supports breastfeeding, but must oppose this legislation. H.B. 7166, AN ACT CONCERNING NONEMERGENCY MEDICAL TRANSPORTATION FOR MEDICAID BENEFICIARIES. I'm just gonna skip to the chase. All of the provisions that are identified in the bill are contained within the contract provisions that currently exist between Veyo, the broker, for any MT services and the agency. We continue to publish the information before MAPOC every month. On average, we complete about 350,000 to 400,000 trips for Medicaid members. We get detailed information. We have call center performance. The pickup and return wait times are within contract standards for approximately 70 percent of A leg trips and 92 percent of B leg trips. To-date, the department has imposed sanctions most commonly related to late pickup times totaling some $22,000. To the best of our information, Veyo has typically passed these sanctions along to the involved transportation providers.
H.B. 7168, AN ACT CONCERNING AUTISM. So, the agency is identified and statuted as the lead agency for Connecticut for autism spectrum disorder ASD services. DDS is responsible for coordinating where possible the functions of several stage agencies that are responsible for providing services to those who are diagnosed with ASD, so we support the coordination with DDS to ensure people with individuals with ASD. Developmental disabilities are effectively served. The department remains committed to individuals with ASD in addition to the above referenced Medicaid waiver and Medicaid state plan services. The department is supporting several initiatives through state funded autism feasibility plan. The department remains receptive to suggestions or innovative solutions on how to improve the state agency coordination for individuals with ASD and ID. And, with that, I'll stand for questions.

REP. ABERCROMBIE (83RD): Great job, Commissioner.

COMMISSIONER RODERICK BREMBY: Was that a record?

REP. ABERCROMBIE (83RD): It was. Condensing 13 pages down. Thank you for that. I'll open it to questions from Committee Members. Really? Go ahead.

REP. WILSON (66TH): Yes. Hi. On the nonemergency transportation bill, I've seen the figures that Veyo has presented indicating that there doesn't appear to be a problem, but yet my experience from constituents is vastly different from that. I'm hearing complaints. I've actually attended a group meeting of people to explore complaints about the Veyo system and there was a collective groan that went up from the people in the room when the name
Veyo came up. I met with the folks from Veyo, looked at the contract, the underlying contract, and for the life of me, I can't determine what the disconnect is between the numbers they're showing and the experience of people in the field.

The contract itself seemed to – most of its emphasis seemed to be on the administrative aspects of managing the contract, so many seconds for the call center to answer, but when it comes to the program aspects of the contracts, how people are actually treated or how they receive the service, there do not appear to be any – there doesn't appear to be anything in the contract to actually manage that piece of it. So, I'm puzzled because on one hand you get great information that looks like everything is fine, but when you talk to people who use the system, it's all but that. Can you help me?

COMMISSIONER RODERICK BREMBY: Sure. I think you're raising an excellent framing concept and vehicle for this conversation that will continue for quite some time. What I would first say is that Veyo is a broker. Veyo does not provide any medical transportation within the EMT service. What they do is they contract with vendors to provide services to our members. We changed the contract, the NEMT contract, because we were not getting good results with the last vendor to enable a program or an organization like Veyo to hold those vendors accountable for their failure to deliver services in a timely way or in a proper way.

What you're hearing is a disconnect. We want this program and I firmly believe that Veyo wants this program to be 100 percent successful, meaning perfection. If we are successful, if Veyo's
successful 99.1 percent of the time, so less than 1 percent of five million rides a year, we've still got issues. And, so what you're hearing is that the data is showing very good results, but they're nowhere near the level of perfection that we need for the services, these critical services, for our Medicaid members. So, we're gonna continue to work with Veyo. Veyo's gonna continue to do their work. One of the resources that we identified within the bidding process that we thought would enable Veyo to outperform anything that we would see was the realtime capability to monitor the timeliness of a broker or a vendor to the service point of contact, kind of like Uber or a lift concept. That has not been deployed as of yet. We need to know how close that vehicle is, and if the vehicle is not available, then we can send a rescue vehicle which is an independent driver.

Independent drivers currently provide less than 1 percent of the rides, but the other vendors are concerned about them encroaching into the space, so this is an issue that we're continuing to give a lot of time, a lot of attention, and rightfully so, because it is a critical service. There has been — I mean, the start was rocky as all get-out. We didn't have all the data loaded into the system, so people who had already scheduled rides didn't get rides for the first couple of days and sometimes for weeks during a very hard winter last winter. So, I can imagine that the — that the belief, the intentionality towards Veyo is still not high, not as high as it should be, but we believe that they are performing to contract standards. We will be continuing to modify the contract as we see a need.
REP. WILSON (66TH): I'm sorry. The problem seems to be with the contract itself because there don't seem to be measures that relate to the services that are actually received by the clients. All of the measures seem to be on the kinds of things that one has to do to please the feds, if you will; make sure that confidentiality is protected, make sure the HIPAA things are in place, all of those kinds of things, but in terms of the actual experience of riders, there doesn't seem to be much in the contract to be able to assist that. And, I've had clients who have lost doctors, who have been sort of upset because they can't make medical appointments, and therefore, they're not getting the treatment that they require and their conditions are going downhill because of their inability, whatever is not working, is really not working in my area out in the northeast corner.

COMMISSIONER RODERICK BREMBY: So, I think your point about the contract focusing more acutely on the relationship between Veyo and the state rather than on the provider results is one that is pretty accurate. I think that we can continue to look for ways to hold Veyo responsible for the consumer experience with the provider. In your area of the state, there are a dearth of providers out in that area. I think it will continue to be a challenge. Veyo has the resources to go out and try to recruit, to bring more providers to the area that is underserved, but I just wanna say that based upon the data that we have, this vendor is performing better than the last vendor.

REP. WILSON (66TH): That's frightening.
COMMISSIONER RODERICK BREMBY: Well, continuous improvement. We believe that the relationship is getting better. It's nowhere near where we want it to be, but they're within contract provisions at the current time. We will continue to work with our groups to make sure that we know where to make those changes. We have begun to think about offloading some services from Veyo to other vendors to make sure that we can routinize – we can be more efficient in the routine services while allowing for flexibility for those that are variable.

REP. WILSON (66TH): I would also wonder if – you said there were $22,000 in fines. What's the total amount of this contract? I mean, it's millions, right? So --.

COMMISSIONER RODERICK BREMBY: It is a – it is a multimillion dollar contract. The fines that we identify are based upon complaints that come in, complaints that are verified, and then we issue a fine up to, is it $10,000? It's $500 and so we issue that against Veyo. As I said to my knowledge, or to our knowledge, Veyo then passes that down to the vendor for their failure in not delivering the ride or the poor service standard.

REP. WILSON (66TH): Okay. It just doesn't seem to be happening. I mean, I hear what you're saying. It's much like reviewing their figures where you see all kinds of wonderful figures and then you talk to people and it just isn't – isn't working well, so I appreciate the efforts that you're – that you're trying to put into it, but it's not working for the people.

COMMISSIONER RODERICK BREMBY: I hear you. And, I think our team is committed to doing what is
necessary to improve that service, but I wanna go back to one point that I made earlier, that is a 1 percent error rate across let's say four million people is still a lot of problems. And, so we're gonna continue to try to drive that towards perfection, but if you contrast this vendor with the previous experience, it is better. Our rides - I mean our utilization is even up, so yes, there are issues. We hear about them. We wanna address them and we're being very aggressive about that.

REP. WILSON (66TH): Okay. Have another question - another bill question on another bill. The other question I had related to 7165 on donor breast milk. I was - my understanding of the use of donor breast milk was more along the lines of premature babies and in instances where the mother cannot provide her own breast milk and so while it is not - while it certainly is a food when you're talking about a preemie, it really does skate the lines of a medical necessity I'm thinking if that's what the child can tolerate and they don't have their own mother's milk and they are needing that supplement.

COMMISSIONER RODERICK BREMBY: Yeah, we fully support the use of breast milk. It is the best food that there is, but Medicaid statutes will not allow us to use Medicaid dollars for food.

REP. WILSON (66TH): I mean, I understand what you're saying. There's no - no one can - there's no way around it. There's no way to redefine this is a medical necessity.

COMMISSIONER RODERICK BREMBY: There's no way around it that we're aware of.

REP. WILSON (66TH): Okay. All right.
REP. ABERCROMBIE (83RD): Representative Case.

REP. CASE (63RD): Thank you, Madam Chair. Good morning, Mr. Bremby. Nice to see you. Just to go back real quickly and not to belabor it because we've been talking about this for a while in this building, but I don't know if the Representative is aware, but when we worked with your office and sat in your office, we did set up an email line that would go directly to you into Veyo with any complaints. Do you have the numbers of how many have gone to that through Representatives?

COMMISSIONER RODERICK BREMBY: I don't have that, but I will - we can get that information. We did have a - we tried to streamline to make sure that complaints come in that we could escalate those and resolve those. I know that Rod Winstead and Kate are monitoring those complaints on a routine basis and in fact I know Rod turns those around very quickly.

REP. CASE (63RD): Right. And, I do appreciate that because I've seen multiple, because we thought that in the meeting we could - as you mentioned, the previous contract we had much more issues than we do right now, but they're about 219 of those emails that went to both Veyo and yourself and out of those, 51 percent of those, were not to be the fault of Veyo through your office and through the contractor, but it is also correct that yes, this is a multimillion dollar contract, but there is a clause in there that it's only a 3 percent profit that's allowed through this contract?

COMMISSIONER RODERICK BREMBY: That is correct.
REPRESENTATIVE CASE (63RD): So, it's not that this company is making millions of dollars off of the - you guys put a stipulation on how much the contractor can actually make, right?

COMMISSIONER RODERICK BREMBY: Yes.

REP. CASE (63RD): Right. So, it's not to their ability to - they wanna work the best to get the best solution. I know I had a - Charlotte Hungerford Hospital called me probably about two weeks ago at 10 o'clock at night because you know sometimes people have to come from the health center in Winsted and get transported to Charlotte Hungerford which is a 24-hour care facility. The Winsted Place is only a 12-hour. Come to find out it's not within Veyo's contract to transport somebody with medical and that particular nurse manager didn't know that, but I field those calls around 10 o'clock at night and they were answered, but Veyo went above and beyond and actually found them a ride which they didn't have to do, but there are some good cases. There are some negative stuff, but I think we're trying to work through the negative.

Anybody who wants to bring stuff forward that - that will help the situation. I tell my phone rang off more with the previous contractor than it has with this contractor and that's that - that's just coming from me, but that's why we set up and maybe the good Representative, if she can work with her office, that email is still viable and is answered within less than a day and her aide in her office can also get the answer that came through on how it was rectified, but I thank you, Commissioner, for coming forward.
COMMISSIONER RODERICK BREMBY: Thank you.

REP. ABERCROMBIE (83RD): Representative Dathan followed by Representative Hughes.

REP. DATHAN (142ND): Thank you, Madam Chair, and thank you, Commissioner, for your testimony today. It was great. I know you discussed with the other Representative H.B. - sorry 7165, the breast milk one. I'm a mom with three kids. I breastfed all three of them for as long as I could not just for the benefits of providing nutrition, but from what - and I actually delivered two of my kids with midwives which is another home problem with what you were talking about, but in terms of my healthcare provider - said that breast milk actually provides not just the nutrients, but also immunities and helps your kids provide immunities and I'm kind of failing to see how we can just say for a premature baby who's immune system may be more compromised than a traditional full-term baby, how we can say why that baby should be more subject to different diseases out there, particularly when we have many health crises going on in our state.

I know during the course of my kids' first year, they were very rarely sick and it was - I really relate it to breastfeeding them. And so, understand what the federal guidelines about this, that it's a food, but is there a way that we can maybe talk about breast milk, especially for premature children, that they can receive this to help with their immune systems to help build up immunity? Thank you.

COMMISSIONER RODERICK BREMBY: Good morning. I really appreciate your argument. I really do. We - and I don't discount what you just said because
breast milk also provides for the transfer of immunities between – immune protection between the parent and the child, but a lot of our federal regulations may not hold up to the rationality that we would like them to or be as forward learning as we would want them to. We know, for example, that housing is a tremendous aid to people who are suffering from a lot of medical conditions, but Medicaid won't allow us to those resources for housing either.

So, I'm gonna and ask to defer to our medical doctor for Medicaid to speak specifically to the point you raised about whether breast milk can be used under Medicaid as a resource. Dr. Zavoski.

REP. ABERCROMBIE (83RD): Dr. Z., just introduce yourself even though most of us know you, please. Thank you.

DR. ROBERT ZAVOSKI: Good morning. Rob Zavoski, Medical Director of the Department of Social Services and pediatrician, 25 years practice experience. You speak about breast milk very well and is better than many I've heard recently. The challenge we have is that, and I sat on a committee with Sam S. in the federal government last year that looked at this very question. And, the challenge is that the federal Medicare and Medicaid rules are etched in federal law and are very specific and were written many years ago and did not foresee many of the new healthcare trends that are happening today, this being one of them, but technology trends, etc.

And, it becomes a challenge and under the federal rules, breast milk is considered a food, not a nutritional supplement, etc. And, furthermore, the way we pay for newborn care in the nursery,
particularly in the NICU with prematures, is that we pay a bundled rate and so technically the payment for the food, nutritional supplements, etc., are included in that bundle grade. So, again for both reasons, we couldn't support this legislation. As the Commissioner said, we are four-square in favor of breastfeeding and all the benefits that derive from breastfeeding and they're lifelong benefits, but we can't pay for it as a medical supply.

REP. CASE (63RD): Can I ask a followup questions?

REP. ABERCROMBIE (83RD): Yes.

REP. CASE (63RD): Thank you. Is there any other supplements that a newborn who is unable to receive milk from its birth mother, is there anything else out there that an infant could receive that would be as good as breast milk to help prevent immune issues?

DOCTOR ROBERT ZAVOSKI: The answer to that is no. There's nothing as good as breast milk. There are other nutritional supplements and medical supplements that we do pay for and provide, but again, despite all of the good things and wonderful things that breast milk does, it's still considered a food under the full – it's food under federal rules.

REP. CASE (63RD): So, we're kind of discriminating against mothers who cannot breastfeed in a sense? Okay. Thank you very much. Thank you, Madam Chair.

REP. ABERCROMBIE (83RD): Representative Hughes.

REP. HUGHES (135TH): Thank you, Madam Chairman, and thank you, Commissioner, and just before you leave because I was gonna ask, so when you said there are
supplements that Medicaid will cover, are those pharmaceutical supplements?

DOCTOR ROBERT ZAVOSKI: There are nutritional supplements. I guess there are some pharmaceutical supplements if somebody's having trouble with electrolytes, etc., but with most preemies, I think most of the supplements are more caloric.

REP. HUGHES (135TH): Interesting. Okay. So, thank you, Commissioner. Thank you very much, Doctor. Commissioner, thank you for your test. I'd like to talk to you a little bit deeper about H.B. 7123 concerning telephone wait times for persons contacting the Department of Social Services. You said something about the second quarter in 2019, an RFP, can you --?

COMMISSIONER RODERICK BREMBY: Yes.

REP. HUGHES (135TH): Talk more about that?

COMMISSIONER RODERICK BREMBY: Absolutely. So, what we worked on over the last year has really been about process change within the organization. What we were wanting to do more quickly than now was upgrade the technology that we have. We have an IVR, interactive voice response system, that allows us to channel calls more appropriately to where they could best be answered. The current technology is limited in that we can't drive a certain type of call to the right location or the right worker as efficiently as we would like to nor could we set up a Tier One call center, for example, one that we pay for along with Access Health to take the initial call to handle all of the light touch questions and then forward the rest of the questions back to the benefits centers for resolution.
When we have the million plus notices on MSP, you could have seen our call volume just spike because people wanted a response. We couldn't offload those calls and then continue to focus on our primary core business, so the technology upgrades that we're anticipating and one of those will allow for something that our peers over at DMV has done and that is to park a call in a queue to allow the caller to go about their business, and once their time in that queue reaches the next caller, then it will outcall the person to make sure that they're available to complete the transaction. Those types of technology are in development. Those are underway. We expect to have a bid back June – at least by June, end of second quarter this year, but those are the technology changes that we believe will help to sustain the reduction in call wait times that we're already experiencing by process improvement.

REP. HUGHES (135TH): Great. Thank you for that. So, help me understand. A tremendous amount of my constituency, especially senior citizens, are very concerned about redeterminations and that that doubt is where they were mostly experiencing these two hour wait calls as recently as October, so you mentioned some improvements and I just want to get a sense of a timeline of those improvements and I also would like for you to speak to this Committee a little bit about how much of this is a reduction of the state workforce in the last budget and especially in terms of being understaffed for that one point office touch that you talked about.

COMMISSIONER RODERICK BREMBY: We understand the concern about seniors having access to services. The modernization efforts that we've made over the
last seven years have been geared towards an I2, not only seniors, but those members who are living with disabilities who can't show up at one of our 12 offices. We still have over 400,000 walkup customers in our regional offices and I would say that there's been a reduction of some 20 percent walkup customers in our regional offices because of the new technology that we made available. Many of our applications are now available online where before they were paper and you had to drop them off at the regional offices. We do all of our interviews, most of our interviews, over the phone. We make that available. We are also pursuing a waiver to extend out the eligibility process or window for seniors and people who are living with disabilities.

So, I can't speak to the October timeframe, but we'll make sure to get the data. I know it's out on our website, but we'll make sure that that's available, but I cannot also link the relationship between employees to wait times because it's more than that. It's also what's happening in the background. We were pretty well staffed in December of last year when the wait times went through the roof, so one other limiting factor with employees, and I would never say that we wouldn't ask for more employees if we needed them, but we are mindful that because of our fiscal limitations, with additional employees we would need to find additional places to put them. We're pretty much full in our offices as they are today.

So again, we would not be bashful to ask about additional resources, human resources, but we believe that what we have planned will not only be sufficient to keep the wait times down, but sustain
them through one of those unusual situations where we have a lot of notices. I mentioned earlier and it may have been passed in this conversation, but our MAGI population, those renewals, are in excess of 70 percent auto-renewals, so you don't have to call us or let us - you just have to send back the form to say, nothing's changed or very little changed. With MSP where many, many of our seniors are parked in terms of services, that's over 85 percent auto-renewal, so we're doing everything we can to make sure that the interaction with the agency is frictionless as possible because we know that most of the people that we serve are overburdened and underresourced, so we have an eye towards continuous improvement. We'll continue to thrive in that way.

REP. HUGHES (135TH): Thank you very much and I know you're already really conscious of this, but in terms of developing, I don't know who the RFPs is and if they're developing, but it's really, really important to center the user's experience with disability or the senior citizen who's not online tech-savvy. It's so important. I mean, as it is, they can't remember how many options there are and which ones are the right ones and they're trying to write it down and it - it's just not very user friendly.

COMMISSIONER RODERICK BREMBY: I agree. It's maddening. The IVR that we have doesn't permit an efficient number of steps to the source of where you're trying to get to. We're also very close to designing or having designed this medical - or not medical, but this mobile platform to allow for access as well. Many of our constituents don't really have access or easy access to computers, but
they have smartphones and phones that can provide easy streamline access, so we're looking to deploy that technology as well.

REP. HUGHES (135TH): Thank you. No further questions.


REP. MASTROFRANCESCO (80TH): Thank you, Madam Chair. I guess still good morning. Thank you for your testimony. It's very thorough. I appreciate it. In reference to, just to follow up on what Representative Hughes had said, I believe you mentioned that your staffing is okay for now. Correct? And, that's not the result of a longer wait time on the phone?

COMMISSIONER RODERICK BREMBY: So, we have put together a staffing plan for the balance of the fiscal year. We have a relationship with OPM such that when we have a vacancy in the eligibility service space or eligibility service specialist, we automatically request a refill for that position. In the budget, you'll also see an additional class of 30 eligibility service workers that will allow us to make sure that we're kind of keeping up and not getting behind where we then have to go out and bring on a new class. It then takes them some six months or so to get up to speed, so going through the training. So, we wanna stay current with the levels that we have today.

REP. MASTROFRANCESCO (80TH): Thank you. Do you know what the percentage is of increased call volume or services that people are inquiring through DSS as compared to last year? So, was it a jump of maybe
20 percent more people were calling into DSS and for what particular reason? Is there a specific area?

COMMISSIONER RODERICK BREMBY: I don't have that in front of me, but let's see if we can't pull that together. You're asking for call type increases over say the last year.

REP. MASTROFRANCESCO (80TH): Right.

COMMISSIONER RODERICK BREMBY: Okay. Let's see if we can't bring something --.

REP. MASTROFRANCESCO (80TH): Right. What is the root problem that are more people calling for.

COMMISSIONER RODERICK BREMBY: Oh. I think I know where you're going with this and what I can say is that we think the technology will solve this. Most of the reasons why people call often is, did you get my material? I sent it in, but did you get it? And, so those calls we want to try to offload to a very quick response so that we can use our benefits centers to work through the process with folks who need really more intentional services. What we'll then do when someone asks if you got my packet is go through and see if there's anything else they could possibly want to have resolved. Eligibility or caseworkers might go into the future and say, well, you got this renewal coming up. Do you need these materials or do you have that or can I take care of that today for you? So, it is truly a one stop resolution, but many of the calls that come in, even the spiking calls that come in, are folks who just wanna check in to see if we got the materials or it's kind of like the old, when we got email the first time around.
You send an email and you call someone up and you say, did you get my email [laughter]. So, it's kind of like that. This is new technology and people just wanna be sure that their work is being processed unlike in the older days, 10 years ago, people would bring in their applications into the agencies and a single caseworker would work that application. Oftentimes, the material would be incomplete and so that application would be piled up or stacked aside and it would get dealt with when the information came back, but then when the information came in to complete that case, not being able to find the original application, we asked them to submit another application. This new technology, this new system, this new approach, eliminates that because once the material is here, available, it's available to every single worker in our system to access online to work and so that's why it's much more efficient than it was before and effective, but we still have these - these processing issues where people just wanna know we got their stuff. The key performance indicators for us while we focus on the wait times to get in is really, did we process the applications timely? Historically, we hadn't done so well, but today or last year and the year before, number three in the nation, 98+ percent on SNAP, and for Medicaid, again, 98 percent.

So, the key performance indicators measuring timely application processing and then automating renewals, increasing the access to service. This eligibility system, this eligibility performance system that we have today, I would stand up against any nationally.

REP. HUGHES (135TH): Great explanation. And, I don't doubt that the people at the DSS are not working very hard. I'm sure they are and, as you
mentioned, people may call in a lot of the time just to find out, did you get my paperwork, but the more people that have a need for assistance through SNAP or Medicaid, you're gonna get a larger call volume. So, that's why I was just curious as to what the percentage is from the prior year, do we have more people asking for assistance for SNAP, for Medicaid, follow me? And as they call as they're more of a need, the more people are gonna call in and say, did you get my application. If you can get me that figure, that would be wonderful.

COMMISSIONER RODERICK BREMBY: We'll work on that. Our largest growth in Medicaid is our Husky D population. Our Husky D population actually calls another call center that we fund through Access Health. We spend about $13 million dollars a year to help fund that call center. They don't come into the benefits centers unless they're routed back to us. On SNAP, our population is actually declining a little bit, so we'll look to see if we can't get you the information about what types of calls are spiking out the calls by program if we have that.

REP. MASTROFRANCESCO (80TH): Yeah and just so percentage of increase overall of how many more people are applying for those services. That would be wonderful. Thank you so much for your testimony. Very thorough. I really appreciate it.

COMMISSIONER RODERICK BREMBY: Thank you.

REP. ABERCROMBIE (83RD): Commissioner, just to follow up on that. Any responses to any of the questions here, please send them to Kaley [phonetic], our clerk, so that she can send them out to all Committee Members. Senator Moore.
SENATOR MOORE (22ND): Thank you. Good morning. Good to see you, Commissioner. So, I just have a question on the midwives 'cause you seem conflicted in your testimony and torn.

COMMISSIONER RODERICK BREMBY: Yes. Yes. We are.

SENATOR MOORE (22ND): I mean, everything seems to come down to the bottom line of dollars and shifting of dollars, but I also have a DOULA Bill coming up soon. I'm very interested in this maternal health because African-American women suffer one of the highest disparities for childbirth and we have some of the worst numbers compared to some of the surrounding states, so I see you have a Pay For Performance for obstetrics for - tell me what that actually does that you - you think that that is the best avenue for now.

COMMISSIONER RODERICK BREMBY: Let me - let me - the testimony was quite conflicted and let me see if I can't land this in the right place. I might also need to ask Rob Zavoski to come up and talk a little bit more about the paper success program or Pay For Performance program that has to do with the Ob/Gyn special - just to be clear, we believe that the outcomes for midwives, nurse-midwives, is superior to what we're seeing with Ob/Gyn clinicians at the present time. The studies that we've seen suggest that there are better outcomes. We know that Connecticut has room to grow, can be better with maternal deaths and with babies being born well, healthy.

Now, because we pay three different types of individuals, 90 percent of the Ob rate, if we do one, it's likely that the other two types will want an increase as well, so that means that it will be
quite costly, and for that reason, that reason cost, that we couldn't support the bill. Do we believe that additional pay should be linked to performance? Absolutely. And, so the Pay For Performance program that we currently have is one such vehicle that we would like to continue using in the meantime. So, Rob, could you come up and talk about the features of the benefits or Pay For Performance that we have with the ObGyns today.

DOCTOR ROBERT ZAVOSKI: Good morning, Senator. We've had a Pay For Performance program for obstetrics off and on now for several years and the way it works is that for the providers who enroll, and this is for obstetricians, the few family docs who deliver, and the nurse-midwives, that they enroll with the program. They notify us when somebody's pregnant so that we can enroll them in our Intensive Care Management program per obstetrics. We give them points for that enrollment. We give them points for early access to prenatal care. For moms who have high risk of premature birth, we give points for the obstetrician or the nurse-midwife administering 17-hydroxyprogesterone which is the one intervention that's demonstrated to prevent prematurity. We pay points for access to postnatal care and we pay points for a full-term spontaneous normal vaginal delivery. We total up the points and there's an appropriation, and once we've settled up the points with all of the providers, then we pay, based on their performance on this chart. As the Commissioner said, this might be one way to enhance outcomes if we were to increase the rates, but there are other ways to do it as well. This is one that we have some experience with.
SENATOR MOORE (22ND): So, those points translate into dollars?

DOCTOR ROBERT ZAVOSKI: Yes, ma'am.

SENATOR MOORE (22ND): So, are midwives included in that?

DOCTOR ROBERT ZAVOSKI: Absolutely.

SENATOR MOORE (22ND): They are? All right. Thank you.

REP. ABERCROMBIE (83RD): Senator Logan.

SENATOR LOGAN (17TH): Thank you, Madam Chair. Thank you for coming before us and it sounds like you're doing a lot with the staff that you have and I appreciate your service to our state.

COMMISSIONER RODERICK BREMBY: Thank you.

SENATOR LOGAN (17TH): When you take a look at some of the folks and the clients that you help, residents here in Connecticut, many of them are underresourced. I'm actually on the board, volunteer board of a local hospital, Griffin Hospital, and patient-centered care is the kind of thing that I've been focusing on and preventative care. My background is engineering, not in the medical field, but when it comes to preventative care and getting folks to their appointments and trying to make sure they stay on their medication, I've discovered is of vital importance in improving the quality of life, extending the quality of life of our residents, and transportation is a huge I'm finding part of that.

In taking a look at the contract that we have with Veyo, they appear to do a tremendous job of helping
folks to get to their appointments and it's my understanding that you've recognized the services that they provide. I certainly feel that Veyo, as certainly as any organization, could make some improvements in certain areas and I would expect and hope that DSS will continue to suggest such improvements to that – to that existing contract and the service that they provide.

COMMISSIONER RODERICK BREMBY: Thank you. I appreciate your comments. I believe that we all share that there is room for improvement with Veyo. There's some unique opportunities that we believe that we can increase the capability to 100 percent if not because there is some very discrete trips that are known and should never be missed. So, we can hard coat some of those and we're looking at trying to provide ways to do that. So, the more variable trips, those are the ones that we can identify some backups for, so we've got some thoughts in mind and I know that the team is committed to providing first-rate service for nonemergency medical transportation, but as I said before, we are doing everything we can to look within not only the contract, but talking with the vendor – the vendors and the broker to see if we can improve the outcomes for Connecticut residents. We may have unanticipated the difficulty that a vendor might have coming into the state to work within the environment, but we don't believe that that's an excuse for poor performance.

SENATOR LOGAN (17TH): Thank you.

REP. ABERCROMBIE (83RD): So, we have some people that wanna ask a second question, but I'm gonna go ahead 'cause I haven't asked a first question yet
and then we'll turn it on to our colleagues. So, [laughing] watch it. So, S.B. 837, AN ACT CONCERNING MEDICAID PAYMENT RATES FOR NURSE-MIDWIVES. I think you can tell by the testimony from our colleagues here that it's something that we feel is very important and should be paid appropriately. My question for you is, in your testimony, you talk about tie to improvements in clinical outcomes. Do we take into account the amount of individuals that now no longer have to have a C-section? Is that part of the outcomes that you look at? You do.

And, we know that the numbers prove, right, that the outcomes are better if someone has vaginal and the cost compared to - that's right. So, I think that there's enough evidence here to prove that the time has come for us to look at the balance of payment between midwives and other practitioners, so I just want to say that for the record, and I get it, it comes down to dollars, but I'm gonna say it on the record again and I've been saying it since last year, the tsunami is here for our providers and we need to start looking at these providers and making sure that they can stay in business and this area in particularly I have some concerns about because as my good colleague, Senator Moore, said in a lot of the distressed municipalities, that's where you see a lot of these issues and I just want to make sure that it’s equal across the board, so I do appreciate your testimony on that.

Moving on to S.B. 899, AN ACT CONCERNING THE TRANSFER FROM HUSKY A TO HUSKY B HEALTH CARE COVERAGE. So, I think your testimony said that there's only a 1 percent of transfer. What's the process now for providers to know when someone is transferring from A to B because my understanding
from the providers is that if someone goes to B, they don't know until that start to submit for claims. So, what's the process currently for providers to know?

COMMISSIONER RODERICK BREMBY: So, the provider can look up the eligibility status of the individual through the automated eligibility verification system, AEVS, prior to services being extended, so you don't have to extend services and then look up and determine one way or the other.

REP. ABERCROMBIE (83RD): If I'm a provider and I've providing service to someone that's a Husky A, no offense, Commissioner, I'm not gonna go into the system every time and see if that person is still a Husky A - a Husky A candidate. I think that's one of the things, and I'd like your opinion on, has the time come for us to combine Husky A and Husky B because we're one of only a few states that does not combine those two categories.

COMMISSIONER RODERICK BREMBY: Well, respectfully, Madam Chair, when I go to a practitioner, they ask me for my insurance card and they look up my insurance card to determine whether I'm still eligible for what array of services and supports. In the same way, before services are provided, the provider should look up the coverage that the individual has, whether they're Medicaid or not, because it could be Medicaid A or Medicaid B and there are limitations on what can be or should be perhaps provided.

REP. ABERCROMBIE (83RD): So, with all due respect back, that's a simple way of saying that, but in the real world, if I'm a provider that has been serving a child with occupational therapy and they come to
me twice a week, you're saying that every time before that child comes, I should be going into the system to still see if they're Husky A?

COMMISSIONER RODERICK BREMBY: That's our process.

REP. ABERCROMBIE (83RD): Okay. Well, so, maybe we need to start thinking about if the time has come for us to merge Husky A and Husky B like I said because other states have done it and it might be a better system for us, so I would like you just to consider that at some point and we can have a further conversation on that. For the SNAP, H.B. 7121, AN ACT CONCERNING SEMI-MONTHLY TRANSFERS. So, your testimony is we can't do this, that it's not authorized under SNAP to be able to do bi-monthly versus monthly.

COMMISSIONER RODERICK BREMBY: That's one issue and that's the limiting issue, but another issue is that no other state does it and the last time another state did it in Michigan about 10 years ago, they surveyed the members and their members didn't want that. What it does is it imposes some additional demands on users of the system to go out and shop a second time, not take advantage of volume discounts. I mean, as we talked, people are overburdened and underresourced, so if you give them the resources upfront, then they can make the best decisions about how to use it. If you're telling them you can only get it once every 15 days, that makes it really challenging for some folks, so what we do is we spread it out over three days, some states go to 10, eight states do it on one day a month, but we think the system that we have works well for the people that we're trying to serve.
REP. ABERCROMBIE (83RD): Okay. Fair enough on that. Thank you. Moving on to H.B. 7165, AN ACT CONCERNING MEDICAID COVERAGE FOR DONOR BREAST MILK. So, maybe you're not aware of this, but there are currently six states that do cover breast milk under Medicaid, New York being one of them. So, maybe what we need to do is take a look at how they're able to get this covered under Medicaid. I understand what you're saying about the bundled rate that we do for hospitals, but I think it's - I think it's unfair to mothers that have preemies that are given breast milk and a fortifier when they're born and then at some point when they come out of the hospital have to transfer to formula, so I think that we should take a look at how other states have been able to pay for the service. I know you're trying to say something, go ahead.

COMMISSIONER RODERICK BREMBY: Yes. We will explore this. What we know, what we know, is that Medicaid dollars cannot be used, but we believe this may be a relationship with managed care organizations who pool other resources to make sure that this is provided as a way of providing that holistic support for the people who they are serving. In the same way, we know that there's some states that are providing other types of supports for their Medicaid members that Medicaid will not pay for through the managed care entity, so let's - let's explore this and see if there's a different way, but --.

REP. ABERCROMBIE (83RD): Yeah. I think it's real - I'll be honest with you, I didn't know a lot about this. I know that we've been in contact - I've been in contact with Yale and CCMC because they currently have this as a common practice because especially with preemies they don't have the opportunity to be
able to even suck on a nipple of a bottle so they have to do it intravenously. I'm learning all about this fortifier. I think it's just really interesting and I think that any way that we can help enhance the growth of a baby, and I'm not saying you disagree with this, sir, so don't take it that way, we should be doing that.

And, it also goes to the cost, right? So, if we give these - these newbies and these premature babies this nutrition upfront, I guarantee you that we save dollars in the long run from medical costs down the road because we all know there's no better nutrient for a child than a mother's breast milk, so I think that this is an area that we could probably have more conversation on and take a look at if there's a way to do this. And, I know, I'm gonna say it for the record, I know it's very expensive to do this because of the process that's in place for it, but at the end of the day, it's what we always say in this building, what's the price of not doing the right thing. So, I'll leave you with.

Representative Case followed by Representative Wilson Pheanious.

REP. CASE (63RD): I had to follow you, huh? [Laughing] I don't know much about breast milk, but I'm gonna talk about it. [Laughing]. For clarification, I have a 14 week old at home so I'm dealing with this and it's interesting because in talking and hearing that six other states do this, there are mothers out there who overproduce and we need to find a way to not waste that, and if we can find a way to where like a blood donor, those - the blood is tested and sent to the right person, and if it's not good - I think we can find the same way to do it instead of need to figure out how I'm gonna
freeze all this stuff that's coming in - have it ready for him in the morning before I leave. It's quite an experience, but I think we ought to look at it farther. I think it's a good thing. And what Cathy said, as far as the preemies and getting them the healthy stuff, I just have to say from experience that breast milk, he's 14 weeks, he's 16 pounds and it's a great way for a child to grow up if we can do it for others who can't get that milk.

COMMISSIONER RODERICK BREMBY: We will certainly go back and explore a little bit more. Congratulations by the way.

REP. CASE (63RD): Gee thanks, Commissioner.

REP. ABERCROMBIE (83RD): He's now an expert in the field of fatherhood [laughter] and I have to just say for the record it's really interesting to listen to him every day [laughter]. New experiences. It's really amazing how far he's come. Representative.

COMMISSIONER RODERICK BREMBY: So, we have a fatherhood program in the agency [laughter] who'd be happy to work with you and share some things about father attachment and how important your role is in the life of your child. So, thank you.

REP. WILSON (66TH): Good recommendation for him. I'd like to talk a little bit more about S.B. 898, establishing a Hispanic and fellow communities of color nonprofit stabilization and growth fund. These are the so-heard monies, right? And, I'm wondering how - how many dollars are we actually talking about here across the state for these funds?
COMMISSIONER RODERICK BREMBY: That's a great question. I don't know that I have that in front of me, but over the years, that fund has been reduced.

REP. WILSON (66TH): My recollection is that it's not a large pool of funds.

COMMISSIONER RODERICK BREMBY: It's not relatively speaking.

REP. WILSON (66TH): And - I - the question was or my concern is that it's a tiny little bit of money. I don't know quite what it is now, but it's not very much money and it's spread across the entire state. Right now, correct me if I'm wrong, there's - it's used for program purposes. It's - is it fairly stable in that the same recipients tend to get it every year or - I don't mean recipients, the same service providers.

COMMISSIONER RODERICK BREMBY: So, the service provider mix is fairly stable with one except - or several exceptions. A couple years ago, we had a recision and by the time the recisions were stored, the contract had elapsed, so those vendors were no longer a part of receiving these dollars. These dollars do go for direct services and to use the funds for stabilization fund for the nonprofits, we felt was extracting the last group of funds, direct service funds, to put towards the use that may better be served by either the Governor's nonprofit fund or community development to work with nonprofits.

REP. WILSON (66TH): I think the rationale might be that it's such a small amount of money, right now the organizations that it goes to may not be adequately funded to be able to do the work
effectively and so I think that's why they may be suggesting calling the stabilization fund and I'm wondering - I hear what you're saying about there may be other ways to stabilize these agencies, but if I'm not mistaken, this has been an issue for at least the last 10 years. The organizations are not adequately funded. The dollars are not sufficient to meet the need and it seemed to me that this legislation was simply an attempt to be able to use this money more effectively to stabilize the agencies that are actually providing these services on an ongoing basis anyway.

COMMISSIONER RODERICK BREMBY: Okay. So, I think we - we are in space of shared understanding in that this bill would move dollars that are going to agencies that are providing direct services to those agencies that are already providing services with other funding.

REP. WILSON (66TH): Providing the same services, right? Essentially because --.

COMMISSIONER RODERICK BREMBY: But the state dollars would not be available to provide those services.

REP. WILSON (66TH): But they would be supporting the agencies which are already providing those services, and therefore, delivering the services more effectively.

COMMISSIONER RODERICK BREMBY: Okay. So, I think we're in agreement. We just didn't agree that the dollars from direct services should go to the organizations that provide services because those dollars would not be provided directly to the individuals or families who are getting those
services, so we've thought there were a couple of alternatives, but I understand your point.

REP. WILSON (66TH): Is there been any increases in these funds over say the last five years?

COMMISSIONER RODERICK BREMBY: No. No.

REP. WILSON (66TH): So, they're dwindling. Okay. All right. Thank you.

REP. ABERCROMBIE (83RD): Representative Santiago.

REP. SANTIAGO (84TH): Thank you, Madam Chair. I just want to mention that DSS did cut the money for the - the herd money last year and we had to, for what reason I don't know, and we had to go and fight to get money from DSS last year, especially with Hurricane evacuees from Puerto Rico who were coming into the state probably close to 3,000, 4,000 people coming from the island specifically to Connecticut and the first place they would go to is a Hispanic agency because that's where they feel comfortable with the language and those are the agencies in the communities that know where the services are and can be the translator, the interpreter, to go to Social Security or whatever agency to get those services.

And, I remember that I had to have a meeting with the Governor's staff along with myself and Representative Reyes and Representative Sanchez because the - because of the issue of the contracts that had expired because of the recision and these agencies not getting money who were still providing the services because they couldn't turn these people away, but also not being able to see the vision that where were these families gonna go in these
communities. It's not only in Hartford, New Haven, Waterbury, and Danbury where you have large Hispanic agencies, but it's important that when this disaster happened, I know that the Governor stepped up and it was going to certain agencies that were gonna provide the services, but again, those community agencies that he has part of his Governor's nonprofit don't have Spanish speakers and they were not bilingual, bicultural, and eventually he did give some of the money back that he - his administration had cut because he saw the urgency that - of these evacuees coming from Puerto Rico and then getting the services.

And, 211, of course, had to streamline that whole process and we didn't find out until later on that 211 was taking these phone calls and listening to these people that were coming from Puerto Rico in a different category than the people that were calling 211 for other issues. I just think that the - from DSS not recognizing that there is still a need for this - for this pot of money to help these agencies - they've been in business for 20 and 30 years. They know what is needed in the community and not all places where they go to get services think of eventually hiring somebody that's bilingual.

And, all these people wanna do is to get a little bit of help to eventually find the resources, where do they go to learn English, where do they go to get their GED, where do they go to transfer their credits from college, and these agencies were vital at that point and the money has been getting cut for the last 10, 15 years 'cause I know that Casa Boricua in Meriden has been cut and keeps getting cut and we still have a building and the staff is there part-time and the Executive Director that gets
paid probably about $30,000 a year, if that, is not making a lot of money as a lot of these nonprofits are making.

And, they still have to be open to help service a lot of those people that are coming from not only Puerto Rico, but from South America and the undocumented community which is getting bigger and bigger in the city of Meriden. So, I think that, yeah, it has shown that the Hispanic population is not gonna get smaller. It's just gonna get bigger, and by 2030, 2040, the majority are going to be Spanish speakers, are gonna be bilingual. It's the fastest growing minority in the country. It's the youngest minority populationed in the country and significantly we need to start making sure that we're paying them to get those resources when they come here because right now if we keep cutting these agencies like DSS has been doing the last 10, 15 years, they're going to disappear and we can't do that. Thank you, Madam Chair.

COMMISSIONER RODERICK BREMBY: With all due respect, I don't think we're on different sides of this issue, but to be clear, DSS did not cut these organizations or the funding. The recision against our budget means that we have eliminated 5 percent or whatever the recision is, but that's not an active decision on the part of the agency to cut. We agree that these funds need to go to people who need the services. We're on board with that in testimony and verbally.

What I objected to - what we're objecting to is that the dollars here would go to nonprofit agency and not to the agencies providing the services. If the dollars are to go to build up the capability of the
agencies and that's the intent of the bill, then that's a different position, but we believe that funding should go in this way to organizations who serve people who need this support.

REP. SANTIAGO (84TH): And, I agree with you on that, Commissioner, but it always seems that the 5 percent that it hits are always the nonprofits that are not getting enough money as it is and from what I understand, in order to get an agency back that doesn't get adjusted to that recision, there is always a recommendation that can be made to put that agency back, all those funds back, to help those nonprofits that are helping the communities directly, so I mean we can agree to disagree on that, but it wasn't - it didn't take long before the Governor at that time saw the need, especially because of the Puerto Rican evacuees that were coming to this country as American citizens and with just migrating here 'cause I don't believe we're immigrants because we don't come from a foreign country. Puerto Rico is part of the United states, but it needed that - there were a lot of families that had to get that help and if we wouldn't have fought for it and we would've kept quiet about it and let it be the status quo, then we wouldn't have been able to help a lot of these agencies that were specifically getting the population coming from Puerto Rico. Thank you. Thank you, Madam Chair.

REP. ABERCROMBIE (83RD): Thank you, Representative. Thank you for your leadership in our community. I'm proud to share Meriden with you. Further questions or comments? Yes, Senator Moore.

SENATOR MOORE (22ND): Thank you. Commissioner, I just wanna go back to H.B. 7166, the transportation
bill. I just have some questions. So, the contract is $160 million dollars over three years?

COMMISSIONER RODERICK BREMBY: I don't believe it's – Kate, would you come on up?

KATE MCEVOY: Good morning. I'm Katie McEvoy. I'm the Director of the Division of Health Services at DSS, Senator.

SENATOR MOORE (22ND): Good morning.

KATE MCEVOY: I'm just pulling up the contract document. If you could, just give me a moment. So, it's structured with several components. One is the underlying funding for the transportation services themselves. There's also administrative funding for Veyo and there is the risk corridor that the Commissioner addressed. So, the overall contract that is – the administrative portion is $21 million dollars, $21,200,000 and the underlying obligation for the transportation services – I'm sorry, I'm just trying to get to that section quickly. I'm so sorry. It's taking me a moment, but we can definitely provide that to you.

SENATOR MOORE (22ND): So, there was a point to knowing what that amount is because I'm looking at the amount that you've imposed as a fine of $22,000. It's comparative to how much money do they received, so that's why I was trying to figure, well, how much money are they receiving because $22,000 on a multimillion dollar contract doesn't seem like very much in the way of a sanction if you haven't completed your job. So, regardless of the amount of people who are not receiving services the way they should be in a timely manner, if you just – if you're talking about anybody who can't get to a
service because of their size, I think that's what you mean when you say bariatric, because of their size. I mean, we're talking about peoples' health and every single one is important and I know you understand that, but at what point do you look at this and say, we could do better and we can do better than what we're doing and how do we adjust this contract. Do you have the option of going back and putting a higher sanction for certain falls within the contract that they haven't met? Can you adjust this contract in any way?

COMMISSIONER RODERICK BREMBY: Madam Chair, I think that the best way to respond to this is that in a mutually agreeable manner, a contract can be adjusted, but we cannot unilaterally modify the contract with this vendor, so we will continue to engage with the vendor. We will continue to try to improve the performance to make it better, but in order to change the contract, there needs to be agreement both ways.

SENATOR MOORE (22ND): And, then my other question is, has this vendor ever received a notice of action?

KATE MCEVOY: Senator, may I understand your question better? When you say notice of action, do you mean have we required corrective action of Veyo?

SENATOR MOORE (22ND): Yes.

KATE MCEVOY: We have. Yes.

SENATOR MOORE (22ND): And, can you just tell me what areas? Do you have an idea?

KATE MCEVOY: Yes. So, I do want to take a moment to confirm that the contract does articulate arrange
of obligations for Veyo as the broker and then also correlate obligations for Veyo's contractors that are subcontractors which are the actual transportation providers and that is to Representative Wilson Pheanious' remarks previously. It does embody a range of obligations around services and supports, timeliness. There's also – for Representative Wilson Pheanious' benefit, there's also a very expansive section supports for riders, vehicle standards, performance standards for the drivers, so all those things are articulated.

When we have been in process of overseeing and monitoring the performance under the contract, both of the broker functions and the subcontractor transportation providers, we examine what are called key performance indicators. Those are articulated in the contract and those relate to a number of very important domains. Are people able to access the riders revision process smoothly and does that yield in scheduling of trips and performance of the trips that are needed to get people to medical services, so that's a big area. Are those trips timely? Are they appropriate to the medical necessity of the riders? And then, if people do not receive the service that is commensurate with what's required under the contract, are they receiving notices as the opportunity to ask for fair hearing for review of that experience. So, in each and every one of these areas, our manager, Rod Winstead, receives monthly data from Veyo on each of those facets. That's data that we have broadcast publicly. We maintain that on our website and where there have been areas that have not met contract standards, we have issued several corrective action requests of Veyo, so those would detail the particular areas
that need remedying and correction under the contract.

So, for instance, the call center. When we launched this contract on January 1st of the first program years, we had many, many calls to the call center because of weather and the transition. On that basis, Veyo found it impossible to meet the contract standards for timeliness of response to calls. That is dramatically improved and now they are answering within under a minute in responding to people. One area of the contract that we feel is very important, the threshold response to people who are looking to schedule rides. Is that timely? Is that process smooth?

Correspondingly, we look at how well is Veyo and its subcontractor transportation providers able to meet the needs of each individual Medicaid member with appropriate mode of transportation. So, you refer to individuals who require bariatric transportation, I think a very important example of a person who may have special need for accommodation, so we do examine what incidence of those trips are not only appropriately scheduled, but are fulfilled, and that's one of the pieces of the data reporting that we get. If Veyo is not able to accommodate that through the breadth of its network, the incidence of providers in a given geographic area, we see that in the data and so that's almost been something we have treated in corrective action and I will point to the fact that Veyo is engaged in many, many remedial and corrective action strategies for the call center increasing volume, using adjunct call center staff during those periods where there has been higher volume. From the standpoint of accommodating the needed rides, they have increased the provider
network substantially over the levels that we saw historically. In fact, more transportation providers are on the ground providing services and supports. They have also used levers in their contracts with the subcontractors to impose sanctions and corrective action by reducing referrals to providers that are not providing timely services. They've engaged new strategies.

For instance, for ambulance trips, we have made agreements with the hospitals and the ambulance providers that they can essentially self-shepherd the documentation of the need for the trips and we circle around later and confirm that. That's designed to expedite access, so these are all types of examples of the work that we and Veyo has done to respond to those early emerging challenges. As the Commissioner said, we are absolutely in agreement that Medicaid members deserve the highest level of service. We in no way mean ever to say that we rest on a certain level of performance. We're in a continuous cycle of improvement, that these are the types of things that were articulated in those letters of correction that we have sent, and we received substantial documentation from Veyo that they acted on each one of those letters from the department.

SENATOR MOORE (22ND): Thank you.

REP. ABERCROMBIE (83RD): Further questions or comments? Seeing none. Thank you so much, Commissioner, for your testimony and thank you to your staff for being here today.

COMMISSIONER RODERICK BREMBY: Thank you very much.
REP. ABERCROMBIE (83RD): So, we have gone over by a little bit our first hour of elected officials, so now what we do is, we will go back to the public and then elected officials. The public, let me just say it again, has three minutes. There will be a timer that will go off, so our first person is Eliza and I think it's Holland. Yes? Come on up. Yes, you come right up here, and if you push the microphone, please just state your name for the record and then what bill you're testifying on. Either one, yep. Just pull it close enough. There you go. Good afternoon.

ELIZA HOLLAND: Good afternoon. Thank you, Madam Chair. My name is Eliza Holland. I am a certified nurse-midwife and I'm here testifying in support of S.B. 837. I'm a certified nurse-midwife in private practice in New Haven and north Branford with births at Yale New Haven Hospital. I'm in support of S.B. 837 which would correct the current policy of a 10 percent reduction in reimbursement for nurse-midwife services to women in Connecticut.

If the goal is to improve birth outcomes and increase access to care for our underserved families, why not make the most of the obstetric workforce that we already have in the state? Although we collaborate medically with the maternal fetal medicine physicians at Yale, from a business perspective, our practice is midwife owned and financially autonomous. We traditionally care for people who are looking for individualized and personal care. Because of our personal commitment to caring for the underserved, we continue to care for families relying on Medicaid, but have always had to cap our numbers of Medicaid insured births each month because of reimbursement rates. If
midwife reimbursement were equitable, my practice would be able to offer more of our monthly spots to families with Medicaid. Given our overall cesarean section rate of 15 percent in my practice despite caring for all levels of risk patients, this compares to 34 percent in Connecticut overall. More midwife care can be anticipated to decrease costs to the state. Studies repetitively show midwife care provides safety outcomes for mothers and babies that are comparable to physician outcomes. Although midwives are broadly associated with birth care, another example of how investing equitably in midwives quickly saves money for Connecticut comes from our experience in my practice of preventing pregnancy.

In the past, the same discounted rates for midwife services was also applied to medical devices used by midwives, meaning we were not reimbursed the full purchase price of devices such as IUDs, intrauterine devices. Rather than letting our small business lose money, we would refer our patients with Medicaid to a Gyn doctor for their IUD insertions. Nearly half of them did not go. When the state eliminated that discounted reimbursements, we were again able to offer Medicaid IUD insertion in our offices. Now these top tier long-acting reversible contraceptive methods are placed by with excellent patient attendance to these visits reducing rates of unintended pregnancies, an obvious cost saving measure.

We're talking about adjusting the Medicaid reimbursement rates for midwives to offer equal reimbursement for equal services, but I put it to you that because every midwife in Connecticut has an arrangement with a consulting physician, each woman
with a midwife attending her care actually has her midwife when things go well and her midwife plus a physician in case of possible or actual complications. Midwife-attended women have access to more care, not less, and therefore, reimbursement should be set equitably rather than at a cumulatively discounted rate. Medicare corrected the inequity back in 2011 and Connecticut is the only state in New England which has yet to make this adjustment. Thank you for your time.

REP. ABERCROMBIE (83RD): Thank you for your testimony and thank you for your work. Sit for a moment [laughter]. Don't think you're off the hook. Questions? Seeing none. Thank you. You did a great job. Nobody's got any questions.

ELIZA HOLLAND: Thank you so much.

REP. ABERCROMBIE (83RD): Now, we're gonna go back to the elected officials. Representative Frey.

REP. FREY (111TH): Thank you, Chairman Moore and Chairman Abercrombie and Ranking Member Case and everybody else. This is almost like déjà vu. I noticed speaker Raymond [phonetic] in here earlier. I first filled - 21 years ago as a freshman, I was on an insurance committee and Speaker Raymond was then Chairman and had to do with medically necessary infant formula, so this is kind of going full circle, but I wanted to, with your permission, turn my moment over to Di Masters who is a constituent who brought this issue to my attention. Di, please go ahead.

DI MASTERS: Thank you very much and I want to thank you very much. My name is Di Masters and first of all want to thank you all for your service to the
state. I'm here because I wrote the original language for the bill, a very modest version of the bill which Representative Frey introduced which was Medicaid coverage for the human donor breast milk and I'm here now to ask for your attention and full support for H.B. 7165. I returned to graduate school to finish my Master's in Public Health. During my research, I discovered a gap in coverage, health equity in maternal and infant wellness that could and should be addressed which has an impact on our most fragile citizens.

Some premature babies in our state are being denied the nutrition that they could digest, human donor milk, because hospitals cannot afford the cost. When these fragile infants are fed complex commercial formula, they're exposed to painful and life-threatening disease which is necrotizing enterocolitis which is – has a very high death rate. You'll hear more about it later this afternoon when experts come. You may have gotten a lot of letters on it. They're underdeveloped and they just cannot digest that.

What they can digest is breast milk. All of these infants should have food that they can tolerate, but there's more to the story to understand. Connecticut has infant and maternal health statistics, especially among minority populations, that must be addressed and I was very encouraged, Senator Moore, to hear you say that. This bill is part of the solution. With infant mortality among black infants well over twice the rate of white infants in this state, and maternal mortality rates for black mothers shamefully out of proportion and statistics that show us that black mothers will deliver their babies prematurely. We need to begin
to put in place good simple solutions when we find them and as soon as we can.

This bill with help to improve the quality of life, reduce morbidity and mortality among premature populations, and on a pragmatic level and to your point, Madam Chairman, the outcomes of the state will be a positive cost benefit analysis. The modern technology advances ensure that babies that are born very prematurely have an increased possibility for survival. These vulnerable infants are in critical need of human milk to further protect their survival, health, and development; however, women who deliver prematurely have not experienced the physiological and hormonal changes of a full-term gestation, and therefore, typically require additional support to begin to produce milk and to build and maintain an adequate supply to meet the infant's needs.

And, yes, milk is a food, but it is also nutritionally required for very early premature babies. It's the only thing that they can really digest without causing them harm. The use of human milk in feeding a premature infant is a health equity issue in Connecticut as premature births occur at a much higher rate among African-American mothers and it's also a public health priority because disease can be prevented by providing this nutrition.

Although these infants comprise only 12 percent of all births, they contribute to about 35 percent of infant deaths. Donor human milk is a critical intervention to prevent morbidity, mortality, complications in treatment, improving health outcomes in the short and long term, and decreasing
the length of stay for hundreds of vulnerable infants each year. The lowest neonatal Intensive Care Unit costs among the very low birth weight infants who receive the highest average daily doses of human milk for days one through 28 are those that get the most human donor milk. Human milk feedings for very low birth weight infants reduces the risks and the associated costs of late onset sepsis and necrotizing enterocolitis. The mothers of all vulnerable babies seek the best path for their babies healing, growth, and development. This population deserves our best support which includes the availability and use of human milk feeding. The opportunity presented by this bill empowers families to know that their infant will be able to gain the nutrients they need and deserve life-saving donor milk. I thank you for your service and I thank you for your consideration of this important bill.

SENATOR MOORE (22ND): Thank you for your testimony. Any questions, comments?

REP. MASTROFRANCESCO (80TH): Thank you, Madam Chair. Thank you for that information. I'm very interested in the subject and I'm just trying to seek more information and I don't know if you would have it. Representative Abercrombie did talk a little while ago about other states that offer the program. Are you familiar with the other states and exactly how does the program work? How is the milk transferred from the mother, who is donating it, and how does it get to the other infant that needs it? Would you know the process? Would you be able to talk on it and explain it?

DI MASTERS: Well, I possibly know the process. I was a breastfeeding mother of seven, but so I
delivered my own, but I am very, very familiar with the human milk thing because it's northeast which is here and they'll be speaking later today so they'll give you complete information it, but mothers all over the state of Connecticut are donating milk, if you want me to explain, and then they'll probably correct some of the things I say.

There are five milk depots in Connecticut. So, women who have milk to donate, produce their milk, they take it to the depot. It then is transferred to a processing facility where it's pasteurized and it's then delivered to the hospitals that are participating. Now, if I've left out some steps or I have missed - missed some bits in there, the experts will be more than happy to fill you in 'cause they'll be speaking later today.

REP. MASTROFRANCESCO (80TH): Thank you.

REP. FREY (111TH): Just a couple of things. Although I've never lactated, I didn't receive breast milk. There are six states plus D.C. who Medicaid covers donor breast milk. New York was the last state to go on board and they included it in their 2017-2018 state budget and it continues there today and it never went challenged. Basically, it's overseen by the Commissioner of Health in the state of New York and when infants meet certain criteria and receive written medical order, they're eligible to receive the donor breast milk. In some cases, it's fortified. In some cases, it is not.

REP. MASTROFRANCESCO (80TH): Thank you for that. I'll be interested in this afternoon to hear them. Hopefully, I'll be here. I have another meeting to attend - to learn more about it. I'm curious, does the breast milk lose a lot of nutrition as it goes
through the process? We've heard testimony and know that it's best when it's given right away, so I'll be interested to hear that testimony, but thank you.

REP. FREY (111TH): I went through it 21 years ago. I mean, obviously breast milk is the absolute best. The bill that we did 21 years ago was when an infant is born and can't accept the mother's breast milk, can't accept formula, can't accept any other form other than what's - it's really strange, it was prescribed - had to be prescribed by doctor, but it is not technically a description, so therefore, insurance companies didn't cover it. So, it was requiring - and if they didn't have this type of formula, they would end up being in the hospital with internal bleeding and whatnot and malnourished, so the insurance company - Speaker Raymond was here earlier. He dropped in - sorry, he left, but he was Chairman of the Insurance Committee as I mentioned and help me pass that that first year. The insurance companies ended up embracing it and years later we actually extended it to years - year five. It's one of the situations were kids do outgrow, but in this case with NICU babies, those who are very young, this donor milk is so important.

REP. MASTROFRANCESCO (80TH): Thank you for that information. Sure.

DI MASTERS: Oh, I'm so sorry. If I could just add that the CDC, the WHO, and the American Pediatric Association all endorse breast milk either from the mother or donor breast milk as soon as the baby's born, no matter how early, because it's the most important nutrient and it's fully endorsed.

REP. MASTROFRANCESCO (80TH): Thank you. I would agree that it's very important. I look forward to
DI MASTERS: We are fully prepared to completely answer your question.

REP. MASTROFRANCESCO (80TH): Thank you.

REP. CASE (63RD): Thank you, Representative Frey, for bringing this up. A question for you going along with the questions that Gale just asked. I won't do her last name. So, when you have breast milk, you're talking a four-hour shelf life if it's just sitting around after it's been pumped, correct? Okay, so the stuff that you're taking, it's frozen, because I know it's good up to four days in the refrigerator and then you can freeze it. I was just curious how this milk, is it taken fresh or is it taken frozen?

DI MASTERS: The donor mothers freeze their milk and it's taken to the depot and so it's --.

REP. CASE (63RD): I haven't gotten into that process of freezing yet, so --.

DI MASTERS: That's your next step.

REP. CASE (63RD): Okay. So, it's taken frozen and then it's pasteurized as it's frozen. I try to use up as much as I can.

DI MASTERS: Nutrients are spared.

REP. CASE (63RD): Good. So, it's frozen right away?

DI MASTERS: Right away.

REP. CASE (63RD): Sorry. I might not have enough to use.
DI MASTERS: It's pumped, frozen, transported.

REP. CASE (63RD): Good. Okay. I was just curious 'cause we were - so, a mother who overproduces or wants to give would have to freeze the milk right away before it went to the pasteurization for it to be used for this process?

DI MASTERS: Yes.

REP. CASE (63RD): Thank you.

REP. FREY (111TH): We do have some experts coming in this afternoon and we can address that issue.

REP. CASE (63RD): Can't wait, Representative Frey [laughter].

REP. ABERCROMBIE (83RD): I am so impressed. You did that with a straight face. Any further questions or comments? And, we're not taking this lightly. Believe we, we do understand the importance and I have to say I reached out to Yale that sent me a lot of information on this and I was just blown away with the statistics.

REP. FREY (111TH): And, I appreciate from the get-go your proactiveness in this - in our earliest conversations so thank you very much.


DI MASTERS: I can't thank you enough. I really appreciate this, thank you.

REP. ABERCROMBIE (83RD): Our pleasure. We're gonna go back to the public, three minutes. Arielle. Is
it Chaifitz? And, then Steve Hernandez from the commission is next.

AIRELLE CHAIFITZ: Hello. Good afternoon. Thank you for having me here. My name is Airelle Chaifitz. I am here in support of S.B. 837, AN ACT CONCERNING MEDICAID PAYMENT RATES FOR NURSE-MIDWIVES. I am currently a student nurse-midwife at the Yale School of Nursing in Orange, Connecticut. My undergraduate degree is in public health where I focus my studies on the maternity care system in the United States and reducing disparities in maternal health outcomes.

Promoting access to midwife care has proven time and again to be one of the best methods for reducing disparities and improving outcomes in women's health. Supporting equitable reimbursement for midwives in Connecticut would attract more midwives to the state and improve access to care for all women living in Connecticut. Certified nurse-midwives and certified midwives should receive equitable reimbursement rates to Ob/Gyns for many reasons. Midwives are trained to provide care for a range of women's healthcare needs including care during pregnancy and birth for women with low risk pregnancies. This allows for physicians to focus on high risk pregnancies, thus reducing the impact of the shortage of Ob/Gyn providers.

Since midwives have lower rates of cesarean deliveries, induction rates, anesthesia use, and higher breastfeeding rates, this would allow reduce cost on the state level for maternity care overall. Increasing access to midwifery is an important way to address inequities in maternal child health outcomes, especially in communities of color. As a
midwifery student in Connecticut, I have seen the impact of unequal reimbursement rates on my patients.

All of the clinics that I have been involved with have had to increase the number of patients that they see in a typical office day in order to make enough money to keep their doors open. This leads to reduction in the quality of care and disproportionately affects communities of color. Many of my classmates are planning to leave the state after graduation. After utilizing the resources available in Connecticut for their training, many will be looking for jobs in nearby states such as Rhode Island, New Hampshire, Vermont, Maine, and Massachusetts, states in which Medicaid payment for midwives is equitable to that of physicians. Equitable reimbursement from Medicaid would incentivize more midwives to stay in Connecticut, again improving access to care. For these reasons, I strongly urge the committee to support this bill. Thank you for your time.


STEVE HERNANDEZ: Good afternoon, Senator Moore, Representative Abercrombie, Ranking, and other esteemed Members of this Committee. My name is Steve Hernandez. I'm the Executive Director of the Legislator's Commissions on Women, Children, and Seniors and Equity and Opportunity. I'm joined today by Rosa Rada who is our 2Gen Fellow and the way we met, she's also a food fellow, a food and security expert I should say. So, we're gonna be
testifying on three separate bills; 7165 on Medicaid coverage for donor breast milk; H.B. 7121 on SNAP; and then S.B. 898.

So firstly, on H.B. 7165, I won't belabor just the fact that we support wholeheartedly the expansion. I take to heart the testimony of the Commissioner that the definition, the federal definition or food or the federal definition of breast milk is that breast milk is food, but when you think about Johns Hopkins best advice on breast milk and the fact that not only -- not only does it prevent and also supplement early nutrition and early development, but it also prevents infections. It has many disease fighting factors. It helps to prevent mild to severe infections and hospitalizations. Breastfed babies have fewer digestive, lung, and ear infections. Babies born early, those who are premature and who are also breastfed, are also less likely to get serious infection of the intestines called necrotizing enterocolitis. And finally, if your baby gets an infection while breastfeeding, the infection is likely to be less severe. There's so many other reasons that breast milk can be medically necessary. And, then I think the question for us as a state is, will we join our other sister states in signaling to the federal government that the recognition of breast milk should be - or that breast milk should be defined as medically necessary in certain circumstances and I would go a step further. I would say that under certain medical conditions, breast milk should also be covered by our private insurers. So, I commend you for bringing this bill to the attention of the public and the attention of this - of this body and we support that bill. Rosa.
ROSA RADA: Sure. Thank you, Steven. Thank you, Senator Moore and Representative Abercrombie and the rest of the Committee for allowing us to testify. I'll be testifying on H.B. 7121 so that's the act that would change supplemental nutrition assistance – I'm sorry. Rosa Rada, the 2Gen Legislative Fellow. This is the act that would change the issuing schedule for SNAP benefits from once a month to twice a month. And, Commissioner Bremby had made an excellent point that federal law currently through the 2008 farm bill doesn't allow for states to administer more than once a month, but there's many states throughout the country that have changed the issuance schedule itself, so I'll be speaking to that larger issue.

So, currently at 437,530 Connecticut residents, a third of which are children, experience food insecurity. SNAP, the largest nutrition assistance program in the state, acts as a primary domestic safety net for families experiencing financial hardship. So, changing the issuing schedule for benefits, while seemingly minute and bureaucratic, offer an opportunity to support our state's food retailers while improving food access and equity for our residents. So, according to the USDA, a majority of SNAP recipients spend their benefits within the first two weeks of receiving them. Since many states, Connecticut included, issue SNAP benefits at the same time each month, grocery stores also experience a spike in sales and then quickly a drop at the – later in the month. That is when SNAP customer's budgets are depleted.

So, given that grocery stores pay significant fixed costs to operate and generally experience low profit margins, such a retail cycle presents challenges.
In our cities and rural town where it's most concentrated food insecurity and lack of access to healthy affordable food, both grocers and residents lose out. Changing the issuing schedule for benefits would smooth business cycles for food retailers, especially those in economically distressed areas of the state while allowing them to provide a more continuous stocking of fresh produce and staple items.

While this is a relatively simple and inexpensive policy solution versus say offering tax credits to grocery stores, there is much room for error. In 2015, Maryland changed their SNAP benefit schedule from a 10-day period to a 24-day period, but due to bureaucratic mistakes and a failure to consider literacy and numeracy levels, language needs, and housing status, the SNAP recipients—a large portion of SNAP recipients did not get notice of the change, so benefits went unused, residents went hungry, and businesses lost money.

So, the Commission on Women, Children, and Seniors supports effort to expand food access and equity while supporting local economies and small businesses; however, we urge the Committee if you do decide to change the issuing schedule, to provide clear instructions to the Department of Social Services so that they may carefully and thoughtfully implement such a change.

STEVE HERNANDEZ: And finally, on raised bill 898, I wanna focus on a couple of components of the raised bill that I think are worth emphasizing. And, one is cultural competence. The other one is language accessible and then the third is owned by people of color or at least run by people of color. Those
three elements are very intentional and they're intentional in that what we find in communities of color, and we heard some of that testimony earlier, is that the cultural competence really does matter. Linguistic accessibility really does matter and it matters not only when you come in the door, but also how comfortable you feel in staying with the services and how enduring the services are in terms of actually making a difference for the individuals seeking the services.

So, part of this bill, of course, is refunding the money that's been lost or the money that wasn't directed or that wasn't—or that was part of former recisions, but a really important component of this I think is the cultural competence component of the bill which—which communities are feeling in every one of our cities. They feel that their access to services are much further than arm's length and that the—that the level of welcomingness that they feel by being able to communicate and also being able to have adequate followup is really making a difference, so I think this bill would do a couple of things.

It would create a bigger pocket for these funds to resource, but also bring the right type of communicative and cultural competency that our communities need.

REP. ABERCROMBIE (83RD): Thank you. Thank you for your testimony. Senator Moore. No? Questions? So, I do. So, I think it's really interesting your thoughts on S.B. 898 which is the Hispanic and follow community of colored nonprofit, stabilization, and growth fund. So, being that I'm on appropriations and this will fall under me, I
just need some clarification. So, is this currently a line item under the Human Services budget?

STEVE HERNANDEZ: So, one of my colleagues, Ingrid Alvarez, is gonna be testifying later and she's the expert on all of the nuances of where this may be, but from what I understand, the line item now is currently funded at $500,000. I think it's $1.6 million dollars per year for $3 million dollars at the biennium, would be full funding of the original intent of the line item. So, that's what I understand, that it is a line item within the current budget.

REP. ABERCROMBIE (83RD): And, so the issue is, 'cause I just wanna understand it more 'cause you know we start appropriations now. So, currently these dollars go to say like an organ - so I'll use Meriden as an example - goes to say new opportunities, right? Could be dispersed in the community. What you're looking for is having these dollars go to direct service providers like Casa Boricua instead of having to be passed through someone like New Opportunities. Is that what we're looking for?

STEVE HERNANDEZ: Well, I'll tell ya. Every hand that this money passes through is sticky. So, you have to ensure that the money goes directly to where the need is and the point - I think the point that was made earlier is really the salient point that people are going to find - to seek services where they feel comfortable, and not only that, but where they are capable of receiving those services. Linguistic competency is critical to that. Cultural competency will determine whether or not you come back. So, that's why it's important to resource the
organizations that are on the ground, and by the way, the organization that communities are turning to first.

REP. ABERCROMBIE (83RD): No. No. I'm not disagreeing with you there because we have a lot of those great organizations in Meriden. I'm just trying to understand how you want the dollars to flow and I'm not quite sure where we're at on that. That's why I'm asking these questions because when we look at the budget and we start the human services piece, I wanna know exactly what line items I'm looking at.

STEVE HERNANDEZ: And, I'll tell you, there's something about this bill which is noteworthy and that's the level of rigor of this local serving agencies that we're signifying here. These are agencies that have been in these communities for a very long time, that have served these communities for a very long, and for one reason or another, are really operating on a shoestring. And, what that says to me is that they're operating on a shoestring because the resources are going where they are needed and not in creating an infrastructure or a bureaucracy within the organization. That is - I'm not - that's not a dig on existing organizations, big operations, but sometimes small organizations because they need to operate on that shoestring, really do get most of their resources right where they need to be.

REP. ABERCROMBIE (83RD): I couldn't agree with you more. Going to the SNAP benefits, so - so, you heard the Commissioner say, right, that we wouldn't - that he wouldn't be in favor of going to twice a month, but he also talked about, and I think you
said it your testimony, that there are some states that have gone - that have the flexibility of the five, 10 day, 24. What would be your - if we couldn't - if we couldn't do it twice a month, biweekly, what would be your recommendation 'cause I think the Commissioner's testimony was five days right now. What would be your recommendation?

ROSA RADA: So, currently Connecticut administers SNAP benefits on the first three days of every month depending on the first letter of the recipient's last name, so it's actually one of the shortest timeframes of any state in the country. I would - I personally would look to some of our sister states that have - that have expanded that cycle and staggered, just not administering it more than once a month, but just staggering the cycle who gets it, yeah.

REP. ABERCROMBIE (83RD): Thank you. Further questions? Senator Moore and then Mastrofrancesco.

SENATOR MOORE (22ND): So, I want to speak to two. One is the SNAP benefits because I do know that bodegas and local stores where most people go at the beginning of the month, shoot up the prices when they know it's that time, but if it was staggered, those prices would probably be stabilized a little bit more, that they would have them all the time because different people are coming into the stores at different time. Is that what you're thinking?

ROSA RADA: Right. And, I can try to find some - some research to support that for you. It's also that those - in these communities that are - that are most often using SNAP, they don't have a nice large grocery store they can walk to. It's a small corner store and those places generally have very
limited fresh produce, and if they do, it all spoils towards the end of the month. So then they say, well, we can't afford to have bananas so we're just gonna stop having bananas entirely, so it would – it would allow for more fresh healthy produce that's affordable throughout the entire month.

SENATOR MOORE (22ND): See, I know that because we did a corner store initiative in Bridgeport to try to get some of the bodegas to have fresh food all of the time, but we had to subsidize it and help them with their buying power to be able to have those things in place, and so then, the other is the 898. I understand what you're saying about the smaller nonprofits who really most people go to because they have a relationship where they know they understand and they're not caught up in the bureaucracy of getting into a big agency like a one door approach. You walk in the small, they know who the players are in the community, and they know who to refer to. It's still not clear to me still where - I mean how you shift that money to just those agencies and how do you select just those agencies?

So, I have a small nonprofit. We struggle all the time, but we do - we do big work and I'm very proud of the work that was done with very little money, but I can't compete with Yale Hospital who maybe is going for the same $50,000, $25,000 as I am, but I know what the work is that we do on the ground and people know what we do, but when we get to capacity 'cause we're doing such a great job, we can't really do the work that we need to do.

But, I've been struggling with trying to figure out how do you set aside a certain amount of funds for the smaller nonprofits with a budget under $500,000,
right? Not a multimillion dollar where the money can get lost. I mean some people get so much money, I'm saying, you don't know how the money's being used. I believe you're using, but you can't really identify that it's not being used in other ways but also the admin on some of these larger grants is more than what I would get in a grant, right?

But, how do you determine who are those organizations in a fair way that is equitable for everyone, not just in Meriden, but all over the state, those smaller nonprofits who are on the ground doing the work every single day and I think that's part of a struggle to figure out how you do that unless you look at - but, I wouldn't want to do it on budget because just because you're a small nonprofit doesn't mean you're the agency that needs to have the funds, so if you have some ideas, I'd like to hear that.

STEVE HERNANDEZ: Well, you know, there's a - there's the elephant in the room is that this bill is attempting to address a bigger issue and the bigger issue is the lack of cultural competence and the lack of reach of the bigger more established organizations with these huge grants into where the communities really are. What happens with these big grants and these bigger organizations is that there's a moving beast syndrome that happens where the nimbleness is gone from the organization. The ability to actually change its practices to accommodate emerging communities is gone and the way they do business becomes static. They lose entrepreneurship and they lose - they lose the ability to actually access to people who the need the services the most.
So, for me, figuring out how to get the money to the – I don't have an answer, but I bet that's easier than figuring out how to make these bigger organizations change their tune and become more culturally and linguistically competent because they haven't done so for so many years despite the need.

REP. MASTROFRANCESCO (80TH): Thank you, Madam Chair. I just wanted to follow up on what Representative Abercrombie was talking about on 898 and thank you for asking those questions. That was very informative. Currently, there is a line item in the budget you're saying and the amount is $500,000?

STEVE HERNANDEZ: That's what I understand, but that's anecdotal. Someone's gonna testify to that after me.

REP. MASTROFRANCESCO (80TH): Oh, okay. I guess I'm just trying to understand the program better. How do those funds get dispersed, like what agencies are they going to right now? Would you know that?

STEVE HERNANDEZ: I don't know that, but from what I understand, they are going to traditional larger agencies that serve communities that – more established agencies within communities, but I don't know – I couldn't give you a list.

REP. MASTROFRANCESCO (80TH): And, do you know what they offer, what those agencies are offering? What are they doing with the money?

STEVE HERNANDEZ: I guess it would depend on the community, but some of these agencies are – are health serving agencies or social service agencies, so they're the bigger non for profits that are
located within the particular community, but I don't - again, I don't have those details.

REP. MASTROFRANCESCO (80TH): So, you're looking to shift those funds from the big agency directly to a smaller nonprofit?

STEVE HERNANDEZ: To a smaller nonprofit that is a very specific type of nonprofit. It's a nonprofit that's culturally - culturally connected or at least culturally responsive to a community and also linguistically accessible, so for me, those - the services can vary depending on the organization, but the hallmarks that we're really looking for here are those critical hallmarks of serving communities where they are and the linguistic and cultural responsivity - I don't know that that's a word, are two critical components to that.

REP. MASTROFRANCESCO (80TH): I guess I'm just trying to find out what specifically are they - are they doing? Can you give me an example of something specific that you would like to see go to a smaller nonprofit as opposed to something so I can understand?

STEVE HERNANDEZ: Yeah. We can get that for you and I know Ingrid Alvarez is right behind me. I would pull phone a friend right now, but I know she wants her full time to --.

REP. MASTROFRANCESCO (80TH): Phone a friend. Phone a friend [laughter].

STEVE HERNANDEZ: But, I know Ingrid will be able to share that with us.

REP. MASTROFRANCESCO (80TH): Okay. Thank you. I will wait to hear. Thanks.
STEVE HERNANDEZ: Thank you.

REP. ABERCROMBIE (83RD): Further questions or comments? Seeing none. So, Representative, just for a little bit of clarification, so in my community which is Meriden, we have - the bigger organization is New Opportunity, so what they are is they're the gatekeeper of the community. So, someone comes in and they find out, do I qualify for fuel assistance. Do I qualify for SNAP, do I - all the benefits. What they're talking about here, we also have a smaller organization which is Casa Boricua - am I saying it correctly? Casa Boricua which is a great organization that works within the inner city part with families that are mostly Hispanic to help them navigate the system, so I think what they're trying to get at here is the money funnels through New Opportunity as a grant down to them. What they're saying is, take out the middle guy and just send the grant over to these organizations so that you don't have to do a bypass.

I think, and I'm gonna be honest with everybody, I think where the challenge comes in, right, is that you're setting up another process, which I'm not saying is a bad thing, but these organizations are gonna have to understand that now you're gonna have to go to a competitive bidding process because under our state contracting laws, we can't just say, yep, Casa Boricua is going to get X amount of dollars or other community, so I think it's not a bad idea. I think it's a little bit more challenging and it's always the devil in the details, right? So, we're gonna have to work on it, but I understand what you're trying to get at and the unfortunate thing is that's very common across human services, right?
So, DCF contracts with Wheeler Clinic who subcontracts with Child Guidance. Well, take Wheeler Clinic out so you don't have that administrative cost and go right to Child Guidance who's doing the services. I get exactly what you're saying, but I think it's a little bit more complicated than what the bill is putting forward and that's just my opinion as somebody on appropriations. Further questions or comments? Seeing none. Thank you, guys, so much for your testimony. Appreciate it.

STEVE HERNANDEZ: Thank you. Thank you all.

REP. ABERCROMBIE (83RD): And, I think we'll have some followup conversations about the SNAP, too. I thought that was interesting. Vicki Marnin. Did I say it right, Vicki? Followed by Representative McCarthy Vahey. I think I saw her come in. Good afternoon.

VICKI NOLAN MARNIN: Good afternoon. Thank you for your time today. My name is Vicki Nolan Marnin and I'm here to support S.B. 837, AN ACT CONCERNING MEDICAID PAYMENT RATES FOR NURSE-MIDWIVES. I am a certified nurse-midwife in Madison. I own one of the few private independent midwife offices in Connecticut. My practice, Birth and Beyond, has offices in Madison, Wallingford, and West Hartford and attends approximately 100 births a year. We also provide full scope midwifery care including preventative healthcare, pap and breast exams, family planning services, and the like.

In 2017, 32 percent of our clients had Medicaid. Because of concerns for our bottom line, we try not to have more than 30 percent of our clients at any time using state insurance. The reimbursement from
Medicaid for maternity care, which is the bulk of our clients, is already approximately $1,000 less than commercial insurances pay us. The fact that 10 percent is taken from our payment compounds the financial challenges of caring for women on Medicaid. We take Medicaid patients because we have a strong commitment to ensuring that all women have access to high quality midwifery care. However, there is already a significant financial disincentive to caring for these patients. Midwives should not have to see more patients to bring in payments equal to our physician colleagues.

Inequitable reimbursement limits women's access to midwifery care to the detriment of women, and in fact, increases costs to the Medicaid system beyond the potential costs of equal reimbursement. Our practice has an 8 percent C. section rate while the state rate is 34 percent. If that 34 percent applied to our practice, 26 more women each year would have surgical births. A cesarean can increase a hospital bill by more than $10,000 which means that our midwives are saving the healthcare system approximately $260,000 per year. Additionally, 96 percent of our clients are breastfeeding their babies at their six-week followup visit. As we've been talking about breast milk, it is universally recognized that breastfed babies have lower rates of asthma, obesity, and other childhood illnesses and that women who breastfeed have lower rates of breast cancer providing a long-lasting health and financial benefit to the system.

As you know, commercial insurance companies often base their reimbursements on guidelines from CMS. The change you make in our Medicaid reimbursement rates may have a longer-lasting effect on our
comprehensive insurance payments for the care that we deliver. I'd just like to address very briefly what the – is that three minutes already? Okay. So, the Commissioner said the Pay for Performance is supposed to equalize our Medicaid reimbursements. It doesn't because if you have a physician who delivers care and gets the Pay for Performance money and the midwife who delivers the care and gets the Pay for Performance money, we might get the same Pay for Performance money, but we're still making 10 percent less of our charges.

REP. ABERCROMBIE (83RD): Yeah, and I agree with what you're saying there, but I think what the Commissioner was saying was with the limited Medicaid dollars that we have, they're trying to do the best they can, so this is an incentive that goes above and beyond what your base amount is. So, my question to you, is how many – do you know how many standalone midwife facilities we have in Connecticut?

VICKI NOLAN MARNIN: I think we have four, three.

REP. ABERCROMBIE (83RD): Three. Okay, and then since we brought up the breast milk, how many of your – how many of your clients end up in a situation where the – they deliver prematurely and then are automatically – the breast milk is given through the hospitals. Do you know?

VICKI NOLAN MARNIN: We have – we have a very healthy population of women that we take care of and we have very few preterm births in our practice.

REP. ABERCROMBIE (83RD): Okay because I'm just trying to figure out what the cost would be long term for the Medicaid program because I'm just gonna
say it again, we're limited in dollars. We have you up here that wants to be equalized in your payments. Providers have not gotten an increase in over 10 years, so there's a lot of need out there and I'm not disagreeing with it. I'm just trying to figure out - there's no new dollars coming in, so is there a way to shuffle the deck of Medicaid dollars that we currently have?

VICKI NOLAN MARNIN: We could - we could split the difference with the docs and they could make a little less and we could make a little more. [Laughter].

REP. ABERCROMBIE (83RD): I'm glad I don't represent the doc. [Laughter]. But, I agree with you. Equal work, equal pay, right? And, let's just, right? That's what we're always saying, so follow up questions or comments? Seeing none. Thank you so much for your testimony. Representative McCarthy Vahey and she has a guest with her, Nancy Burton. Good afternoon. So nice to see you.

REP. MCCARTHY VAHEY (133RD): It's so nice to see you, Chairman Abercrombie and Members of the Committee. Thank you for having me here today. I'm here today not to share facts and figures and not as someone who will financially benefit in any way. It's to share my own experience as the mom of three kids who were all brought into the world by certified nurse-midwives. And, I was looking at some information and I learned that the word midwife means with women. And, I think it's really incredible the power of having women with women as most certified nurse-midwives are with women who in my case supported both prenatal care, postnatal care, breastfeeding instruction, and support, and
the holistic family centered approach that was so important for my family.

I will point out one thing before I turn it over to Nancy in that breastfeeding certainly has many health benefits to save money on assistance level, but when my first was born, my husband was unemployed and breastfeeding saved our family a lot of money. Formula is very expensive as well, so it's just something that I wanted to point out as well, so with that, I'll turn it over to Nancy Burton who's here with me today.

NANCY BURTON: Thank you very much and thank you, Representative Abercrombie. My name is Nancy Burton. I'm a certified nurse-midwife with over 40 years of clinical experience. I'm currently an educator on faculty at the Yale School of Nursing in the Midwifery and Women's Health Specialties. I'm also Chair of the Board of Directors at the Universal Healthcare Foundation. And, I'm here obviously to support S.B. 837, the ACT CONCERNING MEDICAID PAYMENT RATES FOR NURSE-MIDWIVES.

The current rate of 90 percent is having the effect of constraining the availability of nurse-midwifery services to women and families in Connecticut and it affects not only those who are self-employed, but we become perhaps less attractive employees to service providers because of the lower reimbursement rate. There are many studies demonstrating the safety and cost effectiveness of midwifery care. Midwifery care has consistently been shown to decrease interventions and inductions, decrease the use of anesthesia, lead to lower rates in cesarean sections, fewer preterm births, higher rates of vaginal births after cesarean sections,
higher rates of breastfeeding which has health benefits for women, and higher patient satisfaction rates.

Medicaid pays more than $4,400 more for each cesarean birth than a vaginal birth. Connecticut's current rate of cesarean sections is 34.8 percent. Simply by reducing cesarean births to 25 percent, we would save the state $4.2 million dollars. A study of midwifery C. section rates nationally showed our C. section rate to be 13.8 percent. Data from three large midwifery practices in Connecticut yielded a cesarean section rate of 11.4 percent. I was part of a midwifery practice for many years. We did not risk anyone of our practice. If they were high risk, we worked collaboratively with physicians. We counted every patient in our statistics and still our cesarean section rate was always 15 percent at a time when the hospital was 30 percent or more. These statistics make it clear that increased midwifery care will save the state money and do so quickly. We are in a very unique position as compared to some of the other providers that were mentioned because of our work with deliveries and how clearly we can decrease expenses. If you add to this the decrease in preterm births, and therefore, the decrease in NICU admissions, the cost savings grow exponentially.

Limiting our reimbursement to 90 percent of physician rates makes it harder for midwifery services to survive and be available to women. There are other costs to the increased rate of cesarean sections in the form of complications, both short and long-term health problems for women. For the first time in history, the maternal death rate in this country is rising. A previous cesarean
section increases the chances of complications in future pregnancies also. Decreasing cesarean section rates will save money, but it will also save lives. Equal reimbursement for nurse-midwives and physicians for the same service is a national standard. Twenty-six states, including every other New England state, equally reimburse nurse-midwives. Medicare also reimburses midwives equally.

A joint statement from the American College of Nurse-Midwives and the American College of Obstetricians and Gynecologists recognizes the need for equivalent reimbursement for midwives as necessary for the establishment and sustainability of these services for women. For all these reasons, I urge you to support S.B. 837 and thank you for your time.

REP. ABERCROMBIE (83RD): Thank you. Thank you for your testimony. Questions? Thank you for sharing, Representative, and thank you, Nancy, for your hard work.

REP. MCCARTHY VAHEY (133RD): Thank you, Madam Chair.


SARAH CHURCH: My name is Sarah Church. I'm a certified nurse-midwife at Norwalk Hospital. I've been there for the past 10 years. I am also here in support of S.B. 837, the Medicaid reimbursement
rates for nurse-midwives. A lot of what I have to say has already been said very well by my colleagues, so I'm gonna try not to repeat that too much and just speak off the cuff, but I know this bill can seem kind of frivolous, how much are we getting paid, especially with the knowledge that funding is so limited and the resources across the state are stretched thin.

But, I'm trying to remember what I was gonna say - I think it matters on a couple of levels. It matters on how it affects our local businesses. How likely are midwives to feel secure enough to put out a shingle and open new practices and bring in more revenue? How likely are the larger conglomerate practices which are becoming so prevalent now to hire us and to expand those services? What's the impact on the patients and the Medicaid recipients? It's huge.

So, it's a little disheartening to hear the argument about if I give you a cookie, I'm gonna have to give the whole class a cookie because the statistics that we've demonstrated, our low overall cesarean section rates, you'd be hard-pressed to find a midwifery practice with a cesarean section at 30 percent which is the Healthy People 2020 goal. Our return for prenatal care close to 100 percent with the initiation of contraception to prevent close pregnancy spacing and things like that. I don't know how else we can demonstrate our service and our performance, so to say let's - let's reimburse with a Pay for Performance, we've already demonstrated our promise and we deserve that equitable reimbursement with our physician colleagues.
In terms of the patient experience, without that access to the practices, with the practices having to limit and cap the number of Medicaid patients they're seeing, a lot of the Medicaid patients are relegated to the local clinic and have nowhere else to go and those wait times are long and your appointments are limited and the clinics are having to see 30 and 40 patients a day and they don't have the time to be listened. So, women with Medicaid deserve the same access to care as anybody else would. They can find somebody where they feel listened to, they feel comfortable, they feel cared for, and we have to get them into those practices.

REP. ABERCROMBIE (83RD): Thank you. Thank you for your testimony. Any questions? Thank you for your time. Appreciate it.

SARAH CHURCH: Thank you.

REP. ABERCROMBIE (83RD): Lucy O'Connell.

LUCY O'CONNELL: My name is Lucy O'Connell. I'm a certified nurse-midwife in a collaborative group practice with Ob/Gyns and nurse midwives. I practice in the greater New Haven area. Our practice has been around for 40+ years and the midwives in our group provide similar services within their scope of practice as our physician colleagues, including family planning, well woman, preventative care, prenatal care, and childbirth services; however, the current Connecticut C&M reimbursement is 90 percent, and as they were talking about SNAP benefits should be similar to the other states, all of the New England states have 100 percent reimbursement. And, currently the ACA also approved that midwives should also have 100 percent
reimbursement, so falling into line would make a lot of sense.

In our practice, the midwives, we spend a large portion of our time with education and patient education and prenatal patients talking about testing and life adjustment and childbirth and - and we - our visits tend to be longer even though we are paid less so that we can fulfill this title role. Furthermore, our collaborative practice, much like Eliza was talking about, is you get more care because we always have a doctor and a midwife available and the - since the practice incorporated midwives, the cesarean section rate has gone down and the vaginal delivery rate has gone up and patient satisfaction has also gone up.

And, we currently accept Medicaid on a limited basis which is driven by the reimbursement of Medicaid. Very few private Ob/Gyn practices in New Haven accept Medicaid at all, and thus, increasing Medicaid reimbursement rates for midwife providers would directly increase the ability to provide care for underserved women in the New Haven area in particular. There are many collaborative midwife Ob/Gyn practices in addition to the midwife-only practices in the area and this may increase the number of providers who will accept Medicaid in Connecticut. Thank you.


LIZ GUSTAFSON: Hi. Distinguished Chairs and Members of the Human Services Committee, my name is Liz Gustafson and I'm the Organizer and Volunteer
Coordinator for NARAL Pro-Choice Connecticut and I testify in strong support of S.B. 837, AN ACT CONCERNING MEDICAID PAYMENT RATES FOR NURSE-MIDWIVES. Certified nurse-midwives should receive equal reimbursement rates as Ob/Gyns for the same services as it will improve access for women's reproductive healthcare in Connecticut. This increased access will help improve maternal health and child health outcomes, specifically in communities of color.

Midwives play an integral role in reproductive healthcare and provide many types of healthcare beyond maternity care such as contraceptive coverage, annual women's exams, STI screening, breastfeeding support, cancer screenings, and many more preventative services. In 2011, certified midwives gained equitable reimbursement under Medicare as part of the Affordable Care Act. While this may be the case for Medicare reimbursements, Connecticut midwives fees billed to Medicaid are reimbursed as just – just at 90 percent of the physician rate.

We are surrounded by states where certified nurse-midwives are paid at a rate of 100 percent, making Medicaid and Medicare reimbursements equitable for physicians and midwives which includes Vermont, Maine, New Hampshire, Massachusetts, and Rhode Island. Although the ACA improved health insurance coverage, millions still go without health insurance, many of them people of color. For many women, there is still trouble accessing timely culturally appropriate care. Connecticut is currently positioned to take a lead on expanding reproductive freedom which includes ensuring individuals have full autonomy to make decisions
regarding their pregnancy. As primary care providers, midwives will help alleviate the significant pressures on communities and health systems and will serve the growing number of women in our state. I urge the Committee and Connecticut lawmakers to support S.B. 837. Thank you very much for your time.

REP. ABERCROMBIE (83RD): Thank you for your testimony. Questions? Thank you.

LIZ GUSTAFSON: Thank you.

REP. ABERCROMBIE (83RD): And, thank you for what you do. Moving on to Ingrid Alvarez and I'm sorry, the last name is kind of squished together, Demaros? Demarso. Thank you. Hi. How are you?

INGRID ALVAREZ: Good afternoon, Madam Chairs Abercrombie and Moore, Vice Chairs, and Ranking Members of the Committee. My name is Ingrid Alvarez and I am the Connecticut State Director for the Hispanic Federation and today I testify in full support of S.B. 898. I have submitted my full testimony electronically, so in being able to save time, there've been some very remarkable questions asked on S.B. 898 today and I'd like to start from there.

I'd like to set the tone for this isn't an us versus them when it comes to small nonprofits or CAP agencies and this is not a zero sum game, right? This is - there's a longstanding historical context around dollars in communities of color, but I will like to share to start that a consequential loss to the state of Connecticut annually by excluding diverse communities and addressing and having a plan for how even direct service needs have changed
is approximately $34.28 billion dollars a year, ironically really close to what our deficit looks like when we're trying to address really complex fiscal challenges that we're having.

And, using that as a process, right, I'd like to be - to address my testimony and you around some of the questions asked. So, one of the things that S.B. 898 proposes is to use census tracks and research data around being able to define, describe, and educate everyone in the state around the changed face of Connecticut. Latinos and immigrants specifically, and I'm talking about diverse immigrants, not just Spanish-speaking immigrants but immigrants as a whole have driven 43.3 percent of the state's population in the last 10 years which means that after 2013, when the Connecticut state population peaked, we've replaced that and then some.

We're much younger. The average age is 27 which means that that is the human capital that we need to invest limited resources, right, in being able to drive a pro-growth economy that we're talking about and envisioning, but the process for what's called the HHD, or was called 'cause it was taken away, and the HRD, you guys say herd, is that even in really good times, and I have some amazing service providers that will testify after me and can give you some more historical context, but I go back at least 11 years.

The rules or guidance around good partnership, using evidence-based research and data to allocate dollars around the SSBG dollars, both federal, whatever the state matches when it can, is nebulous. And, this has been - there's a misnomer today that community
action agencies are subcontracting these dollars to small nonprofit organizations. That has stopped and really what it's done is pinned one service provider against the other around being able to keep in-house resources when line by line the strategy has been to cut. And so, therefore, no. The subcontracting, and I'm not generalizing, but for the most part the data is there under DSS. That subcontracting that was spoken to here does not exist. Therefore, those class competent CBOs that are small that can provide those direct services and the need for changed services in community no longer get funded through these lines.

And, so that's the crux of the issue. And, so being able to use things like census track or designator create guidance around bringing community action agencies, community-based organizations, and back to the table to clearly delineate their responsibility including and sending those dollars to where and whom it's supposed to go is what this conversation today is about. I'm gonna stop here so that you guys can ask me some questions 'cause there were a lot as I was sitting here in the back of the room.

REP. ABERCROMBIE (83RD): So, how do you – so, thank you so much for your testimony. So, how do you – how do you envision this being allocated to these service providers through DSS? How do you see that happening?

INGRID ALVAREZ: First, it restores a very critical line item, right, in that in being able to drive the investment decisions through an allocations panel and so we're proposing an allocations panel of at least seven people and it should be inclusive of a Representative, if not the Commissioner, a
representative of DSS, a representative or two from the community itself, as well as some others like the Commissioner in Equity and Opportunity to then be able to invite small CBOs or local community organizations to compete on some level for these dollars, right, and are controlled and we don't want it to be sort of a free for all, so part of what we've proposed is that it's capped to organizations with operational budgets of less than $2 million dollars and under and go through this allocations process using census track and the performance - the key performance indicators that we're measuring some of our worst outcomes and who it'd impact to drive those decisions from the allocations committee.

And, then that would ensure then that those resources and those dollars also match the diverse service needs that the community needs right now as well as who drives or who provides those services and I can give you one example. So, there is a humongous amount of data that talks about the positive benefits of turning a legal permanent resident into a U.S. citizen and that includes ESL classes, citizenship classes, and now the Department of Justice, Bureau of Appeals accredited. We have four Latino nonprofits across the state of Connecticut that have been able to raise their own unrestricted dollars to invest in that, and when we're driving get out the vote and civically engaging our people, there's data and key indicators that shows that socially - social economic opportunities for an immigrant family goes up with citizenship.

We don't provide those services not through any cap agency, not through any free service providers in the state except these four agencies. They used to
be subcontracted or directly receive the HRD dollars. That stopped in 2011. And, the issue there and the return on the investment is, is that then through the ability to invest a minimal investment of $10,000 that it costs to become Bureau of Appeals accredited and be able to do the – and $400 so someone can become a U.S. citizen and waive those fees for them, then they're able to civically engage. The likelihood of their economic status goes up.

And, the fact that then they can engage in a forum like this and testify, advocate, all of those things they're all interconnected and being able then to talk honestly about how do we direct or how do we even redesign services because the needs have changed. How then do we direct very limited resources on the state level to where we need to drive them based on data and based on performance outcomes and who that's impacting and where. And, so being able to both bring the cap agencies to the table if possible to ensure that we design guidelines for those who are supposed to be subcontracting, that those subcontractors do go out or to directly contract with the Latino service providers that were the first two in 2011 to disappear from the HRD line as a grantee because of cutbacks.

REP. ABERCROMBIE (83RD): So, you do realize that by adding that extra layer, you're talking – you're taking dollars from that line item to – to fill it back in with staff.

INGRID ALVAREZ: No. So, not fill it back in with staff. So, right now --.
REP. ABERCROMBIE (83RD): Well, if you're talking about a board that has to oversee this, nobody's gonna do it for free.

INGRID ALVAREZ: So, it's not a [inaudible 2:36:29]. We have the commission of authority and opportunity. Now, it's a merged commission, right? We have the representation in the way that the system is supposed to work within CSIs. Right now, DSS just passes through the money over and over whether or not, right? You know, it's going into the organization that it should be. And, the reason — and, the reason why internally within the process creating the opportunity to compete is then it allows an organization to be able to come to the fold and say, this is the return on the investment, in the services and what we provide to be able to be considered by the CAAs who are holding this pot of money to allow us to participate, to include us, to be able to then drive the — drive down these disparate outcomes in our communities.

It doesn't exist and it's so nebulous and it is an elephant in the room, and like I said, I started with this isn't an us versus them, take away from them to give to us. This is about — this exclusion not only is costing us money, but it's preventing us from being able to at a time when we really need to be as cost effective as possible to really direct the caliber and the expertise that exists in communities and ready, willing, and able to provide the services from engaging.

REP. ABERCROMBIE (83RD): Okay. And, I kind of see it from a different lens. I see you setting up a silo and I don't believe that we want more silos, so I think we need to — I think we need to continue the
conversation. I understand where you're coming from, but that's not exactly how it works in my communities, so my fear is, communities that are doing this the right way through their CAAs, are gonna be penalized with this, so I agree there's more conversation to have, but I'm just giving you, as somebody that's on appropriations, I'm just giving you my opinion on this, what my recommendations would be going forward and I'm just trying to be honest.

INGRID ALVAREZ: No. And, I appreciate that. It's a complex conversation.


REP. CASE (63RD): Yes, Madam Chair. Thank you. Madam Chair, as you mentioned, appropriations, I think this - I think it's a bigger issue that we have to take a deeper dive in. As we spoke earlier, the CAAs are the ones who have the dollars and I was just curious if because the good Chair and myself both sit on appropriations and so we have to carry a lot of these things over there, so see what monies are coming out of the CAAs to this that are legislated or actually supposed to be going that might not be going. I know we've had some things in the past, but I think that we need to just move on this before we - we can go into screening and ask for more information and see exactly what dollars. I agree with you as I spoke earlier in the hallway, if we go and we open this up going directly from DSS to somebody, it's gonna be a nightmare and it's got to out to bid. That's why the CAAs carry the dollars, but we need to see if the dollars are being funneled to the right organizations. Is that the
crux, without getting into it any deeper, to make sure that the dollars that are committed, are going where they are supposed to or appropriated to go to.

INGRID ALVAREZ: Yes.

REP. CASE (63RD): So, I think that's the bottom line. I think you and I can look into that. Okay, but I thank you for coming forward. I think we got that down to a little bit easier level to where maybe we can work on it for you.

INGRID ALVAREZ: Okay.

REP. CASE (63RD): All right?

INGRID ALVAREZ: Thank you.

SENATOR MOORE (22ND): So, you mentioned $2 million dollars at different times. A small nonprofit, a $2 million -- $2 million dollars is not a small nonprofit.

INGRID ALVAREZ: Well, no. So again, in not being able to create silos and being able to ensure, right? But also, then also being able to - Commissioner Bremby earlier testified to the nonprofit program in the state. Well, smaller nonprofits also have not been able to pierce through that due to the fact that they are not competitive enough due to some of the infrastructure that they need to build. And, so also in being able to propose a way where - it is a risk to put it out, to bid or create additional guidelines, to bring people together to be able to figure out an equitable way of ensuring that this goes out.

And, so that - and, so we said if there's a cap of $2 million dollars on organizations, so who actually
applies through this right? Large organizations have the infrastructure, have the grant writers, have the strategic plans, have all the things that when they apply to the nonprofit programs or large foundation multiyear grants, gets them funded. It's an infrastructure that needs to be built and it's not from a deficit point of view. For me, you build community from the ground up. Community solutions from the ground – from the boots on the ground is how we start to drive down some of the disparate outcomes, but it's a – there's a capacity building paradox. There's a paradox when we talk about what agencies need in order to be able to reinvest it in and it's a catch-22 and so without being able to again, it's not a measure to hurt – again, it's being able to create guidelines to ensure that the limited resources that we have are actually going where they need to be in an inclusive conversation.

REP. ABERCROMBIE (83RD): Thank you. Thank you for your – thank you for your testimony and thank you more importantly for your – your passion on this. It comes through, and listen, nobody's gonna dispute that, so thank you for what you do each and every day.

INGRID ALVAREZ: And, I'm happy to provide and reach out and meet one on one. It is the proposal. It is the first olive branch in saying it's a big elephant every year in the room. Can we figure out how we can find a solution together?


Good afternoon.
DANIEL REYES: Good afternoon. My name is Daniel Reyes and I'm the Executive Director of Junta for Progressive Action. The mission of Junta for Progressive Action is to collaborate with Latinx in immigrant communities in the greater New Haven area to advance the social, economic, and civic environment for all while embracing Latinx cultural traditions. Now in our 50th year of operation, we are the only multiservice organization left in New Haven dedicated to providing premier services in a culturally and linguistically appropriate manner for Latinx participants.

Our departments take a whole person approach and are designed to stabilize low-income households experiencing acute needs, engaging households in community and economic advancement to secure long-term financial stability and promoting community-wide regeneration through youth programs, laying the foundations necessary for youth to become New Haven's next generation of leaders. Junta for Progressive Action would welcome the opportunity to apply, engage, and receive the organization development support and opportunity like the communities of color, nonprofit stabilization fund presents to us in CT.

A grant investment in my organization would transform our capacity to engage Latinx families in sustainable solutions designed to economically advance everyone with a particular focus on access for Spanish speakers with limited English proficiency. It would increase the ability to diversify funding streams to ensure organizational revenue is more balanced between public and private support. It with expand our capacity through technology to effectively and impactfully
communicate with recipients of our services and our supporters.

And most importantly, it would increase our ability to respond to crisis much like we did last year when we responded to the acute needs of Hurricane Maria evacuees from Puerto Rico arriving in Connecticut and we continue to do so despite our limited resources. Investments of this kind make it possible for nonprofits created by communities of color serving communities of color to create infrastructure that meets the acute and critical needs of communities that have been locked out of the opportunity to advance their social, economic, and civic environment.

This capacity-building initiative would dramatically level the playing field by assisting historically excluded organizations in receiving consideration and qualifying for state funded and or contracted human development service opportunities. Investment in capacity goes well beyond the dollars spent in the moment. It ensures that the safety net created by nonprofits like Junta and other people of color led nonprofits is tightened and buttressed so that the most vulnerable in our communities never fall through and suffer unnecessarily. Thank you for your consideration.


SENATOR MOORE (22ND): Thank you for your testimony. I'm just wondering. Much of the money that you're talking about, the state dollars, have you all ever thought about the federal dollars that you could apply for because I think you're talking about a lot of displaced people who're coming into the United
States from some of the areas that were hit hard by the hurricane. Have you applied for federal dollars?

DANIEL REYES: We have been looking at it. We are looking at it and I am looking at it. Just for full disclosure, I'm relatively new to Junta. I've only been there for a few months and I do know that we have not - really the challenge has been the capacity in order to be able to do that. And at this point, given our really - taking the limited resources we have and focusing it on direct services, our ability to kind of buildup infrastructure that would allow us to do that is very challenging. So, what at this point I'm doing is myself as the Executive Director really looking at it and I will, full disclosure, it's an incredibly harrowing experience and I'm a career nonprofit professional and looking at it myself without a team to actually help me with it is quite challenging. At this point, we - it's myself in essence running the organization with an office manager with no development department whatsoever that could actually support us in that endeavor.

SENATOR MOORE (22ND): So, the Hispanic Federation is a membership organization. I know that was the young lady before you and so I'm looking at the organization's listed. I didn't see the organization listed that is in Meriden. So, is this list complete of all the memberships or are the other people that are part of this - 'cause I'm just saying that if you have this large federation, there's an opportunity for you all collectively to apply all your social capital or whatever you have to make - get this money federally. I mean, it seems to me and I understand the need for it, I do
understand the need for it, and I don't see in our budget, and I'm not on appropriations, being able to pull this out, but I think your need is immediate.

And, so, and this looks to be statewide, the membership, that another approach may be in conjunction with doing this is going to some of the federal legislators, going to Congressman Himes, going to Rosa DeLauro and trying to put some money together to help – help with this because I think this could be a huge burden at a time when we're – you know I heard Governor Lamont talk about the deficit we're in and that's gonna be ongoing, but this problem is right now, right? I don't know what else you have done to try and pull this together, but I would suggest that that is another avenue and that I understand how hard it is to write some of these federal grants and get federal money, and if you don't have that person in your organization that is specifically writing federal grants, how complicated they are, but each one of those – those federal legislators have people that will help you write your grant and even loan someone to you and then there's the University so we have grant writers who are – could be an intern to help you build a larger sum of money because I think you're talking about $500,000? No. Do you know what the figure is?

DANIEL REYES: Yes. It's about $500,000.

SENATOR MOORE (22ND): So, what is $500,000 gonna do for the amount of people you're talking about? It mean, when you look at admin, you take – what is admin for the state? It's gonna be like 15 percent off the top, right? So, what money do you really have left to spread over these organizations. That
is just like a drop in the bucket to what you really need, so I would suggest that be one of the ways that you look at trying to address this. I understand the importance.

DANIEL REYES: I completely agree with you and I do think that - I think that we as a federation - I mean, I don't wanna speak on behalf of the entire federation, but I do think that this is definitely a shift in the paradigm that we really need to look at. The challenge, though, is that especially with small nonprofits, it's very much in the starvation cycle. It's really struggling to survive and the ability to kind of focus on your constituents and then to at the same time kind of think about the federation is very challenging. I mean, I agree that that is the approach we need to take. We do as a block need to be able to kind of look at those federal dollars. I also think that - I think it's important to understand that as - myself as the leader of a nonprofit, the diversification of those funding stream is incredibly important at the federal, state, local, private dollar corporations, individual giving. All of that is important in order to kind of shelter and shield an organization from economic downturns, but again, it's very challenging to do that when we're at a place where there's not even personnel that can do that and there's only in essence one person driving the administration while we're really focused on meeting the acute needs that are happening in real time.

I mean, I would also add that I think one of the things that we should also really consider is that organizations like Junta are in fact really in essence generating economic viability for these - for these communities by securing people with SNAP,
by securing folks with health insurance, by working with folks to think about economic advancement with better paying jobs. We're fueling local economies and there should be some level of return on investment not just for the state, but for the nonprofits that are really struggling to continue to provide these services.

SENATOR MOORE (22ND): So, I feel your pain and I totally understand. I do. I know what you're talking about 'cause I get hit a lot of times with, when I - well, why don't you just find someone to write the grants for you? Well, I got to run the day-to-day business and make sure I can sustain what I have right now instead of expanding what I need to do, but I still have to do it. I'm not saying I've been successful at it, but I understand the need to still do that. And, then I just think there's many an approach, but I think what you're really talking about here is equity. You know what? We want our fair share of the dollars for the work that we do and it's fairness and it's equity and I understand that, too. I'm just trying to figure out how do we -- how do we get you a little bit more than $500,000 because I don't see that being the answer, but I think it's - it may be the beginning of equity, addressing equity, acknowledging the lack of equity in the systems.

DANIEL REYES: I mean, it's not my intent to disparage other organizations or large organizations, but I will tell you that in the time that I've been at Junta, the number of people who say that they have partnerships with us in order to secure large grants is astounding and none of that ever trickles down to us and we really - we're not going to say to an organization, no, we're not gonna
help your constituents because we're dedicated to serving everybody, but really what happens is that when you need - the people of color, you turn to us, but you don't follow through in actually supporting us as well.

And, I think that's really where the challenge comes, that we're not gonna turn away from our constituents. We're not going to say, well, no, there's no money for us, then we're not gonna do it. I mean, that's just never gonna be the case. I mean, we never did that when we dealt with the evacuees from Puerto Rico. I mean, we didn't even have the dollars and we still did it and we continue to do it, I mean, but so - I mean, it's challenging, but it puts us in a precarious position because we absolutely have to respond and yet at the same time we're in essence being utilized when it's convenient.

SENATOR MOORE (22ND): So, your argument could be used on, I wish I had you when I had to give testimony for breast cancer and funding for dollars because the argument is the same all the time. You come to us, communities of color, when you want to write a grant, you throw our name on it, you say you're a partner and but we never see the real dollars that help us make a difference even if you give us a little part of the program. I get that and I'll just tell you what I did. I ran something in the Connecticut Post that would not allow anybody to use my trademark name of my organization without a written authorization from me because I was actually in Washington, D.C., at a federal event and a federal grant writer or the person who awards the money said, oh, we just gave you - I'm like really. I went back. I never saw the money. So, I
understand what you're saying. I think we have to work together to figure out how to get this done. Thank you.

REP. ABERCROMBIE (83RD): Further questions or comments? Senator Logan.

SENATOR LOGAN (17TH): I'd like to say comment. Yes, I do have a comment. And, thank you for coming on board. I think Junta plays an incredible role for our community. I grew up in New Haven. My mother lives in - still lives in New Haven. My uncle sat in your chair. He was the Director of Junta in the late 70s, Frank Taylor, and Junta gave my mother one of her first jobs as she came here to Connecticut from Guatemala so you've been playing that role in the community for many, many years. Anything I can do to help out, please reach out to me. I'd love to sit down with you and talk about ways to support the good work that you're doing for our community in New Haven - greater New Haven and for Connecticut, so thank you.

DANIEL REYES: Thank you. I'm proud to say we're celebrating our 50th anniversary this year.

REP. ABERCROMBIE (83RD): Any other questions? Thank you so much.

DANIEL REYES: Thank you.

REP. ABERCROMBIE (83RD): Next up is Bernard Thomas.

BERNARD THOMAS: Good afternoon. My name is Bernard Thomas. I'm the Executive Director at the Hartford Knights Youth Organization where we serve at risk youth. The Hartford Knights mission is to create hope and opportunity to promote self-esteem and social competency, academic achievement, by
providing mentorship that builds characters, preserves resilience into the greater Hartford youth.

Hartford Knights serves 43 percent of Hispanics and 37 percent of African-Americans throughout the community in greater Hartford area. I fully support S.B. 898 and ask for your leadership to support it, too. With this nonprofit stabilization and growth fund, our organization will be able to expand capacity and better serve at our at risk youth in the greater Hartford community area. It would help us with strategic and organizational development, leadership development, new board and new program planning and development, needs assessment for the community, planning of new programs, staff development, and support the initiative.

Hartford Knights would welcome the opportunity to apply, engage, and receive the organization development support. The community of color nonprofit stabilization fund creates the opportunity for us in Connecticut. The Hispanic Federation sends out grants for $1.4 million throughout the community to help support not only our organization, but other organizations throughout the state of Connecticut. Investment into the community of the colored nonprofit stabilization fund will ensure nonprofits embedded into the community of color will be able to provide a critical service that properly addresses the diverse and growing needs of our state diverse community. It levels the playing field by assisting historical included organizations in receiving consideration and qualifying for state funding and/or contract for human services development opportunities. Thank you for your time.
SENATOR MOORE (22ND): Thank you. Thank you for your testimony. I just need some clarification. So, you receive funds from the Hispanic Federation for your program now?

BERNARD THOMAS: I do.

SENATOR MOORE (22ND): May I ask you, what's your budget range, annual budget?

BERNARD THOMAS: Under – under $500,000.

SENATOR MOORE (22ND): Under it. I consider you a small nonprofit.

BERNARD THOMAS: I consider myself a small nonprofit, too. [Laughter]. And, it's hard – it's hard when I'm competing against some of the higher nonprofits that are nationally recognized throughout – throughout the city of Hartford. The amount of children that we help, the impact that we're doing throughout the community, we give – we provide mentorship for within the school system. The schools will take all the mentors that we could provide. We have an 85 percent social and behavior issue within our school system, and without the support for the mentorships throughout the community, it's really hard. Our organization has to fight for funding that other big organizations draw, so it's – I understand what you go through for your day to day. When we have a small staff, to be able to go out there and support the nonstop of phone calls where organizations that should be giving the proper information and the proper help and support, when you're a fee for service for certain organizations, you don't get paid for 45 to 60 days. It's hard to manage your organization throughout that.
SENATOR MOORE (22ND):  Any questions? Thank you for your testimony.

DANIEL REYES: Thank you.


FERNANDO BETANCOURT: Good afternoon Honorable Representative Abercrombie and Moore and Members of the Committee. My name is Fernando Betancourt. I am the Executive Director of the San Juan Center, Inc., a Latino nonprofit agency in Hartford Connecticut providing social services to low and moderate income people in the greater Hartford area. We are testifying today in favor of raised Bill No. 898, AN ACT ESTABLISHING THE HISPANIC AND FELLOW COMMUNITIES OF COLOR NONPROFIT STABILIZATION AND GROWTH FUND.

Established in 1957 and incorporated in 1972 as a 501-C3 nonprofit organization providing services to an average of 1,200 low income individuals. This one center administers programs such as housing for the elderly, workforce development, computer literacy classes, affordable housing, advocacy, translation services, tax preparations, civic engagement, and management of the thrift stores that serves an emergency center for dispossessed families in Hartford.

During that period, we have witnessed the disparities affecting the Latino and other communities of color in terms of access to opportunities and distribution of resources. For decades, nonprofit organizations as defined in this legislation or proposed legislation and under
contract with the Department of Social Services to provide, and this is the category - human development services have been extremely successful in the providing of high quality services while at the same time saving millions, and I want to emphasize this, millions of dollars to the state. Unfortunately, over the last decade due to the economic crisis, we have also seen the decline and erosion of funding to this particular line item going precisely to the same bicultural nonprofit organizations that have been so successful reduced to zero. I want to remind by the way that it was the act of the legislature on two occasions that that line item was reduced to zero and you incorporated the monies allocated on that line item. We applaud the proponents of this legislation by creating this forum. You are investing in an important network of grass root nonprofit organizations that provide valuable services to a segment of the population that trust these organizations and feel more comfortable interacting with them than with agencies from the state.

In particular, we support the areas in the legislation that invest in infrastructure development and accountability mechanisms available to these organizations. By investing in this social service agencies, you are averting a dangerous trend that had the undesired effect of abandoning a significant amount of the most vulnerable members of our society. And, I would like to just finish and in my testimony by clarifying a number of things that have been said here before.

The specific line item that we're talking about used to be under HRD Hispanic Services. That line item was less than $1.1 million dollars. Now, over the
years, for the last decade, it has been reduced year after year and those forums were with the same contracted agencies for 20 or 30 years. We – the ones that we have those contracts that go directly to those agencies, not necessarily to a conduit through any cap agency in the state because they're some that do that through the cap agencies, some others through municipalities, but many of us have contracted directly with the Department of Social Services for decades and we have always been monitored and audited by the state.

If we were not performing at a high quality, if we were not saving those millions of dollars to the state, we would not be in business on that particular contract with the state. So, this proposed legislation is going through another way of trying to fund the same institutions that have served the state so well by providing a mechanism to at least provide an access to those dollars for infrastructure. So, I wanted to clarify that because when the Commissioner stated before that it's only the 5 percent reduction, that's not the case and I can give you two more examples.

On several occasions when those contracts mirrored the federal government because this money originally came through CSBG monies through the federal government, the contract year with the state was starting October 1st onto September 30th. At one point, it was changed to nearer the state fiscal year. At that point, there was three months on the allocation, so when we had to do and entering the following year contract, three months were taken immediately. So, we're talking about close to 25 percent of reductions and we're talking about 2 or 3 years ago. In addition to that, when you
incorporated again the same dollars on the same line item, the contracts expired and they have not been contracted with us. The department told us that now instead of renewing those contracts, we were going to go through an another repeat process. For five months the dollars are there, no RFB has been issued. In the meantime, we are providing those services and I want to make another thing. The Hispanic Federation has been mentioned. The Hispanic Federation, we're a member agency. We in the case of Puerto Rico, we formed, raised nationally more than $24 million dollars here through the efforts of our own small organizations. We fund raised more than $50,000 only in Hartford, so we are providing real service to real individuals and we are incorporating those resources into our communities to develop the communities which indirectly and directly brings more dollars to the state.

REP. ABERCROMBIE (83RD): So, two quick questions. What's your definition of infrastructure money?

FERNANDO BETANCOURT: Well, according to this proposed legislation, there's a number of things that through the panel – this is not a bureaucratic entity that is newly created. This is only using the same structures that exist for the committee to review the RFBs of the agencies that are gonna be applying for this as long as they meet the criteria under this proposed legislation and then that panel decides how much money and to where this - this monies go, so --.

REP. ABERCROMBIE (83RD): So, how much - so, what you're saying is you need dollars to be able to put this board together so --.
FERNANDO BETANCOURT: No. No. It's not a board. The language in the legislation talks about the panel to just go through like you go through the state with any RFB and you decide who meets the criteria and how much money.

REP. ABERCROMBIE (83RD): Right, but some – but, even a panel has to get paid. Nobody's gonna do this for free.

FERNANDO BETANCOURT: No. No. No. First of all, you don't have to pay because they're existing employees in different capacities. It has been mentioned, for example, I was the first Executive Director for the Latino and Puerto Rico Affairs Commission in 1995, so I served in this body for 14 years, so the example of Steve, who testified before, serving in that panel, you don't have to pay him if that was the case extra dollars for that – for that – serving in that capacity, the same way you would not pay extra dollars to any members of the Department of Social Services to assign another RFB.

REP. ABERCROMBIE (83RD): So, do your dollars come through another agency or do you receive your dollars direct under that line item?

FERNANDO BETANCOURT: Well, the department has stopped contracting. They don't have any more contracts. Remember, the $1.1 million dollars that I referred to before on that line item, it was distributed through about 30 different agencies in the state, so what we're talking about is about 80, 60,000 contract for each agency. That's all. So, the language in this legislation is talking about the creation of a fund to achieve the goal of allowing this committees of color and Hispanic
entities to apply for this fund to create an infrastructure and develop an infrastructure. It's not, at least the language in this legislature, is not to provide direct services.

REP. ABERCROMBIE (83RD): Okay. Thank you for your testimony.

FERNANDO BETANCOURT: You're welcome.

REP. ABERCROMBIE (83RD): Sheldon Toubman followed by Kathy Flaherty.

SHELDON TOUBMAN: Good afternoon, Senator Moore, Representative Abercrombie, and other Members of the Committee. My name is Sheldon Toubman. I'm an attorney with New Haven Legal Assistance. I'm here to urge you to pass favorably on H.B. 7123 and S.B. 836, but with amendments which are attached on page three of my testimony. The free legal services programs in Connecticut have for some time been advocating to address the administrative and processing dysfunction at DSS which prevails.

DSS has been asked by this committee, by the MAPOC, by legal services advocates, many other constituencies to fix the system, but major problems persist. Long waits, I know - I heard this testimony this morning that it's 10 minutes, but the latest official report says 28 minutes average with some people still being over an hour to get through on the phones. Long waits at the regional offices known as service centers, clients being turned away when lines are especially long, in violation of federal law when it comes to federal benefits and clients being discouraged from even applying for benefits.
Delays in processing of redetermination papers resulting in termination of benefits for eligible individuals when all requested documents have been timely submitted because DSS has programmed the computer to automatically shut off at the end of the one-year redetermination period if the papers haven't been reviewed by then. They haven't been. They're sitting in a queue waiting to be processed 'cause there aren't enough bodies to get to it. And, repeated requests for regular reporting have – to this committee, to MAPOC, repeated requests for documents and regular affirmative reporting have been rebuffed or ignored. So, despite all those meetings and hearings, the dysfunction continues and the department has been unwilling to commit to any specific requirements for what it should do as far as the phone system. It has said now it's down to 10 minutes. Back in 2015 and 16, it was down below 10 minutes for several months, but then it went up to an hour-and-a-half, so they are unwilling to commit to anything that's reasonable. Ten minutes is long. We propose 10 minutes is long especially compared to what DSS requires of its own contractors, between 30 seconds and three minutes average.

Veyo, doing a terrible job. There's no question they're doing a terrible job, but they are complying with their requirement of 80 percent of calls being under three minutes. In fact, their average is under 60 seconds. So, that's just one of the contractors. Another contractor, Beacon, does behavioral health, is meeting its 30 second average requirement. These are reasonable requirements. They will not commit to them. We urge several things, specifically in our written testimony – in
my written testimony you see the language to do certain things. Improve the response time and make a commitment to 10 minutes as the average. Second, improve the service center delivery at the regional offices including a prohibition on turning away individuals who arrive on a particular day to apply for benefits without accepting the application that day required by federal law for federal benefits, doesn't apply to state benefits, but that seems reasonable. It's like the DMV. You show up when they're open. You should be taken that day.

Timely processing of eligibility renewals with protection from termination of benefits if the individual has timely submitted a completed redetermination form which is a waiting, review, and processing. We propose that for all benefits except SNAP – I know the Commissioner said, well, federal law doesn't allow that, but that's only true specifically for SNAP. Lucy Potter is after me and she knows this stuff really well, but I can tell you for any other benefit, there is no federal law, prohibition on saying the person stays on if the document is waiting to be processed.

And lastly, regular and consistent affirmative reporting to the MAPOC on data that tells us how DSS is doing in these areas. Finally, we acknowledge the department cannot fully comply with these matters without an infusion of resources. We urge the Members of this Committee who are also on approps – I know Representative Abercrombie you're in that situation – to support these necessary new mandates by also giving the agency what it needs. We saw that the Governor's budget provides for 30 slots in the appropriations budget for eligibility workers. Those aren't new slots. That's just gonna
tread water. That's not gonna solve the problem and you can ask them. There are specific mandates that the advocates are asking for. They're asking for 10 minutes average for the call center, they're asking never turn somebody away at the regional office. How much staff will it take for you to do this, and if the answer from the Commissioner is we don't need any staff more, that we have enough to do it, fine. Put those mandates in law and they'll be held to account if in fact it wasn't true that he didn't have enough staff, but really that's the answer. We've gone long enough without putting any mandates in and it hasn't really helped the problem. I know they're down to 10 minutes for now, but it'll just go back up next month and the month after. Thank you for the opportunity to speak with you today.


REP. HUGHES (135TH): Thank you, Sheldon, for your testimony. You confirmed what my experience has been in the field as well and I just wanted to ask you from your clients, are you still getting some of that experience say within the last quarter of more than 10 minutes wait.

SHELDON TOUBMAN: Oh, absolutely. It's over an hour.

REP. HUGHES (135TH): So have I, so I just wanted to - we haven't got the data to back that up, but I wanted to confirm that with your experience. And also, do you feel like the language that you've submitted in terms of improving the language, the substitute language, would bring parody to federal and state - bring parody across the - the
requirements of beneficiaries trying to comply with the redeterminations?

SHELDON TOUBMAN: Right. I mean, we are - our language treats all benefits the same with one exception of keeping people on pending the review of the documents waiting in the queue, the redetermination documents, because of the federal law saying specifically for SNAP. That's the one area, but other than that, our language is designed to treat all the programs the same.

REP. HUGHES (135TH): Great. Thank you. And, through you, Madam Chair, also would you say that - you talked about the current experience being - I don't think you said unconstitutional, you used a different word, but my concern is that we are in fact being unconstitutional if we're not complying with accessibility for those with handicaps or special needs in terms of eligibility and access to the same services that they have a right to. Can you speak legally from your position to that?

SHELDON TOUBMAN: Lucy Potter will be the better person to speak to you on that because she is involved on issues related to access to people with disabilities and the Department of Social Services, but the one thing I will say - I know I have to get down to three minutes - I didn't include, but it's in my written testimony specifically a problem where clients are being discouraged from requesting - clients with disabilities are not being identified or assisted while in these long waits. Sometimes they are, but not consistently, so it's actually a significant problem and there's these client service representatives who're supposed to be helping people with disabilities, but they're acting as just one
more receptionist, so there are significant issues. It's not an unconstitutional issue. It's a violation of the American Disabilities Act.

REP. HUGHES (135TH): That's the terminology I wanted to put on record. Yeah. Thank you. Okay. Thank you.

REP. ABERCROMBIE (83RD): Any further questions or comments: Thank you, Sheldon. Always appreciate it. Kathy Flaherty followed by Lucy Potter.

KATHY FLAHERTY: Hi. Kathy. Well, good afternoon Representative Abercrombie and Members of the Human Services Committee. My name is Kathy Flaherty. I'm the Executive Director of the Connecticut Legal Rights Project and also the Co-Chair of Keep the Promise Coalition and the Connecticut Cross Disability Lifespan Alliance. I submitted written testimony on three bills here today, so I'm just really gonna try to hit some real high level things and then be available for questions, but one of the things that folks need to know is that every time we have a KTP meeting or every time we have an alliance meeting, people are still making complaints about dealing, whether it's with the department or whether it's with Veyo, and for whatever reason, we have not been able to make the systemic changes that we desperately need to have happen so that people get the benefits they're entitled to.

And, the three bills I'm in support of are S.B. 836, H.B. 7123 with the changes as Sheldon outlined, and also H.B. 7166 with changes that are outlined in the written testimony. I just also want to point the Committee to testimony that's available online from people who are recipients of DSS services or Veyo 'cause not everybody was able to stay and I just
want to in terms of H.B. 7123, Kelly Phoenix was here and had to leave. If you look at her testimony - I know the Commissioner testified that wait times were down to 10 minutes. Kelly was really clear in her testimony that in three separate calls to DSS, she spent six hours on hold between December and January. Eventually had to go to the office in person, was informed that she could have provided the information over the phone, and that she had mistakenly been dropped from the Medicare savings program.

This kind of stuff just is not supposed to happen and especially for our clients. We serve low income people with mental health conditions. Technology does not always work for them. They have limited minutes on their phone. They have difficulty navigating transportation systems and they also get very frustrated as their advocates do as well. And, there seems to be a point at which we get the system to work the way it's supposed to work. When it comes to any MT issues, my concern has always been two things. One, people are not getting the level of transport that their clinician has determined is medically necessary because under a capitated contract, Veyo makes more money if they provide them a cheaper level of service and also for people with mental health conditions their providers deem them as noncompliant with treatment when they don't show up for their appointments on time, and if people are getting dropped from their healthcare because for whatever reason the transportation system is not getting them to those appointments timely, that is a violation of their rights under the Patient's Bill of Rights, the Americans with Disabilities Act.
And just honestly, what this state should be doing for the most vulnerable residents that everybody says they wanna serve. And, at this point, I'll just take any questions anybody has.

REP. ABERCROMBIE (83RD): Thank you, Kathy. Questions?

REP. WILSON (66TH): Yes. Thank you. I wonder, have you seen the various reports that Veyo puts out indicating their success in serving the public?

KATHY FLAHERTY: I do and I have looked at them and it's really hard because the print's really tiny and my eyes are getting worse, but there have been some times where we have sat in the meetings and honestly I think we need an audit – an independent audit of the numbers and I want to desperately believe that Veyo is doing a good job. I'm a taxpayer in Connecticut. I've lived here my whole life. I pay taxes to the state. They're getting some of them. If they're doing the job, I want to give them full credit for doing the job. I hear from too many people that they are failing and the thing that makes me very nervous, if you really sit down and your eyes don't go blurry looking at those numbers, you look at a report that you get in say November, that reports on past months. When you look at the December report, which also reports some of those same past months, the months are literally different and there's just something that is questionable about that and I think they get enough of our money that the state for whatever reason, and I've said this – I know the Commissioner isn't here, but he's heard me say it, we're paying them enough money, you have a contract, they're not doing the job. I don't know what it'll take to make the department enforce
its own contract, so if that means that this legislature has to pass a mandate to make sure that happens, I encourage you to do that because a lot of the stuff that's in the proposed bill is in the contract, but for whatever reason, the department does not seem to be acting on it.

REP. WILSON (66TH): Thank you. That is my experience as well.


LUCY POTTER: Good afternoon. I'm Lucy Potter from greater Hartford Legal Aid and I - these guys have said a lot of what I was going to say. I would just - it's - the phone system has become all the more important as we've gone from the case system to now impact and the call center and the standing center because that is where the interviews happen and everybody in SNAP has to have an interview and then in other programs when there is other issue that's gotta be sorted out, that happens also by phone.

I would say that DSS, unlike some other states, did keep the regional offices open and that was really part of the Raymond versus Rowland lawsuit which I'm sure Representative Wilson Pheanious will remember. And, that's a good thing. You think of disabilities and you think of people having physical disabilities not being able to get to a place, but I think with cognitive and those types of issues it's really important to have the option of in-person communication and there are lines there, but you know, not always. And anyway, I'm glad that those things continue to be there. As Sheldon noted, the delays have been as bad as 110 minutes like earlier
in 2018 and they were — it was quite — they were doing quite well for about five months in 2016.

DSS talks about actually getting down to a half-hour last month and there was talk earlier that it's down to 10 minutes. I actually got through once in nine minutes, I have to admit. And, when it works, it's fantastic, but it's — you can — the worker can do everything. They can pull it all out of the system. They can make the changes. They can figure out what went wrong four months ago, but it's gotta be that way all the time and that's the concern. And, so through all the things that other people have said, the language that is attached to Sheldon Toubman's testimony is — I would also support that.

And in particular, I think it's really important that anybody who shows up at an office can have an application taken on that day. That's required under the Medicaid and SNAP rules. It'd be really good to have that in state statute for everybody else. Just to clarify and Sheldon also said this, but I think the Commissioner said you could not have benefits continue when DSS doesn't get to theredit forms. That's only the case in the SNAP programs. For the other programs, you can do that and that's what this bill — the language in the bill that was proposed. And, I think it's really important for there to be the data so that we can know what's going on, particularly with recerts. We've never been able to get that data and what we'd really like to know is, how many people monthly lose their benefits and have to get reinstated and even have gaps in eligibility just 'cause DSS couldn't get to the paperwork, so that's kind of where I wanted to — the points I wanted to make and thank you very much for the opportunity.

DEB POLUN: Good afternoon. Just for clarification, did you want me to testify on both my bills now? I can do that. For the record, my name is Deb Polun. I'm with the Community Health Center Association of Connecticut. And, thank you for raising some really important issues today that impact people's ability to get healthcare and other important social services. I did submit written testimony which I don't think has been uploaded yet, but I assume will be uploaded later on today, but to speak on the wait time issue, it's like déjà vu all over again.

I think this is, I don't know, my seventh or eighteen time coming before this Committee asking you to proactively try to fix this issue. We support this bill. We would recommend even lower than 60-minute requirement. Ten minutes would be great. And, as you can see when you look at my testimony, yes, it has been improving, right? So, 28 minutes is better than 107 minutes, but I don't think many of us in this room would be willing to sit on hold for 28 minutes for anything and these are some of the most vulnerable people in our state that we're asking to do that. And, about a third of them just give up and they wait first. They are not impatient. They're not saying oh, I don't get my answer done in two to three minutes, I'm gonna hang up. They're waiting an average of 14 minutes and saying, like okay, I need to move on with my day. So, we do love the idea of a callback option. We've recommended this in the past. I was thrilled to hear the Commissioner say that that's something that
the department is moving towards. I remember reading in December that the DMV published some data after they had done their callback option last spring and they said 71 percent of callers are choosing the callback option. They saved 10,000,000 minutes of time for people in our state. And, I think if DMV customers are worth it, then DSS customers are worth it as well.

I do want to read you one of the stories I received from one of the health centers around the call time issue. My client, Grady, scheduled a 7:30 a.m. redetermination appointment for her individual SNAP and Husky entitlements. After checking all the paperwork, we called DSS at 7:45 a.m. in an attempt to be the first call in the bank for an 8:00 a.m. opening. We were put on hold for three hours until we were connected with a representative. Once they picked up, the DSS worker only assisted with one of the redetermination forms and informed me that I would have to call again in order to get assistance with a second redetermination form.

We were on hold for a total of five hours for this client. So, another change that could be made is allowing the call center representatives, the benefits workers, to assist with more than one issue at a time. That would be of benefit to many people. I've included a number of stories around nonemergency medical transportation in my testimony as well and we've all heard about late pickups, missed pickups. This was a new one to me; too early. So, somebody had received a voicemail saying they would be picked up at nine. They had a text confirmation for a 9:00 a.m. pickup. By 10, they arranged alternate transportation so that they could get to the health center for their appointment and
they were actually able to get rescheduled as a walk-in appointment which was amazing.

The people at the health center called Veyo on the client's behalf to try to figure out what happened and Veyo said, well, we came at 8:30 and you weren't ready and they said, yeah, but you said nine and oh, look, here's a voicemail and here's the text. And, this is the part that just got me. Veyo was not able to offer the patient an explanation and stood strong in its stance that Veyo made no error in attempting to pick up the patient at 8:30 a.m. So, that's a problem. There's a few other stories in here.

There's an 80-year-old woman who had to wait upwards of three-and-a-half-hours after her pickup time in a wheelchair with a health worker. Didn't get picked up until two hours after the health center closed and then another issue, and we heard about this in the working group, was inconsistent training of the representatives, so one of our health centers let me know that a Veyo representative told the patient, you have Husky as your secondary insurance, and therefore, you're not entitled to this benefit. And, that's not true, so the person from the health center hopped on and said, that's not true, got it worked out, but the concern is if this person thought that and we don't know how many people are being told that same piece of misinformation, so would really appreciate the Committee's assistance with both of these issues. Thank you.


REP. CASE (63RD): Thanks, Deb. Thanks for the info. Hey, just real quickly 'cause I'm trying to compile
information, if we have stories and things on Veyo, can we get the customer client number so we can look into it to see if there have been complaints filed?

DEB POLUN: If you do or if I have them?

REP. CASE (63RD): Whoever.

DEB POLUN: Oh, I think we sometimes can. Sometimes, I ask – I usually ask the health centers to send me deidentified information so we don't have to worry about any HIPAA issues, but there are ways of doing it or getting the information securely.

REP. CASE (63RD): There are ways and we've had it because we have a legislative email where we can send off a date of birth or something that's not and get an answer. I agree it's not a perfect system, but I think we need to carve more of the concrete instead of stories. We need to have the concrete stuff in and documented. As of right now, there's only 219 complaints from legislators and 150 of them was substantiated as not Veyo's issue. So, the complaints aren't getting there from us, so we need more complete things 'cause I'm in agreement with you, if there's a problem, I wanna go after it, but I just don't wanna hear - I wanna hear that it's been a lodged complaint.

DEB POLUN: Gotcha. So, just one comment on that which is I don't know who gets to decide what's substantiated and what isn't, but it appears to me that Veyo is making that determination on its own.

REP. CASE (63RD): These are DSS. This is from DSS 'cause our emails go to DSS and to Veyo, so they get determined together of what is and what isn't. As I explained before, I had one that came from Charlotte
Hungerford Hospital at 10 o'clock at night and the person needed a ride and it wasn't Veyo's job to get them a ride because it was medical, but in the previous contract, it was because going from a health center to a hospital when the health center was closing, it used to be in the contract, but it was no longer. We solved that. It was a medical issue that somebody needed an ambulance, so --.

DEB POLUN: Yeah. So, I mean in the example, story, that I gave where Veyo said it wasn't their fault that they came at 8:30 instead of coming at nine, so that would probably be an example I imagine of Veyo saying it was an unsubstantiated complaint even though the patient had both a voicemail and a text message indicating nine o'clock. Nobody should have to expect to be ready and standing outside a half an hour early in the middle of the winter or any time of year really, but especially in the middle of winter.

REP. CASE (63RD): No. I totally agree with you.

DEB POLUN: So, we can try to get the word out to get stories to you all.

REP. CASE (63RD): As legislators, I think we need to see the concrete information and the number of complaints. Stories are good, but we need to have concrete information to actually impact with the DSS contracts.

DEB POLUN: And, I know that Veyo submits sort of a dashboard, a performance dashboard every month that does have data. Yeah and it's given out at MAPOC. Right.

REP. CASE (63RD): Thanks, Deb.
DEB POLUN: Thank you very much.

REP. ABERCROMBIE (83RD): So, I would just like to comment. So, I find it interesting, Representative, that you've gotten responses from DSS on complaints. I think the most complaints are coming from my office and I haven't gotten one response in over a year from Veyo or DSS on any of the issues that I've raised. So, I find it funny that you say out of 219 that have gone, I would say the majority of those came from my office. I don't have one email back on any of those issues when it comes to Veyo, so I'd be interested to see your emails to see if there are any of them that came through my office 'cause I'm not getting them.

REP. CASE (63RD): I follow up to see if the email has been sent and if the issue's been completed and I have multiple that come to my office with complaints that I've sent off to DSS myself.

REP. ABERCROMBIE (83RD): And, so I had a meeting with DSS on Friday, and according to them, they're not allowed to respond to some of our emails, okay. So that kind of contradicts what you're saying as far as you saying that you've gotten a response when --.

REP. CASE (63RD): I can get a response from the client if they got a response that they were taken care of - the person who called in and made the complaint to my office.

REP. ABERCROMBIE (83RD): So, I still believe that there's a little disconnect with what's going on with Veyo. I believe that what these providers are trying to say is that they are trying to on their own and on their own time trying to take care of
these issues versus taking the time to email them to us which is another step, so I think that - what Deb is saying is there's concrete evidence on their side that there's still some gaps in the system and what I will also say is, to this day, over a year later, every issue I've brought to Veyo, yep, the person was wrong. Veyo has not made one mistake in a year even when constituents call my office and say, I called Veyo because I had a problem and Veyo says to me call Cathy Abercrombie's office. That's not the response they should be getting, yet, Veyo says they check the voicemail and they can't seem to find it. It's amazing. In a year all of these issues and they can't substantiate any of them. So, I, with all due respect, disagree. I think that it's - I think that Veyo is still not where they should be and I'll just leave it at that at this point. I think we still have a lot of work to do. Questions or comments from colleagues?

REP. WILSON PHEANIOUS (53RD): I have a question. Do you think an audit would be appropriate of Veyo's numbers? Does that seem like something that might down the difference between what they're saying and what everybody who uses it is seeing?

DEB POLUN: I guess that would be up to the legislature and the auditors, but I will say that it might be difficult to figure out what's actually happening because we don't know how well things are being documented in their system, right? So, if somebody's supposed to be picked up at 2:45 p.m. for the B leg, the home trip, and they - the health center calls Veyo multiple times, we don't know how that's being logged. We don't know - so, the information may not be available to audit
appropriately. I have no idea how they log all the information.

REP. WILSON PHEANIOUS (53RD): That's not reasonable if that's the case. With the millions of dollars that we're paying them, it's not reasonable to hear that. I mean, I'm not blaming you for that --.

DEB POLUN: No. I don't know whether [laughter]. They may have lots and lots of information. I'm just - I'm not sure how everything is kept track of.

REP. WILSON PHEANIOUS (53RD): They appear to have a lot of information that validates that they've done nothing wrong, but there seems to be a dearth of information that supports clients who are having - who are losing their appointments and losing their doctors because of a lack of care, so there must be some way to get to the bottom of it.

DEB POLUN: Right. I will say I was grateful to hear that the department is open to hearing other ideas because it's kind of a low bar to set to say, well, it's better than it was when - with just the care - like, okay, sure and waiting on hold for 28 minutes is better than waiting on hold for 107 minutes, but you know, we should be delivering better service to the people of our state, and when we're talking about essentials like getting to a medical appointment, we're talking people who've had transplants, people with cancer, major behavioral health issues, I mean these are sometimes life and death issues. Thank you.

DEPUTY SPEAKER COOK (65TH): Thank you, Madam Chairman. Hi, Deb. Thank you for your testimony. You were telling a story about somebody that was
waiting for three hours and they waited well after the office was closed?

DEB POLUN: Yes. The health center closed at 4:30 and they kept two staff members and the CEO hung back, called Veyo multiple times, and finally the CEO at the health center called Veyo at six o'clock like screaming and she got picked up at 6:20, so this was an 80-year-old woman in a wheelchair who had been waiting to get home since 2:45.

DEPUTY SPEAKER COOK (65TH): And, do we know – obviously this was an error in pickup I would suspect.

DEP POLUN: I don't know whether Veyo considers this to have been an error, but it seems like one. I mean, she was scheduled for 2:45 pickup. Didn't happen.

DEPUTY SPEAKER COOK (65TH): And, we don't know how that was tracked or how that was logged otherwise?

DEB POLUN: Yeah. We should ask them.

DEPUTY SPEAKER COOK (65TH): Okay. Thank you.

DEB POLUN: I know that the health center called multiple times, right? But, I don't know why the error happened. I don't know if --.

DEPUTY SPEAKER COOK (65TH): And, we don't know how that was documented in their logs obviously for whatever the reason. Can you share --.

DEB POLUN: Yeah. I would not be the person to ask about that.

DEPUTY SPEAKER COOK (65TH): Can you share the details - that you can share with us like the time,
the location, so we can possibly look and see what the reasoning was on that?

DEB POLUN: I have that in my testimony, in my testimony that I submitted.

DEPUTY SPEAKER COOK (65TH): Written. Perfect. Thank you, Deb. Thank you, Madam Chair.

REP. ABERCROMBIE (83RD): Further questions or comments? Seeing none. Thanks, Deb. Thanks for all your hard work. Appreciate it.

DEB POLUN: Thank you very much. Thank you.

REP. ABERCROMBIE (83RD): Senator Formica. Thank you for being here. Crazy day out there, huh?

SENATOR FORMICA (20TH): Thank you very much, Madam Chair. Good evening, good afternoon, or good morning, whatever the appropriate attitude is [laughter]. I appreciate the opportunity to come before you, Representative Case, and talk a little bit about S.B. 899. I have brought a resident expert. Cathy Risigo is a pediatric occupational therapist and knows of this issue more in depth and I would be happy to yield my time with the Chairs' permission to Cathy to go over a little bit of her testimony.

CATHY RISIGO-WICKLINE: Good afternoon, Chairman Abercrombie and Representative Case. My name is Cathy Risigo-Wickline. I'm a pediatric occupational therapist at Jumpstart Therapy & Physical Fitness Network which is one of the few pediatric occupational and physical therapy providers - providers that provide service to our most vulnerable of our state, children with autism, ADHD,
behavioral health issues, developmental delay, and more, who are all on Husky insurance

I have – also have a seat on the Medical Advisory Oversight Council at the pleasure of Senator Formica. So, today I represent independent small groups on that council and I think I'm the first OT to ever occupy that seat, so over the years what I've found is people don't understand the value of occupational therapy and the great benefit we have on the residents and children especially of CT. So, it really does have a significant impact on cost savings to Connecticut. Pediatric occupational therapists really help to develop skills in children to help become functional adults and not become a financial burden in the future to the state. I am in support of raised bill 899, AN ACT CONCERNING CHILDREN WHO TRANSFER FROM HUSKY A TO B HEALTHCARE COVERAGE. This bill does not ask for more money. It just wants to get paid for the services that were already rendered. Servicing these children has become increasingly difficult over the years for many reasons. All the details are in my testimony. I have summarized them. I will summarize them here.

So, I'm going to do it by telling a little story. There's a little boy named Kyle who has Husky A insurance. Multiple times throughout the year, his mother makes a little bit more money than other times of the year and he suddenly gets switched to Husky B. Now, I was told on the phone multiple times, even have a reference number to my call to CHN, saying that if the parents' income gets noticed not within 10 days of the month, it's retro to the first of the month. When you call up and you get a verification number, you get a verification number and it says – it gives you one number. If you call
up three days later to get verification for that same day because you were denied on that service, it's a different number, so they always say, oh, we don't have verification. Well, of course not, you have a different number this time. So, that's a little bit of a problem.

So, we check every single day. It takes my staff 200 - I mean we do 200 kids. It takes like a lot of kids for both insurance, but it takes almost two hours to do the verification of those children. You have to do them one by one plugging in lots of information, so Kyle gets treated say on the second, fifth, and eighth of the month. On the ninth, the mom has increased income. Husky B takes over. We don't get paid for those services that we rendered. How do you run a business like that? Providers are providing service with no reimbursement for the visits that are happening in good faith. Now, let me tell you about this. The process begins when we find out that a child turns to Husky B.

I'll go slow so you can try to understand what I'm - it's a little complicated. So, when you have Husky B, authorization - you need authorization for one time a week. When you have Husky A, our 29 diagnosis code, which is for developmental disabled kids, autism, the ones I mentioned, you do not need authorization. You don't need anything ever. We as professionals do a progress note every three months for the doctor and get it signed. That's our professional ethical duty, but it's not required. But, let's say now, we're two months into it and the child switches. We do not have a recent progress note, so we send in the progress note. Now, CHN has 14 days to get back to us. So, I have to send it
immediately because I already didn't know about it, so I send that report.

Two weeks later, I get a response saying, oh, we need a more updated – more of an update. Now, obviously I've already started planning to do a progress report on this, but now I've got to send that plan of care to the doctor's office, wait for them to sign it – that can take up to 10 days sometimes and we're always calling and calling, but sometimes they're busy – up to 10 days to get that plan of care signed. Now, you're almost three to four weeks into this. I'm providing services in good faith as I feel it's morally and ethically my responsibility to not stop these child services. Yes, I know that most likely Husky B is only going to offer us one time a week, but I don't know that because sometimes with real severe cases, I do request for two times a week because these autistic kids, these children with autism, sometimes they can't go without services that long. So, we continue to provide the services. One time in this Kyle case, it was 47 days before we had authorization. And, I can give you the ICD-9 numbers or ICN numbers to all these children. I have like almost three of them from this past year.

Okay, so anyways, I got that part. Does that make sense to you, that piece? Okay. So, I'm moving on then to say that who in this room would like to work and not get paid for their services? Nobody's hands go up. So, how would you feel if your handyman came by to fix something and then the next day, the next time your cat is broken, you didn't pay him for the first visit, they're not gonna come back to do the second things, so we're losing people – first off, we don't track the OTs and PTs that wanna provide
services to Husky and now this is one more reason why people don't wanna. And, I went ahead and called people that take Husky insurance. There's very few that I found that do accept them regularly; myself and Craig from Schweizer Fitness are probably the largest two groups that accept them and both of us have the same problem. And, he doesn't even – he goes I limit how many I can take because logger in these to make it happen, but I don't wanna deny people services because all these kids – Cathy, you've been there. You've seen how much these kids need the services.

All right. Just to go on then, so independent groups are financially challenged in providing services to Husky stakeholders because we get paid 50 percent less than all the rehabilitation centers get paid and our reimbursement rate is the lowest of all the reimbursement states. How can you run a business like this? And, you just can't when you have to then lose getting paid. You're barely surviving with what you're getting paid and now we have doctors. Before - we have Master's Degrees and doctor degrees. We're paying these people a lot of money. This is challenging for us, without getting paid for those extra visits. So, don't wanna repeat myself. Oh yeah, so occupational therapy independent groups may be a small part of the 7 percent of the other category on the grid of services Husky provides, but we have a really big impact on cost savings for Connecticut.

We've been known, just not research studies, but I do have some studies by the way we give to DSS that we do reduce ER visits. We do keep parents back to work instead of their kids not in the principal office, doing better at school, so we do a lot to
help children become more independent adults and saving the state a lot of money. So, passing raised bill 899 would save the state money in future expenses.

My suggestions are that you look at a more efficient turnaround time for authorization and preauthorization denials, maybe possibly three or four days. That's what regular insurances usually have. Simplify the eligibility process by maybe some sort of — I don't know if you could do a communication system of some sort in real time — that denies the services. Even the parent doesn't know that they've been kicked off Husky B sometimes. Most importantly, and I think this one is very good — regard this one to be really helpful — if we could allow initial authorization for clients transferring from Husky A to Husky B to be based off of any existing reports that we have for the first 30 days, give us the 30 days and then make us have to get the report to you because you can't — sometimes the kids are sick for a week. We have certified OTs who are treating the kids. It may be the occupational therapist isn't available to coordinate that schedule with that child. So, we don't want to be holding up the process on our end anyways. So, lastly, I'd just like to say that if you don't pass this bill, how will this affect the future of Connecticut and as these children become close to their adult years who's gonna take care of the most vulnerable stakeholders in our state? So --.

REP. ABERCROMBIE (83RD): Thank you, Cath. Thank you for what you do. Yes. I'm a field trip girl and I've gone out to her facility and I can tell you she does exceptional work. I think just so members around this table understand where the challenge is,
is independent are paid at a different rate compared to the rehabilitative services that you get like at a CCM stay which is the Children's Medical Center. It is something we are working with DSS on. I know it hasn't been done in a timely manner, but for some of us up here that believe in what you do and the population that you serve, the time has come. Now, will we find a resolution at the end of the day? I can't guarantee it, but you know that there's a lot of us that have been trying to work on your behalf. So, I just want to say thank you for what you do. Representative Hughes, did you have your hand up? Yep. I saw her hand.

REP. HUGHES (135TH): Thank you, Madam Chair. Thank you for your testimony both of you and advocating to the reality of this untenable system and it's untenable because it is denying needed people - I mean the qualification and the income does - level of a parent does not change the need of the child and that is where we have to center the coverage on and - and not put that burden on the providers because the income level of the parent does not change the needs of the child, so it's that simple. And to me, it's a parody issue for the children. So, I think we just need to frame it in that way and make progress.

CATHY RISIGO-WICKLINE: Thank you. Yes. That's my comment. Thank you.

REP. ABERCROMBIE (83RD): I know Jay and Representative Case and I was just saying it's not an easy - an easy solution to what you have going on and I totally respect what you do and I totally get it and we're trying to work through. You know, we're wondering if DSS would be - would be open to
taking Husky A and Husky B and combining them. Some states do it that way. We're actually one of a few states that doesn't, so that's an option. The reimbursement – I'll be honest with you, Cath, I don't think the reimbursement is ever going to be where you need it to be because of the fact that the reality is, we don't pay our providers enough. We don't. We all know it, but I do want to say thank you for what you do because I know the service you provide, I know the kids, you know those are my kids. I know that your heart is in it and that's why you do it. You're not gonna get rich of this population. We know you're not. So, I just want you to know that I really personally – you know, these are my kids. I personally thank you for all that you do every day.

CATHY RISIGO-WICKLINE: Thank you so much.

REP. ABERCROMBIE (83RD): Yes. Go ahead, Representative.

REP. WILSON PHEANIOUS (53RD): Yes. Earlier I believe the Commissioner testified that it was the expectation of the department that in order to check on verification that you would call each time to see whether somebody was on Husky A or Husky B before you provided services, can you speak to how onerous or – or can you just speak to that issue?

CATHY RISIGO-WICKLINE: I know we're not crazy and I know the person – I've switched people. I've had two people call up sometimes to verify. We write down the verification numbers. I wish we could copy off the computer so we can – 'cause we're just handwriting it, so it's not really proof in a way. I mean, it's sort of proof, but I could've made an error. So, I call up and I'll say – they'll say
yep, Johnny – Kyle is eligible for Husky A services and I go, okay, so we're doing the treatment. Fifteen days later, I get my check and they say denied. No author – they switched to Husky B and I'm going, wait, that's okay, I got the authorization number.

No, I don't 'cause they switch the authorization number 'cause I can call right now and check on Kyle's authorization from that day. I could've called today, three days ago, and four days ago. Every time I call the verification number, they're different. So, they really can't track it. And, it's DHS tells me this, that's what he said to me. He goes, we can't - I understand - I know, I understand, but we can't track it. So, that's what really happens. I appreciate – I do what I do for the kids, not for the money, believe me. You know, I used to make some good money when I was in [inaudible 3:54:37], but I don't make that kind of money doing this, but I do it because I love it. I work late at night because email time is late at night 'cause we really care about these kids and I don't wanna a high reimbursement. I want - you think about it. We have doctors and Masters Degrees and getting paid such a little bit of money doesn’t even cover that. I'm really relying on private insurances to cover that, so missed visits do not get paid for 30 visits? That's a laugh. So, anyways, thank you for listening and thank you for your feedback. I hope we can do something. And, I could provide you with more information.

REP. ABERCROMBIE (83RD): Yeah. We're gonna have to work through this. Yes. So, thank you both for your testimony. We really do. Senator, did you want to add anything, sir?
SENATOR FORMICA (20TH): Just one moment of thanks to you and all of the hard work you've been doing on this with Cath and I, too, made a field trip out there and saw firsthand the work that she does and when I first got here then Senator Cane explained how wonderful Cathy was on MAPOC and she has been part of a solution before. It's not that she's just up there complaining about billing. She's down here educating working with MAPOC, working with you, working with me, and trying to get this done. So, she's at ground zero of what we need to try and do and a great resource. So, I appreciate her taking the time off.

And then, one last thing. I've like to lend my name to H.B. 7166. I have a great representative from New London here, Jeannie Milstein, come up and I know you more than anybody have been working hard on this Veyo thing and you'll hear some comments and some examples about what's going on. So, I will continue to try to help in the small way that I've hopefully helped you in the past to try to get this done, but people like Jeannie Milstein are really working hard for this, so thank you for your courtesy and consideration of me sitting here today and allowing us to speak to you.

REP. ABERCROMBIE (83RD): Thank you and thank you for your kind words. These - I always say that human services is not all partisan issue, right? We all work together on all these issues, so I thank you for hard work on this also, Senator. Representative.

REP. CASE (63RD): Just - and thank you, Senator, but remember when Cathy and I come to appropriations [laughter], you're there for us.
SENATOR FORMICA (20TH): I can tell you, I will use all my power as a Ranking Member to try to get things moving. How's that?

REP. ABERCROMBIE (83RD): Thank you. Have a great day, guys. Bonnie followed by David Lowell.

BONNIE ROSWIG: And, I just want you to know that I put your copies in your office as well and it's just fabulous - it's a fabulous place. Representative Abercrombie, distinguished Members of the Human Services Committee. Good afternoon. My name is Bonnie Roswig and I'm an attorney with the Center for Children's Advocacy. Thank you for giving me the opportunity to testify in support of H.B. 7166.

Connecticut is in dire need of this legislation to positively impact the functionality of the nonemergency Medicaid medical transportation program. Veyo continues to violate the NEMT contract and the federal mandate. As you have and will continue to hear today, patients are being denied requisite modes of transportation. Medical documentation from healthcare providers is ignored by Veyo staff and patients are cut off from transportation without notice in violation of federal law.

Connecticut's current capitated contract with Veyo has not resulted in higher quality transportation, but rather in widespread denial of transportation. Under this $160 million dollar capitated contract, Veyo has not only advanced monies for administrative costs, but has prepaid for transportation for any Medicaid recipient. Denial of transportation does not result in savings to the state. It only results in profits to Veyo. Veyo practices also drastically
impact the available pool of transportation providers for Medicaid recipients.

Under Veyo, companies who have been doing NEMT transportation for decades were falsely accused of refusing rides, suspended for not taking assignments that were in fact out of their geographic area, and sanctioned for being late to rides that were assigned by Veyo at the last minute. The actions of Veyo have resulted in transportation companies laying off staff, selling vehicles, and closing their doors. Veyo has consistently failed to pay transportation providers in a timely manner as in mid-February payments to transportation providers were behind by four weeks.

Veyo blamed their customers for not making the timely payments. The problem is the customers for the state of Connecticut who states that they have paid in a timely manner. Veyo does prefer to assign rides to Uber-like or independent drivers who at the very least do not have the availability or diversity of vehicles as traditional transportation providers, but they do accept a lower rate of reimbursement resulting in higher profits to Veyo. Another preferred transportation provider is a company who Veyo assigns over 30,000 rides a month multiple times more than any other transportation company.

It should be noted that as reported by the Office of the U.S. Attorney, the owner of this company pled guilty to federal tax crime as of Monday of this week. Vigilant oversight of the NEMT contract is the responsibility of the Department of Social Services. Connecticut has committed to a robust NEMT program in their state plan with the Federal Center for Medicaid and Medicare services. Stronger
contractual terms and rights of Medicaid recipients need to be enacted; however, without appropriate commitment to oversight, patients will continue to suffer. Connecticut companies will continue to be put out of business and federal funds will be put at risk.

And, just in regard to H.B. 2173, I agree there are multiple problems with our most vulnerable families. Wait times absolutely must be limited. These are essential benefits. People going without food, they're going without money, and they're going without medical support. Thank you. I'm happy to answer any questions that you may have.

REP. ABERCROMBIE (83RD): Thank you, Bonnie, and thank you for being on top of this for over a year now. So, any questions? To you, Representative. No? Okay.

BONNIE ROSWIG: Thank you. And, just to follow up on one of your previous questions about an audit, it would be so helpful for those of us who are so frustrated by the problems with this program. Under the LogistiCare contract, Mercer came in, did an audit, they went into LogistiCare, they oversaw what was going on. They had really helpful recommendations. We do not trust the Veyo data. We've talked about it. As Representative Abercrombie and many people have said, it is inconsistent with experience. Nobody has to believe the loud blare in the room, but if we get an independent evaluator in, I think that would be incredibly helpful so that we can assess what's going on, but really truly strong enhanced oversight by the department is essential because without that - they're the ones - it's their responsibility and
we continue to put federal money at risk by not complying with that CMS contract.

REP. ABERCROMBIE (83RD): Do you think that our state auditor, would you consider that an independent audit?

BONNIE ROSWIG: If the data that they were using was not Veyo's reported data.

REP. ABERCROMBIE (83RD): So, where would you get the data from then?

BONNIE ROSWIG: So, I believe Mercer went in, reviewed what was going on a daily basis. They went in-house to LogistiCare and they could oversee what's going on because as Cathy testified, numbers have changed, numbers of denials have changed over the months. It was – there was – one of the sheets there was November where there was 3,000 denials and then six months later, November showed 500 denials. It's very concerning, so I think someone really has to go in. We have looked for – we have asked for Veyo policies, training manuals, what are people being taught. This information has not been disclosed and actually at this point there is no transparency. There is the working group, Sunsetted. MAPOC obviously has oversight. MAPOC has many other things. It has not been on the agenda and is not on the agenda for this month as well.

So, really there's nothing. There's no one except the department to oversee what's going on, and again, we continue to have huge concerns.

REP. ABERCROMBIE (83RD): But, just for clarification, two things. One, we do have
oversight 'cause we have the Subcommittee under MAPOC. That is the oversight at this point. If you're requesting under the MAPOC as whole, which you know I'm Co-Chair of, for us to do a report, we can do that, but the reality is that I ask at every - at the end of every meeting every month what people want on the agenda and it hasn't been asked to have them on there, so if you're gonna call out MAPOC, then you gotta be honest in what you're saying as far as it not being on our agenda. All you have to do is ask and we will have it on the agenda.

CATHY ROSWIG: I'd appreciate it. It would have to be through a MAPOC member and MAPOC has many other important things to do. I think the given the level of concern statewide, it just - it needs intensive ongoing oversight.

REP. ABERCROMBIE (83RD): And, I'm not disagreeing there with you, Bonnie. I'm just saying if you're gonna call - call something out, we need to be factual on it, so --.

BONNIE ROSWIG: Right. No. And, I serve on the MAPOC Coordination of Care Subcommittee. It is our agenda item, but we also have behavioral health. There are - it is not fair to those people and those needs that we - that NEMT is the only thing on the agenda. It's just this is such a serious issue and such an ongoing issue that it really needs attention of the people that absolutely have the amount of time to devote to it.

REP. ABERCROMBIE (83RD): And, I'm not disagreeing with you there. The second point is, I don't believe that financially we would be able to have Mercer come in and do an audit under this particular
group. I think financially it's not in the budget right now under DSS, but I would be willing to work with you on identifying specific in an audit and then go to our state auditors and request an audit from them because that's what they're there for, right? So, they can drill down to, and not just the agency, but a service within the agency, and I'll be honest with you. I've already talked to the state auditors about this and they're willing to look at it, but we need to drill down what the specifics are that we want them to look at. So, I'm more than willing to sit down with you, have this conversation, and figure it out.

CATHY ROSWIG: I'd be very happy to do it. My other suggestion would be that the department has the opportunity to sanction Veyo for failure to comply with the contract. We would – they have done some sanctions. I think the last time the department reported, it was in the tune of about $30,000. We all would like those sanctions to be enhanced and an ongoing concern of mine is that generally the sanctions, even though Veyo is not compliant with the contract, those sanctions get turned to the transportation companies and so what's the incentive for Veyo to really comply with the contract. It would be very helpful if the department was directed to be vigilant about imposing sanctions every time a contractual violation appears and then we can use that pool of money towards oversight.


SENATOR MOORE (22ND): Thank you. I was trying get at that earlier with Commissioner Bremby, like what are the sanctions compared to – I mean it's $22,000
in his testimony which is a very small amount of money when you think about the depth and breadth of this contract, but I wasn't clear and I just want for clarification – were you speaking of having someone, not just audit, but have oversight over Veyo or were you just thinking of an audit?

CATHY ROSWIG: Well, I – when Mercer went – we are concerned about the information that Veyo call center staff are giving anyone who calls into the call center. That's patients. That's healthcare providers. I have story after story by healthcare providers who have - they themselves have requested wheelchair service for a patient. Veyo has said, okay, fax me the documentation. They called the next week and Veyo says, I never received that and they re-fax it, and then next week it happens again and again. And, you know, the great thing – it is wonderful to work with healthcare providers because they are required to comply with electronic medical records, obligations, so everything is in their system and you can see week after week after week.

So, why – what is happening with that information? Veyo came in to the state and one of their selling points was they have this wonderful advanced technology and that is going to be doing so much for the state. Well, we know they have an Uber-like app because they use a lot of independent drivers, but why don't we have fillable forms? How – it's 2019. It's not such advanced technology. So, what is happening at the call center? Why is incorrect information being given? Why are healthcare providers being told people aren't eligible? And that, someone really needs to go in-house. It's the same things with complaints. You know, when we - it was a big issue with LogistiCare over – over
complaint documentation, and when Mercer went in, they found that LogistiCare was only counting something as a complaint that LogistiCare decided was a complaint.

The complaint numbers for Veyo are incredibly low. People have articulated again and again they don't know how to access the system. I'm sure Veyo will disagree, but that's not even a point we've been able to get to because we've been so busily working to get dialysis patients where they need to go or children to intensive outpatient mental health treatments. There are aspects of the contract that we haven't even gotten to in terms of requisite compliance, the nice thing about an auditor going in was they over the shoulders of the staff saying, what are you doing? What are you saying? What are your processes? And, that was very helpful and that really worked to improve the system and help compliance with the contract.

REP. ABERCROMBIE (83RD): Thank you, Bonnie. Appreciate it.

CATHY ROSWIG: Thank you very much.

REP. ABERCROMBIE (83RD): David Lowell and Donna Hunter.

DAVID LOWELL: She bailed on me. I'm sorry. Senator Moore, good afternoon. Representative Abercrombie. My name is David Lowell and the testimony I'm gonna provide today is on behalf of my position with Hunters Ambulance as the Chief Operating Officer. I've been with the organization 33 years. I have a paramedic background. I have a business and organizational leadership background.
I also serve for full disclosure as the President of the Association of Connecticut Ambulance Providers.

And so, from those perspectives, I would like to offer testimony in support of H.B. 7166 and I would like to thank you for raising this bill and putting the elements in it that you have. I think it's a good start and perhaps it might need to go further. In particular at my onset, I would like to call out Representative Abercrombie for your work on the Subcommittee with MAPOC because this entire year has been quite overwhelming with the issues related to nonemergency medical transportation. And so, kudos to you and Representative Steinberg for enduring those meetings, engaging the dialogue, getting the stories told, and striving for the accountabilities that are necessary and some are revealed in this bill. My testimony has been provided and I would like to just highlight a few things.

Our organization, Hunters Ambulance, is 56 years old this year. For that amount of time, our organization has been doing emergency and nonemergency medical transportation in the state of Connecticut, so we are not new to the system. We have grown based on the capabilities and opportunities in the state. We've maintained a great reputation. We have been a collaborator both on the legislative side, the administrative side, and with all the rest of the players out there from healthcare to other transportation providers, so we're pretty well versed in what the right thing is to do for the constituents out there that need these services.

At the onset, prior to 2018, we met a number of times with Veyo to talk about capabilities,
capacities, not just for our service, but industry-wide. There was a certain amount of preplanning, albeit it was with very junior members of their team. No senior member was present at those two initial meetings. I broke my testimony out into two major areas; the nonemergency EMT wheelchair and I'd like to speak on that because effective May of this year, we for the first time had to lay off a great deal of employees and park and sell our vehicles in the wheelchair division.

From the get-go in 2018 and in January, there was mismanagement at all levels of call distribution, call assignment, approvals, authorizations. We were collaborative. We sat at CHA with all the other healthcare providers. We offered solutions. We met with Veyo. We had weekly phone calls with Mr. [inaudible 4:14:19] to try to reasonably work out for months solutions that would not disenfranchise the people that we were there to serve to no avail. We were forced after 56 years in business to lay off employees and park vehicles all the while, and I provided in my testimony, a picture as of January 21st of that year, with the vehicle. DRM was the company, parked at the Hospital of Central Connecticut with a Wisconsin phone number on it.

So, while my vehicles are sitting and my employees are on the payroll not doing any calls, with call distributions that I used to do, 300 calls a day, knocked out for no reason. The patients didn't go anywhere. They weren't put on public transportation in the districts that I serve. They were medically necessary transports. Not given any. And yet we create this manufactured crisis, Veyo did, to say, well, we need a rescue company so let's get this DRM from Wisconsin to come in and be the rescue company.
Not one company in Connecticut who was existing, us for 56 years, could provide any of those services and yet this white horse from out of state could come in and do it instantly. DSS was complicit at every point in this process in enabling that type of behavior. We used to have a requirement in the contract between DSS and LogistiCare at the time and I think it's still with Veyo, that the transportation broker could not be a provider and yet all over Facebook and Career Builder there's solicitations; come, become a driver, make your own hours, make your own money, totally unregulated.

As a result, our service has been displaced, the wheelchair book of business. I know my time is just about up on the - that's very pleasant. [Laughter]. In closing, if I may, on the ambulance side, there is some good news. After a burdensome year of back and forth on the ambulance transportation side in working with the healthcare facilities, we have seen some positives occur just recently with the hospital referrals to the transportation providers directly so that the forward movement of patients can go. There were a lot of payment issues through the year, but I can't paint an all bad picture. The ambulance side of it and the coordination is going much better now. My testimony has been submitted. I will close because of my time and be available for any questions you may have.

REP. ABERCROMBIE (83RD): Thank you and I think that part of why the ambulance portion of it is working is because it's a direct link between the hospitals and you guys. There isn't any prior authorization that has to go into effect, so you're right. We do have to thank DSS for that. They will be doing a state plan amendment to make that permanent because
I know we've been just rolling this service over and
now the time has come to making it permanent - a
permanent arrangement, so thank you and thank you
for what you do. Questions?

DAVID HOLLAND: Thank you.

Seeing none. Thank you so much. We appreciate you
being here and what you do. Is it and I apologize,
is it Orest? Oh, thank you.

OREST DEMKOWCYCH: Good afternoon, Senator Moore,
Representative Abercrombie, Representative Pat
Wilson Pheanious. My name's Orest Demkowcych. I'm
a registered voter. I'm also a member of Keep the
Promise Coalition. I'm here to speak about H.B.
7166, AN ACT CONCERNING NONMEDICAL EMERGENCY
TRANSPORTATION FOR MEDICAID BENEFICIARIES and the
constant obstacles for getting rides and the poor on
time performance. Prior to November 9, 2018, I was
told by Veyo that they require 15 business days to
process a request for transportation outside their
mileage area. So, on November 9th, Yukon Health
Center from Farmington faxed a request and I had
gotten her direct number that day and I made the
next available appointment on January 19th Veyo. I
got a confirmation letter and I asked them, you've
had enough time to process this request and would I
get a ride and I never got a definitive answer.

So, on November 17, 2019, I was waiting for my ride
at 9:30 and 9:50 I didn't get a ride. So, I called
Veyo and they said my ride was denied and I asked
the reason and they said I didn't have health
insurance and they said they never got the original
request for a ride. And at that time, I asked to
speak to a supervisor and I was put on hold, and
while I was on hold, I put Veyo on hold, called Yukon and asked the woman who's telling me the exact date that she faxed it. She said November 9, 2019 which is 42 business days. And, she has a confirmation letter. So, I went back to the call with Veyo and I'm still on hold and finally I'd just had enough and I hung up and I called Susan Johnson and she had told me that she's not my representative since I moved and she gave me Pat Wilson Pheanious' phone number and told me to speak to her aide 'cause I'd get through much faster.

And, I told her aide what had gone on and she said she'll do something about it. And, two hours went by and I got a call from Veyo and the woman stated, oh, you have insurance and you'll get your ride and we are gonna have to retrain our employees and that the woman from Yukon only got the fax that day and I go, that's impossible because she's had the confirmation number from her fax. So, I got my appointment a week later, but that same day that I had gotten that confirmation from Veyo saying I had insurance, I got a letter from Veyo stating from Dave Coppock that I did not have health insurance and I feel that this was blatant lie 'cause I have confirmation from DSS that I had insurance on November 9, December 28th, when I received the approval letter from DSS that I had insurance and I had had health insurance on January 4, 2019.

I also faxed the documents over to Kathy Flaherty. If you need to see these documents, you may get them from her or from me if you have any questions. Thank you very much.

REP. WILSON (66TH): I have a question. Can you tell me something – whether or not you lost any
medical care or your doctor or what other kinds of consequences you had as a result of this very frustrating experience.

OREST DEMKOWCYCH: Well, I missed several appointments because the standard answer was, we didn't receive a fax. And, I had to go through a lot of pain because I was going for procedures to get rid of pain, and not only - I have gotten my rides on time, I actually looked at one of the driver's logs when I had to sign up. I was supposed to be picked up at 8:30 for a 10:00 appointment in Farmington and she had left Hartford at 8:30 to pick me up when I was supposed to get picked up at 8:30. And, I got picked up maybe 9:15, 9:30, but I can tell you certainly she got me there on time. She was driving about 80 or 90 miles an hour.

REP. WILSON (66TH): And, in your experiences, is the kind of frustrating experience that you've just recounted for us, is that a common or uncommon experience amongst your peers where you're living?

OREST DEMKOWCYCH: It's a common experience. Also, when I was speaking to the drivers, they're telling me that they're overbooked with rides, so they can't accommodate the on time performance.

REP. WILSON (66TH): Okay. Well, thank you for persevering on trying to get your health needs met and I'm very sorry that this has happened to you. We'll see if we can work to improve the system.

OREST DEMKOWCYCH: Thank you very much.

REP. WILSON (66TH): You're very welcome. Are there any other questions from anyone? Okay. Thank
you very much, Orest. Next will be Kathy Flaherty. Yeah, I see. Okay. How about Matt Dillon?

MATT DILLON: Hello. Good afternoon, Members of the Human Services Committee. My name is Matthew Dillon and I'm an attorney at Connecticut Legal Services in Waterbury. My legal work focuses on the areas of public benefits and Social Security Disability law. My testimony today is on behalf of CLS's low income clients who would benefit from H.B. 7166. As you know, the NEMT program in Connecticut has been administered by Veyo since January of 2018, and since that time, my colleagues and I have heard complaints, frustration, and stories of missed appointments from our clients.

One of the recurring complaints I've heard is from clients who've received the wrong type of transportation such as a client who suffers from anxiety and PTSD and needs vehicle transportation to therapy, but is instead given bus passes. Their symptoms would prevent them from taking public transportation, so a cab is needed. In other cases, the client is physically unable to make it to the bus stop. In these situations, the client's doctor can complete a specialized transportation form to certify that the patient cannot use public transit due to a medical condition; however, those forms are often not received or processed timely by Veyo resulting in the medical provider having to resend the form multiple times.

It is eventually found and processed, but not before both the client and the doctor expend unnecessary time, and during this time, the client misses medical appointments. It is unknown how many other consumers have had problems receiving the wrong type
of transportation; however, it's clear that the NEMT recipients need a place to turn to when they encounter problems. I've also heard from clients who tell me that the ride just does not show up despite confirming the day of that their ride will be there.

Clients have had to find new providers because they've just been dropped from their current – previous providers over too many missed appointments. While these rides are not emergencies, there are still serious health consequences to missing appointments like the patient who had an outpatient surgical procedure scheduled or the patient who is out of their mental health medication and needs to be seen before their refill can be processed. H.B. 7166 would propose to create a private right of action and I believe a private right of action would create a fairer playing field for consumers and allow NEMT recipients to seek judicial resolution. Another benefit of creating a private right of action is the deterrence allowed aggrieved NEMT consumers to sue could alleviate some similarly situated consumers without the need for additional lawsuits. Since NEMT provides vital medically necessary transportation, the courthouse door should not be closed to their claims. Thank you.

SENATOR MOORE (22ND): Thank you for your testimony. I thought that I read, 'cause I'm thinking what you're thinking about the ability to sue or have some recourse when the service is not – but, I thought I saw something in Commissioner Bremby's testimony that didn't allow that. Is that – did you see that?
MATT DILLON: I was not here for Commissioner Bremby's testimony, but I did review it prior to arriving here.

SENATOR MOORE (22ND): Oh, there is? So, he – I have it. He does say that the provision is unnecessary and will not provide a timely effective remedy. Under the provision of the state and federal law and the Constitution, the department is required to issue a notice of action, but not file suit. That's in Commissioner Bremby's testimony.

MATT DILLON: Right. And, in my experience, clients are not getting the notices of action. The notices of action are not being issued. When a ride does not show up, notices of action are not being sent, so there's no opportunity to request a fair hearing.

SENATOR MOORE (22ND): Somebody – then I would follow up saying, what stops you or stops the clients from if they're not satisfied by the finding to take it to Superior Court to file?

MATT DILLON: You mean, after a fair hearing?

SENATOR MOORE (22ND): Yes.

MATT DILLON: Right. They would be able to file an appeal to Superior Court, but I believe what this legislation is proposing is that they could file a lawsuit outside of the fair hearing process and not have to exhaust those administrative remedies prior to filing a lawsuit.

SENATOR MOORE (22ND): Thank you.

MATT DILLON: You're welcome.

REP. WILSON (66TH): In your experience or knowledge, has creating this kind of a private right
of action, how has that resulted in better service in other places that you're aware that that may have occurred?

MATT DILLON: Well, it's my opinion that Connecticut will be the first state to create such a private right of action, but I think given the stories and complaints we've heard today, I think it'll definitely help this situation.

REP. WILSON (66TH): Would it facilitate creating a class action kind of suit, this particular statute?

MATT DILLON: I mean, it's possible, but I think it would also more importantly allow individual clients to go in and seek resolution as well.

REP. WILSON (66TH): Okay. It just that in my experience individual clients may not have the wherewithal to obtain an attorney, to do what one has to do to file a suit, and so I just wondered whether or not the thinking would be that it would facilitate a class action suit.

MATT DILLON: Yeah. I have no reason to think that a class action suit will be precluded by this legislation.

REP. WILSON (66TH): Are there any other questions? Hearing none. Thank you, sir, very much and for all the work you do to try to make it right. Appreciate it.

MATT DILLON: Thank you.

REP. WILSON (66TH): Okay. Next we have Josh Komenda.

JOSH KOMENDA: Thank you, Chairwoman Moore and Ranking Member Case and Members of the Human
Services Committee. My name's Josh Komenda, President of Veyo. I appreciate the opportunity to testify on behalf - testify on H.B. 7166. Over the past year, we have sought the partnership of Connecticut state agencies, legislators, healthcare providers, advocates, members, ASOs, and countless other stakeholders. To-date, Veyo and our transportation partners have successfully managed over 4.3 million trips with a substantiated grievance rate of 0.3 percent.

However, we fully acknowledge and want to make clear that this is of zero consequence when the system fails an individual member. Even when a small number of trips fail, Veyo recognizes how critical it is to continue to strive to improve and will not be satisfied until that is achieved. We want everyone who shares in that game to partner in that effort. Through its third party operator mobile application and its electronic integration of provider dispatch systems, Veyo currently captures the GPS and timestamps of 58 percent of trips in Connecticut electronically and completely objectively.

No other NEMT broker has the capability to achieve that level of objective performance measurement. Further in 2019, we're striving to have 100 percent of providing technology to ensure that all parties can be held fully accountable to performance. Veyo believes that many of the sections of H.B. 7166 are already represented in our contract with DSS and include ramifications for noncompliance. If the language in the bill represents modification of the current contract, Veyo is more than willing to engage with DSS to review contract provisions and discuss revisions if necessary. One extremely
noteworthy challenge that Veyo likes to draw
attention to is the dramatic increase in demand over
the past year driven by population increase and a
sharp increase in substance abuse treatment.

Veyo is now complete - Veyo and its partners are now
completing about 20 percent more trips than they
were in 2017 or about 2,000 or 3,000 trips each
workday. This has placed a strain on Connecticut
transportation providers and effective performance.
Veyo's team work tirelessly to onboard every single
qualified commercial provider in the state, increase
capacity of existing providers, and supplement
available supply with its IDP, Independent Driver
Provider program.

No other system or broker would have access to more
providers than Veyo. At the same time, Veyo has
been working hard to coach, discipline, and/or
remove providers that continuously underperform or
fail Husky members. Between one-quarter and one-
third of Veyo's providers are currently under
corrective action plans and improving the system
requires getting these providers to an adequate
quality range or removing them from the network. In
order to succeed at this process; however, new high
quality providers needed to be added and licensed.

Veyo has been working with DOS - DOT and DSS since
June of 2018 to aggressively add license capacity to
the state, but is constrained by administration of
delays related to licensing. We are making
progress. We'd like to continue to stress this is a
critical success factor and continue to request
partnership from state agencies and legislators to
assist in this process. I'd like to thank all the
stakeholders for continued collaboration and for
helping us to always become a better organization. We know that everyone is committed to improving the lives and health of Husky members and Veyo shares that aim passionately. We have relentlessly pursued it since the beginning of the contract. We'll continue to vigorously fight for going forward.

REP. WILSON (66TH): Thank you. Thank you for your efforts, but I continue to be confused about the disconnect between the numbers that you present and the experience of people in the field and I'm puzzled by that because it would appear from the various documents that you represent that you're doing just fine, but that is not the experience of - of people - everyday people with whom I interact, some of whom have testified and many providers have testified and I'm wondering if you have any thoughts about where that disconnect might be.

JOSH KOMENDA: I definitely do. If it's okay with the Committee, I'd like to invite our local representative, Dave Coppock, as well to help me answer more specific questions.

REP. WILSON (66TH): Certainly.

DAVE COPPOCK: To speak - to speak - generally speaking, Veyo completes approximately 380,000 trips per month which I believe is somewhere in the vicinity of 15,000 to 16,000 trips per day; 99.1 percent of those trips go without flaw, without concern, without issue. Even though it is a small portion of trips, just given the sheer volumes, there are sometimes a number of factors that can go into a failure, so could be related to - sometimes it's human errors. Sometimes it's a system error. Sometimes, it's an error by different stakeholders. It's a number of factors that go into it, so there's
really a large volume of trips. There still are issues and flaws I think come about. Our goal is to continuously improve, continuously make it better. This is not limited to Veyo, not limited to Connecticut. I think if you look at programs throughout the country - I can even suggest in the last 30 days, we've seen catastrophic failures of NEMT systems in Rhode Island, in Arkansas. Every month these large scale programs with many, many trips do have - do have failures. I think - I have been extremely encouraged by a level of progress and reduction of defect rate. In fact, the vast, vast majority of trips do happen on time and without issue. Of course - of course, it's troubling to me whenever I hear stories and testimonies that we've heard earlier today.

My goal and my team's goal is to vigorously root cause, fix any systemic gaps and holes, and partner with stakeholders to make the program as good as it possibly can be. I think we are succeeding at that. It's not perfect. It's not happening overnight. It's taking time, but I think we're - I believe that we have the passion and capabilities and technology to become the best program in the country.

REP. WILSON (66TH): Can you tell me who is responsible in your agency, not by name, but by function for substantiating complaints or finding that complaints aren't substantiated? Is that just someone within Veyo who takes in the information and then makes a determination as to whether or not a given complaint is substantiated?

JOSH KOMENDA: I can speak a high level and I would invite Dave to fill in any gaps or more details if he'd like. We have agreements - we've got several
levels of compliance and oversight within the organization. Veyo is a [inaudible 4:37:17] accredited organization so we also have compliance accreditation from external agencies that come in and audit all of our documents, processes, adherence to those processes, etc., so we are recognized by outside agencies and third parties that – that regulate NEMT. From the corporate level, we have a corporate compliance team which reports not only to me, but also to my board and really oversees all of our compliance oversight and overview at the corporate level, develops policies and procedures, steps, everything from training of employees to steps to investigation, etc.

We also have a local grievance investigation team that goes through standard operating procedures. Generally when a complaint comes in, and a complaint can come in really from any method or vehicle, there's no one specific system. The user has to remember, has to become accustomed to. Could be by phone call, by email, through DSS. We have an electronic intake process that tracks and tickets every complaint. It goes through an investigation process where the grievance team will make phone calls. Every phone call in our call center is recorded, so they will listen to all of our interactions with that member. They will call and talk to healthcare providers, transportation providers, drivers if necessary. Document all the circumstances of the complaint and then rule a complaint is either what we call substantiated or unsubstantiated.

Substantiated would mean that we agree that there was an error or a flaw or defect on either – Veyo's fault or one of our transportation party's fault.
Unsubstantiated would mean that it's clear that the circumstances don't support the evidence of the initial complaint and generally we also err on the side of substantiated, so if there's not sufficient evidence to provide one way or the other, we would default to agree with the member's complaint.

REP. WILSON (66TH): And, do you – can you give me an idea of what your substantiation rate is or how many times have you found that it is the client's problem versus your organization's issue?

JOSH KOMENDA: And to be clear, Representative, I'm not saying if it's unsubstantiated, it's not necessarily at the fault of the client. It may just be a misunderstanding of how the benefit works or something that we adhere to our policies and procedures and contractual standards. So, wouldn't necessarily be somebody's fault. Dave, do you have handy the substantiated rate in the state of Connecticut?

DAVID COPPOCK: I don't. There's one thing I wanted to add to what Josh was saying, is that during the entire process, we enter every complaint that comes in into a program called Sales Force. DSS has clarity into that system at all times, so they can see from the start to the end everything that's happening when it happens, almost like real time. So, there is complete transparency on our part with – with the agency as we're doing those investigations.

REP. WILSON (66TH): I have no doubt. I have seen the complaint process come back. DDS tends to agree, at least in the ones that I've looked at – tends to agree with your findings. The problem is,
the clients can't always be wrong and it just appears that in the system that's what happens.

JOSH KOMENDA: Representative, absolutely. That's true. The clients under no circumstances, let me be clear, we're not suggesting the clients are always wrong. There's definitely in the --.

REP. WILSON (66TH): No fault on the part of Veyo. Somebody's wrong other than you.

JOSH KOMENDA: Oh, no. Absolutely. I don't want to quote a number and I can get back to you. I don't want to quote a substantiation number. There is -- some significant portion of complaints are substantiated and Veyo fully acknowledges that, so in no way am I saying that all complaints are unsubstantiated.

REP. WILSON (66TH): But, apparently there have been a mere $22,000 in fines by the department against this multimillion dollar contract and that seems like a very small number given the kinds of complaints and concerns that we're hearing from virtually everybody who uses the service. Now, I admit people don't tend to when somebody does a good job, people don't tend -- don't tend to call in and tell you, gee, they got one right. So, I realize that I'm hearing the complaints, but still $22,000 and what is it $500 an occurrence, I believe --.

JOSH KOMENDA: It depends on the infraction.

REP. WILSON (66TH): Somewhere between $100 and $500 an occurrence, so we're talking about out of the thousands of rides that you provide and the millions of customer interactions, DDS has only seen fit to fine -- make a finding that was worth a monetary ding
if you will of $22,000 and that strikes me, given the size of the contract and the numbers of people that you serve, it strikes me as an exceptionally low number and I'm --.

JOSH KOMENDA: Representative, I can only comment that the contract indicates really clearly under what circumstances a sanction is imposed and what the monetary value of that sanction is, so I can only comment that we strive and make every effort to be as transparent as possible with all - the entire complaint process, give DSS full visibility into that, and from what my interpretation of the data and everything that I can see is we're providing every opportunity to be sanctioned or fine when the contract indicates that that should be so. I would also - I mean - and I say this with a degree of caution, I am not - any individual failure is painful for me to listen to and needs our attention. I want to be extremely clear about that. Statistically speaking, we just - we run an absolutely massive program and 99.1 percent of trips are happening successfully, so this is a very large scale program. I know it's difficult to listen to the volume of complaints, but just understand that statistically speaking, it a small number of the overall trips.

REP. WILSON (66TH): Thank you. Are there other questions? Mr. Case.

REP. CASE (63RD): Thank you, Madam Chair. So, DDS is oversight 'cause back maybe three or four years ago, Cathy and I, Representative Abercrombie and I were working on because the previous contractor - this hasn't gone out to bid this type of transportation for years. It was just continued on,
so it went to bid and you guys won the bid. You talked about Sales Force, so is DSS on Sales Force real time with you?

DAVID COPPOCK: Yeah, the answer to that is yes, Representative Case. They have full clarity into everything that we enter. They can see when it's entered and they actually have access to full visibility of what we're doing during every case that we're investigating.

REP. CASE (63RD): And, I thank you Josh for coming in. I personally feel it, too, when we hear the complaints and I make a valiant effort to try to work and that's why when we sat in the Commissioner's office - I don't think you guys - maybe, Josh, you were there - when we decided that we would do a legislative email and a direct line into DSS which would be attached to Veyo so both sides would see it and there wouldn't just be a one-sided complaint. How has that worked out?

DAVID COPPOCK: If you don’t mind?

JOSH KOMENDA: Of course.

DAVID COPPOCK: It's been very successful. In 2018, I don't have the numbers right off the top of my head, but there was approximately 220 legislative complaints that came through the legislators to us with 100 - approximately 120 of them where we found - substantiates about - a little over 50 percent were substantiated, so it has worked very well. It has dropped off considerably. Those are always - we still get them periodically and those are like any other complaint, when anything comes in, it's automatically immediately entered in Sales Force and the process is started for the investigation.
REP. CASE (63RD): So, without giving out client information, I think you talked about this earlier, which I agree with you. I'm on Sales Force every day with my other job. I can see real time what's happening with my people in Ohio, California, Canada. When there's a sale that comes through, Sales Force gives it to you. Is there any way of redacting information so that us as legislators through DSS, I'm assuming, can see the - the body of the complaint and see how it was handled just so that - I think that with give some indication of what type of complaints are going. I'm not trying to ask for personal client information or anything because I know with me using Sales Force, I can go in there and see anything that anybody has ever entered. It can't be erased. Sales Force doesn't allow you to do that, but is that something - I guess we have to ask DSS 'cause it's DSS contract, is that correct?

DAVID COPPOCK: Yeah. I would say that would be a bigger discussion with us and the agency. I believe that the only way it would possibly be able to be done is old FBI or CIA style as printing it out and blacking it out so there's no HIPAA violations, but from our standpoint as Veyo, once again, we're fully transparent with the agency, and if that's what the agency as well as the Representatives wanna see, then that would be a conversation with them.

REP. CASE (63RD): So, for full clarity 'cause I've heard some comments that all complaints, and once again, working with Sales Force most of my life, you cannot delete anything. Nothing can be taken out of that, so all the information is there of the complaints that came through, so we should be able to get that in a redacted type form if that's so
what we decide to do up here and ask the Commissioner. Obviously, we wanted this to go out. We've had some major problems with the previous supplier.

In fact, at least I did up in the northwest corner and that's why we decided to ask for it to go out to bid with the new Commissioner. Nobody wants us to miss rides. Nobody wants people to lose business, but I think we as legislators here in human services didn't have any input on how DSS wrote this contract. So, we're not in the contract writing business, but we need a company like yours to be accountable for any rides that are lost or not there and I know we had many meetings, and correct me if I'm wrong, that in the beginning stages not all the information from the previous company was put into the system to give rides and that's where we had a very bumpy road in the beginning. Is that not correct?

JOSH KOMENDA: Yes, absolutely. We had – we had a very difficult and very challenging transition. NEMT transitions in our industry are notoriously difficult for anything, let alone a program of this magnitude. One of the challenges, or a number of the challenges that we faced during this transition, is that when we received the data from the outgoing contractor to begin rides in January – January 1st and beyond, we had a significant number of rides where our providers were showing up and the member had not lived there for two years, the member was deceased, so it was just clear that that data was not accurate. We were not provided with accurate data.
And, given the nature of the program, it's difficult, sometimes often impossible, to reach every utilizer of the system ahead of time so we could provide data for accuracy, so during the first two weeks of January, we had providers that were reporting up to 60 of 80 percent of trips being no-shows, meaning never showing up. They were not real trips, so it was a very bumpy ride in January, February, just getting the data cleaned, working with members, working with providers, working with healthcare providers to really just get the proper trips into the system. And, then we started to see that smooth out through February and March.

REP. CASE (63RD): We're beyond that point. We're in the second year. Was this a three-year contract?

JOSH KOMENDA: It is a three-year contract with two optional extension years, correct.

REP. CASE (63RD): And, I think the last contract went for 12 years. It was three that on for four times, but we need to turn around and make sure that everything is handled. I mean, a lot of us don't know exactly. I mean, I've read parts of it, of the DSS contract, and it's not like the last contract. There are some things that the last contract allowed to be done that this contract doesn't allow, like - and trust me, I - we gotta hold you guys accountable. We gotta hold you accountable with DSS because they're the ones who wrote the contract. Is - mean, this is a money making venture for you guys, but it's the first contact I've ever read because I write for a contracts for a business to actually have a cap of what you can profit. Everybody thinks you're profiting millions of dollars on this. Is there a cap on this profit?
JOSH KOMENDA: Yes, there is.

REP. CASE (63RD): So, the cap on that profit, and you can tell us what that percentage is, the sanctions that they put against you comes out of that profit?

JOSH KOMENDA: Correct.

REP. CASE (63RD): And, was is that say – what is that percentage?

JOSH KOMENDA: I believe that the – the standard or anticipated gain would've been approximately 2 percent of the overall value of the contract and that can change depending on performance, so if we underperform and there's a number of – that could potentially be limited profit, available gain, to be limited down to zero I believe. If we perform exceptionally, that could go up to 5 percent.

REP. CASE (63RD): Okay. I don't have that many more questions. I guess, just a comment, and you know, there's a lot of – we hear a lot about this and I've spoken a lot as along as everybody else has on this Committee, whether negative or whether positive. What I take out of it is what I'd like everybody to understand is DSS wrote the contract that you need to follow. We are legislative committee that oversees DSS, but they wrote a complex contract in RFP to which you guys responded to, to try to alleviate some of the things from past practice.

We can't be missing rides, but if we tried so hard – Cathy and I did and the Commissioner's office to set up a complaint process so that we could have you
guys available and I guess, Josh, you come from – where'd you come in from today?

JOSH KOMENDA:  San Diego.

REP. CASE (63RD):  And, you've been here many times, so you've been accessible to us. You can't be accessible to us every today, but as much as you can, and I guess the bottom line is there is negativity out there. As far as I know, my complaints, things have been responsive. Am I happy with them all? Maybe not, but my main complaint goes to DSS at the end of the day because it's their contract and I guess I'd just like to thank you all for coming out and hopefully we can turn this around and we can make this positive as we're trying to do with the whole state. Thank you, Madam Chair.

JOSH KOMENDA:  Is it okay with the Committee if I make a comment on --.

REP. WILSON (66TH):  Yes, please.

JOSH KOMENDA:  I mean culturally as a company, we are fully embracing of the nature of being transparent, of being open, of being honest and full of integrity, and that's up and down throughout the organization. We strive to – data can be a very complex thing, a million different ways to measure and report on things. Every month, we provide a report that becomes part of the public record of DSS and I believe it's somewhere in the vicinity of how many pages, 57 pages, of statistics and data and operational performance and we strive – we record every phone call. We try to be as transparent as possible with our complaint process. I do hear thoughts or challenges to our data integrity, our honesty, our data, that troubles me to a great deal.
To the extent that we're allowed to by law with HIPAA or protecting our confidential and proprietary information, I invite new dialogue about the types of transparency that people would like to see.

I - we take pride in our honesty, integrity, and data and it's important to me, that this committee, the state legislators, the departments have a high degree of trust in that integrity.

REP. WILSON (66TH): I appreciate your willingness to be willing to continue to work on this. Clearly, there's room for that. We need to do something. We cannot continue to, just in my districts alone, to get the numbers of complaints and I admit I'm from a rural district out in the 53rd. I understand some of the complexities of providing transportation in a rural area, but too many people are missing their appointments, are not getting to their appointments, are falling out of the system because they can't get to their drug treatment when they need to or other or dialysis or other kinds of situations. And, it can't continue to be tolerated, so I appreciate your willingness to work on it. I have reviewed the contract. I find the contract seriously wanting, but I guess that is not an issue with you, it's an issue with DSS because all of the checks in the contract appear to be on sort of the administrative end of things and not enough on the customer service end of things. People are having to either arriving too early and the person's not there or they're not coming. In other words, the customer touch side of the piece is where there's no - there's no - there doesn't appear to be any ability to manage, so I'm just unhappy.
JOSH KOMENDA: Representative, can I comment on one item? Specifically with respect to some of the problem, difficulty areas to serve and you pointed out some rural areas. I did — in my initial testimony I did refer to really sharp increase in demand for transportation over the last year. A lot of it has been driven or almost all of it has been driven some by Medicaid population increasing, some of it by a sharp increase in substance abuse treatment and getting people to drug rehabilitation treatment.

The net net of it is the Connecticut transportation system is doing 2,000 to 3,000 more trips a day than it did a year ago, and when you think about, there's a fixed capacity of vehicles on the ground. To absorb that increase in demand has put strain on us and the team has gone out and contracted with new providers, people that probably have never done NEMT in the past. We're trying to get more and more capacity in the system. And, we've been very successful to a degree. There are some still areas of the state that we're contracted with every available car and those transportation providers are doing whatever they can to service every member. In some cases, they are a bit overloaded and doing the best they can. We've been working with DOT and DSS to say, how can we get more companies licensed? How can we get more vehicles on the ground? And, we're aggressively working on that and making progress, but it has been a strain on the system.

REP. WILSON (66TH): Right.

SENATOR MOORE (22ND): Thank you for your testimony. So, one of my fears has come true. You didn't have the capacity to do this. I remember you
specifically, Dave, coming into the office talking about what this was gonna be - what it was gonna look like and what you would be able to do and I sat there that today because I know call centers. Customer service is the core of everything that I try to do to make sure that whoever I say I'm going to serve I serve them up here, not I don't have a standard here, I want to always be above that, right? 'Cause there's a safety net here and I had reservations that you really could deliver on what you were saying that day in my office.

And, as I listen to the complaints, I am overwhelmed by the number of complaints even though when you look at the scope how many you're serving that you have this - you have these complaints, it may seem like a small number. When you start to think of those numbers as individual people, then it's for me it's - there has to be some improvement. So, I think part of the problem is the capacity and some of the things that you wanted to implement coming into this. I think we have to look at we need to find somebody else to do this and we entrusted you all to do this, right? And, I think the contract could've been a little tighter in the way of transparency even to us without providing any HIPAA data to show us what really is going on for the people that we serve in Connecticut.

And, I heard you mention that you would be willing to sit down and figure something out on how we can get some of this information in real time and I think that might - you might have to do that to make us feel comfortable that when this contract is over, or your contract ends, that we feel comfortable to give it back to you. Otherwise right now, we should be looking at somebody else and finding out who
could do this. I wanted to ask you, comparatively, because this is not your only - Connecticut is not the only state that you serve, right? So, when you look at your level of service in places where you're more established, what does your data look like in the way of being able to provide services in those places where you're established versus here in Connecticut and is there a difference, and if there is, when - and if your numbers are better in other places than Connecticut, when can you get to that level of we can believe that you have the capacity to deliver on what we expected, not what DSS looked for, but what we as legislators would have to present our case to the constituents - when do you think that you will be there?

JOSH KOMENDA: Do you mind, Senator, if I ask a clarifying question? When you talk about your fear - your fear of our preparedness for capacity, with respect to the call center capacity or --?

SENATOR MOORE (22ND): Not just - not - I heard on the call center that you have overflow, right, into other places.

JOSH KOMENDA: I do want to point out our service levels have been north of 85 percent nearly every month since March, so I think the vast majority of our calls exceed contract standards and industry standards in terms of our call center performance.

SENATOR MOORE (22ND): I understood the call center 'cause I heard somebody in the testimony that there was overflow to someplace else when the calls come in. I get that. I'm talking about the level of service for picking people up. So, I think it said 70 percent if it was one leg trip, your performance is 70 percent, right? That's the standard?
JOSH KOMENDA: I'm not sure. Dave would be able to comment on the --.

SENATOR MOORE (22ND): That is the standard, right, 70 percent that you reach for single leg A?

DAVID COPPOCK: Yeah. Are you asking, Senator, that is that where we're at right now on the average or is that what we're stri - or where we should be?

SENATOR MOORE (22ND): I understood that was the - that was the contract, that you had to be at 70 percent. Is that not right?

DAVID COPPOCK: No. It's higher than that, Senator.

SENATOR MOORE (22ND): It says pick up - pick up and return wait times are within contract standards for approximately 70 percent of A-leg trips and 92 percent of B-leg. So, what is the standard?

DAVID COPPOCK: So, yeah, what that is saying right there is that 70 percent of the time we're within contractual standards on the A-leg and 92 percent of the time on the B-leg.

SENATOR MOORE (22ND): And, what was - what would be the standard for 70 percent? If you're only doing 70 percent, what was the level that you should be at?

DAVID COPPOCK: I believe it's 95 percent.

SENATOR MOORE (22ND): That's 25 percent you're not serving and A-leg means one way, right?

DAVID COPPOCK: Yeah, that is correct.

SENATOR MOORE (22ND): One destination.
DAVID COPPOCK: Yes. That's the initial trip, picked up from usually the residence to the facility.

SENATOR MOORE (22ND): And, 25 percent equates to how many people?

DAVID COPPOCK: I couldn't answer that right off the top of my head. I would have to go back and look at data. Right now, I couldn't equate that.

SENATOR MOORE (22ND): So, I just think that we really need to sit down collectively with some of the legislators and I understand – let me finish that thought – with some of the legislators and other people who have a vested interest in this and figure out how do we work this to a point of satisfaction beyond the contract. I did ask Commissioner Bremby, is there an opportunity. He said it had to be negotiated if you both agreed that the contract – you could relook at the contract. I think the standards are low and I'd like to see more in the contract in the way of transparency and who you can share some of the data with without going outside of any laws, HIPAA or anything like that to do better than what we are because if I was here in two years, I would really be questioning do we wanna go down this road again. We took that – that contract with that other vendor because they were not performing, right? And, I don't think anybody's talked about that timespan it gives you to ramp up to be who you need to be because you don't have that when you have people – those people are still waiting. They don't care that we switched vendors and we went to this and you couldn't take the data from the old vendor.
I remember that problem, that the data didn't switch over or didn't format the way you needed to format. The people who need the services, they don't care about that. They know that they need to get to where they need to get for the medication, their treatment, or whatever it is and so when I go out and I talk to somebody in the community, they don't wanna hear about that. I know if it was me, I don't wanna hear about it. I want to know that you told me that you could deliver something and you deliver it. That's what I wanna know and I think that there needs to be some type of negotiation and I think I will ask the Chairs and the Ranking to sit down and figure out what can we do because I know Commissioner Bremby, he did not want to do some of this stuff in this bill and he pushed back on a lot of it, but - and he is the executive branch and he oversees contracts, but we serve the people. We're the ones elected to serve the people and that's all I care about.

I don't care about the executive branch of what they say when it comes to my constituents and all of our constituents. I care that we are giving them the service that we said we were going to deliver, and if we're not delivering it, how do we get to that place that we feel that we've done the best we can working with you and other people outside the systems to make sure that we're providing a level of service for the constituents of Connecticut and that there is a level of transparency and that I want to feel comfortable that you have the capacity to do this in Connecticut and when are we going to see that.

So, I'm gonna tell ya, I'm just really dissatisfied. I'm dissatisfied because you - I'm right and I
didn't wanna be right that day. I really wanted to believe that you could deliver on those things that you said you could 'cause I remember you talking. I asked you about Uber and all these different services that you would — and I was like thinking, this is gonna be great, but I don't see it. I don't see it and I don't use the services, so just think about this. I'm this frustrated and I don't use the service. What are the people who need the services, how do they feel and what do they think about us as legislators who are supposedly looking out for them? And, spending this type of money for a service that they should be getting that they're entitled to. So, there's no need. I don't need you to respond to me. I just wanna let you know I'm frustrated and I want to see a clear path to wherever we need to be. Thank you.

REP. WILSON (66TH): Thank you very much. Thank you for being here. I believe Ben Shaiken is next.

BEN SHAIKEN: Good afternoon. Good afternoon, Senator Moore, Representative Abercrombie, Representative Case, and distinguished Members of the Human Services Committee. My name's Ben Shaiken. I work at the Connecticut Community Nonprofit Alliance. The alliance is the statewide advocacy organization representing nonprofits. We have a membership of more than 300 community nonprofit organizations and associations.

As you well on this Committee, nonprofits deliver essential services to more than half a million people each year and they employ almost 14 percent of Connecticut's workforce. I want to thank you for the opportunity to testify in support of H.B. 7166 which would establish a statutory right to timely
and appropriate nonemergency medical transportation for Medicaid beneficiaries. Without going into all the history and background of my written testimony which you should have, I wanted to just make sure to highlight two points, some of which – some of which have been talked about today.

Nonemergency medical transportation is incredibly important for people receiving, especially behavioral health and substance abuse services, in Connecticut. During the initial period that this contract not working as well as it should, we have one community provider report that 19 scheduled rides for Children's intensive outpatient treatment were not provided and those children – those children missed on an essential behavioral health service to be sure, but the provider also lost time and resources both in not delivering those services which they bill Medicaid for, but also the staff time to address the transportation issues for their clients was substantial.

And, I also want to draw attention to an issue that this Committee heard at a previous public hearing – heard a lot about which is methadone maintenance treatment and that treatment requires people to – many of the people who receive it to be daily arrive at their treatment provider to receive their treatment. Many of those people arrive through nonemergency medical transportation and when those appointments are missed, we put people in incredibly dangerous situations, relapse, and worse.

And so, the last thing I want to just highlight, you should have some written testimonies from some of my members who couldn't make it today. One provider has just taken to buying their own bus passes and
has spent $150,000 to-date on bus passes that should - their clients should be eligible for through the Medicaid program. We talk a lot about cab rides as we talk about the nonemergency medical transportation system, but that contract also manages bus passes for Medicaid beneficiaries and I believe a substantial portion of the trips are on buses that are through those bus passes. That provider - I'll wrap up, reports that the cab ride situation has actually gotten better for them in their particular part of the state, but that the bus pass system is still a big problem. And so, I just highlight that to say that's is bigger than cab or individual personal passenger vehicle transportation and I think that the bill that is before you will be a good first step to try to make this better for the people my members serve and also for them and I urge you to support it. Thank you.

REP. ABERCROMBIE (83RD): Ben, let me just say thank you for all that you do and it's always been a pleasure to work with you and I think some of these issues we're really gonna need your help on, especially as we start. You know that I just came from the Subcommittee for Appropriations for Health and Hospitals and we start Human Services next week, so I look forward to working with you on a lot of these issues.

BEN SHAIKEN: Thanks. We'll see you tomorrow night.

REP. ABERCROMBIE (83RD): You know it's date night so it's not really a fun night for me. [Laughter]

REP. WILSON PHEANIOUS (53RD): Next, we have Kelly Phenix or Phenix. Phenix, okay. Thank you. All righty.
KELLY PHENIX: Hi. Good afternoon everyone. Hi. You just asked about what were the number of complaints versus substantiated complaints?

REP. WILSON PHEANIOUS (53RD): Yes.

KELLY PHENIX: I can tell you the numbers for January. January was - total complaint count was 396. Substantiated complaints was 179, but there's a lot more to that number and that's part of my testimony, so I will get to that. I understand there was some confusion and Kathy Flaherty read part of my testimony about the call wait times. I also - for those two ladies who don't know me, I'm - I am an appointed member of both BHPOC and MAPOC and a Co-Chair of the Subcommittee that does have oversight over Veyo as Representative Abercrombie mentioned. I'm also a Husky member. I'm an independent consumer. I don't work for anyone. I'm not a lobbyist, so just to make that clear.

When Commissioner Bremby was testifying this morning and he spoke about how the calls are down to 10 minutes, I was sitting over there. I called and I actually got picked up in just under four minutes. I hung up, so it's technically an abandoned call. I then received two calls back from a Waterbury number. Last summer, Commissioner Bremby said that the system is changing so that when the callbacks came, it was going to say DSS call center. It doesn't or it hasn't changed. So, I did tell him that, let him know, showed him my phone afterwards.

But, I did lose six hours of my life that I'll never get back to being on hold because I was 20 percent - - I was in the 20 percent of the Medicare savings program folks who had to provide additional information. Okay, just like Commissioner Bremby,
H.B. 7166 is very puzzling to me because all the language referring to what they shall not do is spelled out on the contract. Number one; failing or refusing to provide NEMT to eligible members is quite frankly a breach of contract. Plain and simple. I have all of the - all of my supporting evidence on my research I have with me including the contract, so if you would like it, let me know.

According to Veyo - this has come from Dave Coppock at many meetings, a ride is considered late when it arrives one minute after the scheduled pickup time. Sanctions start at the one-hour mark for a regular appointment. For a hospital discharge, it is - they have, so it's three hours or more. Each one of those incidences can be $500. It's capped at 10 grand a month. That's part of the issue. That's why there's no incentive. Ten grand a month is what to them? Nothing. The coordination of care - we asked for a stranded list which is to be produced next month, so this stranded list - I specifically requested the number of rides late in 15-minute increments up to three hours for A&B legs and then late in 15-minute increments in excess of three hours for a hospital discharge.

I think that's going to prove to be a very interesting set of data. Every month, we just heard, they provide DSS with information and it is then posted publicly on the website. It's about 55 pages long. Yes, there's call center info and that's all very nice and lovely. It is the 10 pages of the monthly trip report which lists all of the providers, how many trips they were assigned, how many were late, how many were no-shows. The January report that was posted on Tuesday is missing, all of
that information, so the only info I have are the latest is from December.

You kinda have to dig it apart. December reporting, there were 356,249 completed trips. Well, not really. Take out the buses and take out the mileage reimbursements and the actual number of completed trips by providers, by the cabs and ambulances, is 138,921 which is actually 39 percent of all those total rides. Of those trips, 22,002 were late and 368 were no-shows, so I find it really hard to believe and agreeing with you, Representative, that all of these complaints that have been submitted, you mean to tell me that none of them were Veyo's responsibility, 22,002 times? I mean, I was not a math major, but I can add and subtract. So, those 22,000 and the 368, that represents 16 percent of the rides of the 138, so like what Bonnie was saying about why we would like an audit, is because it looks pretty on this page and then you start digging it and it's not so pretty.

REP. WILSON PHEANIOUS (53RD): Kelly, can you – we've already let you go a minute over the three and we have other people.

KELLY PHENIX: Oh, I apologize.

REP. WILSON PHEANIOUS (53RD): If you could just summarize, that'd be great. Thank you.

KELLY PHENIX: Sorry. We have requested through coordination of care that an independent third party audit be conducted just like it was for LogistiCare. The last BHPOC meeting I asked how it was paid for. I was told by Bill Halsely there were extra funds in the Mercer account. I don't know what line item in the budget that is, but I think we should find out.
And, it also should I believe be included in any future or amended contract with an NEMT broker, third party audit. The sanction money is returned to DSS from sanctions that go back to the general fund. Well, this money could be used for an audit. It also could be used for the providers and the hospitals who paid out-of-pocket for the members who were stranded. They have never been reimbursed from January last year on.

And, that's really more a thing. The last part of my testimony you can read, but we were basically sold a bill of goods in the request for information response from Veyo about technology and like you said it's not working. You have said this is a bad contract many times. I've sat next to you and shook my head saying, yes, you're right, it is. There have been improvements, but there are far too many that haven't and it's costing the state additional dollars negating the whole reason for the nonemergency medical contracts and our members deserve better. That's what I have. Do you have any questions?

REP. WILSON PHEANIOUS (53RD): Thank you very much. I don't have any questions, but I do appreciate the energy you put in to collecting that data and digging it out because it's hard to find, so I will look forward to reviewing some of that with you and better understand the situation.

KELLY PHENIX: I am more than willing.

REP. WILSON PHEANIOUS (53RD): Oh, I'm sorry. Sorry.

REP. CASE (63RD): You did. You caught me in the hallway, so I came back --.
KELLY PHENIX: I did. Thank you.

REP. CASE (63RD): I had to go to higher ed and come back. We're all over the place today.

KELLY PHENIX: I appreciate it.

REP. CASE (63RD): And, I'm sorry.

KELLY PHENIX: That's okay.

REP. CASE (63RD): Representative Abercrombie. I missed a meeting you and I were supposed to be at. I owe you one. So, I just wanna say because Representative Abercrombie wasn't in the room and I agree to this point where I didn't realize the program that they were using, 'cause you heard me talk about it which is Sales Force, and it's very - Sales Force is very open and that is the program that DSS is using with Veyo to get the complaints and put together. I use Sales Force on a daily basis and it's very transparent.

I was mentioning to Veyo if we could get DSS to redact the information, but for us as part of an audit type thing so see what the complaints are because you have to put a final action in Sales Force in order to close that particular thing out, so it's interesting that that is the program because you cannot erase things out of there.

KELLY PHENIX: Were you here? So, for the month of January, there were 396 logged report - complaints, but Veyo only substantiated 179 of them.

REP. CASE (63RD): Right, but we - what I want to see is what comes in and what gets entered into Sales Force because that's what has to go over to DSS to their - they're tied to it, so --.
KELLY PHENIX: If you look at the trend of complaints over the course of last year, it was sometime in the summer where we asked them to clarify what they consider a complaint and when it is resolved. When the person calls in and they say, where's my ride, that's not a complaint if the call center person resolved it right then and there. It should be, but it's an hour-and-a-half later, where's my ride? Oh, let me fix that for you. That's not lodged as a complaint. So, we went back and said but it should be or it needs to be. You'll see over the course of the year, the number of complaints that they reported went up substantially once we called them out on how they were logging complaints. With LogistiCare, we used to tell consumers, you have to say the magic word, I am filing a formal complaint and I think it needs to be the same way with Veyo.

REP. CASE (63RD): Well, and I agree with you because that's one of the things Representative Abercrombie and I when I was into my second or third year - we weren't happy with LogistiCare. We had a lot of problems especially in the northwest corner, three to four hour waits. I mean, it was horrible. And, we came out with this contract. I think you and I can sit down, we'll drill down, and let's get some better results and let's - like I said before, let's not only make this better, but hopefully with budget stuff, we can make everything better because you weren't in here when I was speaking before and you know we have a lot to talk about coming up. So, I appreciate it. I do have another meeting I have to get to.

KELLY PHENIX: I appreciate you coming back.
REP. CASE (63RD): And, then we're here - oh, you're not on government BC, you're not here all night. Thank you. We'll spend Friday together.

KELLY PHENIX: You're welcome and I just would like to say that the next coordination of care meeting is on March 27th from one to three in Room 1E. Please come. Question Veyo. That's your opportunity to do so again without the necessarily three-minute time constraint and hopefully they will - and they're supposed to have that stranded list ready for us, so we'll see what happens. Thank you so much. I really appreciate it.


JEANNIE MILLSTEIN: Well, the first line of my testimony reads good morning, so [laughter] hope springs eternal. So, good afternoon Senator Moore, Representative Abercrombie, and Members of the Human Services Committee. My name is Jeannie Millstein. I am the Director of Human Services for the city of New London. Thank you for the opportunity to testify in support of H.B. 7166, AN ACT CONCERNING NONEMERGENCY MEDICAL TRANSPORTATION FOR MEDICAID BENEFICIARIES. I have submitted written testimony and attached to my testimony I have many, many stories about experience that folks have had in New London with Veyo. In addition to many other responsibilities, I oversee the New London Senior Center and I also Co-Chair the Opioid Action Team. I'm here today to share with you the substantial problems we have encountered with Veyo.

Last year, the Health Improvement Collaborative of southeastern Connecticut created a data entry portal for local providers to enter reports of what their
patients and clients are experiencing, both positive and negative. In addition, we help seniors arrange transportation to medical appointments, so New London is the number one distressed municipality in the state, so as you can imagine, we have a lot of reliance on transportation. In our 2016 community health needs assessment, we found that 42 percent in the greater New London area making less than $15,000 a year stayed home when they needed to go someplace in the previous 12 months and that 20 percent of that population reported never or almost never having access to a car.

Significant numbers of people reported problems getting to appointments. Between June and November, there were 51 incidents entered in our survey. This is not scientific and certainly not everybody even knew about it, but it's not a representative sample or a systemic way of collecting data, but it gives us insight and it is generally dependent on an individual case manager taking the time to answer the questions. So, of the 51 incidents, 72 percent reported that the cab did not come at all, 24 percent reported that the cab was late between 45 minutes and three-and-a-half-hours late, 48 percent of these incidents resulted in people missing medical appointment, and again, I've attached comments that people made. At the Senior Center just last week, the Veyo provider showed up three hours late to pick up one of our seniors for one of her appointments and at another time they didn't pick her up from her doctor's office, so she stayed there until after the office closed and ended up calling a cab to bring her home. This is in a tiny little community. Another example; a driver denied a reason for - a completely illogical reason,
telling the person to take a bus and then I also, as I'm Co-Chair of the Opioid Action Team, and the opioid crisis has devastated our community and many folks now in our community are receiving medically-based treatment for their disorder.

So, for the person who does not have access to their medication for opioid disorder, this can be a matter of life and death. For a patient recovering from a stroke who missed a neurology appointment, a senior dependent on dialysis, a child living with asthma who needs an adjustment. Anyway, recommend direct DSS to invoke any and all remedies for noncompliance under the contract, direct more meaningful oversight of Veyo, and then as was mentioned earlier, conduct a performance audit. And, I want to say one thing. Veyo did attend collaborative meeting last summer. We are very grateful for their time and effort. We were, however, disappointed that they were not able to provide us with insight and understanding about their methods for tracking service. Again, as the overwhelming experience differs from what we see day to day and the call center staff has not been – has been unable to provide accurate information regarding complaint procedures, so thank you very much, and I'd be happy to answer any questions, and again, as attached to the written testimony.

REP. WILSON PHEANIOUS (53RD): Are there any questions? Thank you very much, Jeannie, for those statistics and your work. Okay. Next, we have Dr. Jeff Bartlett.

DR. JEFF BARTLETT: Good afternoon.

REP. WILSON PHEANIOUS (53RD): Good afternoon.
DR. JEFF BARTLETT: Good afternoon, Senator Moore and Members of the Committee. My name is Dr. Jeffrey Bartlett and I am the Medical Director of Neonatology for Western Connecticut Health Network which includes Danbury Hospital, Norwalk Hospital, and New Milford Hospital. I want to thank Representative Frey for raising the critical issue of regulation and reimbursement for donor human milk and to the Committee for including such an important issue in today's meeting.

I wholeheartedly support the intent of H.B. 7165, but in order for the bill to have the intended impact on Connecticut's most vulnerable infants, the legislation must be changed. At all of the NICUs at which I practice, we strive to provide the best care possible for each child we treat. This includes a focus on nutrition and providing a human-based diet to the greatest extent possible. In our NICUs, we work with mothers to help them provide milk for their babies either by breastfeeding or by pumping.

Unfortunately, for many of our very low birth weight infants, a mother is often unable to provide her own milk for a period of time or to a volume at which her baby needs. In these cases, the baby is fed with donor human milk. At the Danbury and Norwalk Hospitals, we use donor human milk purchased from Prolacta, a milk bank based in California which is not a member of HMBANA. For our very low birth weight babies who are so small they fit into the palm of your hand, we supplement donor human milk along with a human milk-based human milk fortifier which is known as the exclusively human milk diet and is crucial to meeting the nutritional and caloric needs of our tiniest babies. It is a particularly critical component for our care of our
very low birth weight babies because it delays the introduction of cow's milk into these babies' diet which reduces the chance of them developing a life-threatening disease called necrotizing enterocolitis by approximately 80 percent. The results we have seen from the exclusively human milk diet are quite literally life-changing. Our babies are growing stronger more quickly than ever before. Feeding intolerance, which often leads to disruption in feeding plan, insertion of an invasive peripherally inserted central catheter for nutritional support, and has symptoms that overlap with necrotizing enterocolitis has been reduced dramatically.

The use of an exclusively human milk diet in our very low birth weight infants has resulted in a reduction in the incidence of necrotizing enterocolitis. Additionally, the length of time to reach full feeds and that a baby remains on intravenous nutrition has been reduced in our units. Each of these also has the potential to reduce the length of time each infant stays in the NICU. I realize that my time to testify today is limited, so I will allow others to provide further education and information on the importance, efficacy, and cost reductions resulting from exclusively human milk diet. However, I do want to leave you with one takeaway.

As physicians, one of the most frustrating experiences that we encounter is having our hands tied when we know the best treatment for our patients. In the case of neonatologists, we spend weeks and months with our patients. We know these babies and what they need to survive and thrive. With this legislation, the Committee has the chance to greatly improve the availability of critical
therapies for Connecticut babies regardless of their birth date or location or of their socioeconomic status, but in order to do this effectively, I urge you to ensure two things. First, that this legislation also covers human milk-based human milk fortifier so that our most fragile babies that require an exclusively human milk diet can receive it, and second, to ensure that milk reimbursement by the state includes milk from the Department of Health Certified Banks which ensure donor milk is of the highest possible quality. This will allow each hospital to procure donor milk based on specific needs and clinical decision-making. Thank you for your time.

REP. WILSON PHEANIOUS (53RD): Thank you, Doctor. I have a question. I don't know if you heard Commissioner Bremby's remarks, but he indicated that this couldn't be - that the donor breast milk could not be paid for with Medicaid dollars because it was considered food and there might have to be alternate ways of paying for milk. There was no dispute about the fact that it was the most appropriate thing for babies. It was just that Medicaid couldn't pay for it. I'm wondering, are you aware of other hospital settings where perhaps in other states or where they are in fact using this as a Medicaid expense?

DR. JEFFREY BARTLETT: Yes. I believe that there are six or eight states where this is being covered by Medicaid.

REP. WILSON PHEANIOUS (53RD): I'd be very interested in your information on that because if they can do it in one state, they can do it in all states. That's call the United States of America [[laughter], so I'm just interested in what the
difference is in either their state plan or why it does not appear to be coverable in Connecticut at least according to DSS. So, if you have that information, if you can give me that information, I would appreciate it.

DR. JEFFREY BARLETT: Sure. I mean, the states that I have listed are New York, New Jersey, Tennessee, California, Michigan, Missouri, Texas, and Washington D.C.

REP. WILSON PHEANIOUS (53RD): Okay. Thank you. Thank you very much. Are there other questions, please?

REP. MASTROFRANCESCO (80TH): Thank you, Dr. Bartlett. That's your name?

DR. JEFFREY BARTLETT: Yes.

REP. MASTROFRANCESCO (80TH): Thank you for coming and testifying. Do you know how many in the state of Connecticut, how many babies are born where the mom cannot provide milk for the baby where they have to go to a bank? Any idea what the number is in Connecticut?

DR. JEFFREY BARTLETT: No. I don't know the specific number. I don't know if somebody else has that information, but --.

REP. MASTROFRANCESCO (80TH): That's okay. I didn't know if you would happen to have that number, and in your experience, when they cannot - where the mom, mother, cannot provide milk, the hospital gives them an alternative, a supplemental - what is the proper treatment I guess for the baby?
DR. JEFFREY BARLETT: Sure. For those babies, the tiniest babies that are at risk, we would give donor human milk and that option is offered in various forms depending on which hospital you're at. At Danbury and Norwalk Hospitals, we use Prolacta which is a donor human milk and at other hospitals there are donor human milk from the Human Milk Bank in North America.

REP. MASTROFRANCESCO (80TH): So, they are having - they are using donor milk right now and it's paid for through their private insurance or is it just part of the hospital bill?

DR. JEFFREY BARTLETT: It's just part of the hospital bill.

REP. MASTROFRANCESCO (80TH): So, it's part of the hospital bill now. And, is the - is the intent possibly to have the mom go home and be able to still continue to get the donor milk so she can continue to feed her baby?

DR. JEFFREY BARTLETT: From our standpoint, ensuring that they get donor human milk in that critical time period where they're at risk for invasive procedures and necrotizing enterocolitis and feeding intolerances is most important.

REP. MASTROFRANCESCO (80TH): Okay.

DR. JEFFREY BARTLETT: But, you know, anything - continues into the outpatient --.

REP. MASTROFRANCESCO (80TH): Right. Okay. Thank you. Did you have numbers or --?
DR. JEFFREY BARTLETT: Yeah. So, 1.5 percent of all babies, 1.1 percent of non-Hispanic whites, 3 percent [crosstalk].

REP. MASTROFRANCESCO (80TH): [[laughter] I'm trying to write this down. It was 1.5 percent of all. Go ahead.

DR. JEFFREY BARTLETT: Of all babies, 1.1 percent of non-Hispanic white, 3 percent of non-Hispanic black, and 1.5 percent of Hispanic.

REP. MASTROFRANCESCO (80TH): So, what does that come out to number-wise?

DR. JEFFREY BARTLETT: So --.

REP. MASTROFRANCESCO (80TH): And, I'm just looking at Connecticut, so we're -- so I understand.

DR. JEFFREY BARTLETT: I mean, that's --.

LEISL SHEEHAN: So, these are babies that are born under 1,500 gm, so in Connecticut we were looking at --.

REP. WILSON PHEANIOUS (53RD): Can you just tell us who you are for the record, please.

LEISL SHEEHAN: I'm sorry. I'm Leisl Sheehan with Proactive Bioscience. It's -- so it's -- we're looking at 513 babies in Connecticut according to the CDC in 2017.

REP. WILSON PHEANIOUS (53RD): We still don't even know who you are for the record.

LEISL SHEEHAN: Sorry. Leisl Sheehan with Proactive Bioscience. We make the human milk-based fortifier.

REP. WILSON PHEANIOUS (53RD): Thank you.
DR. JEFFREY BARTLETT: So, I think the question that you had was how many moms cannot produce breast milk?

REP. WILSON PHEANIOUS (53RD): Right, that would be effected that need to have this - that deliver - the babies that are in the NICU unit, I guess.

LEISL SHEEHAN: Sure. So CDC and Humana will testify later. Someone from Humana will testify and I'm not sure what numbers she has. The CDC doesn't track moms that can't breastfeed. They track preterm births and not - most moms that are preterm birth can't breastfeed, but not all. So, the numbers we have are the amount of babies in Connecticut that are preterm babies that would've likely --.

REP. MASTROFRANCESCO (80TH): That need human, but I guess my point is, if the mother can produce the milk, obviously you want her to do that. It's the best thing for the baby. The purpose of this bill is for people who cannot. Am I wrong with that? Am I correct?

LEISL SHEEHAN: Yes.

REP. MASTROFRANCESCO (80TH): So, that's why I'm trying to determine how many babies are affected because the mother cannot produce because it correlates directly to this legislation.

LEISL SHEEHAN: Right.

DR. JEFFREY BARTLETT: So, someone from Humana would have better numbers on that, but we're saying that all of these babies - all of these 513 babies would qualify, if they were born at Danbury or Norwalk Hospital for human milk-based human milk fortifier
which is a way to supplement the calories in human milk.

REP. MASTROFRANCESCO (80TH): Right. And, I'm just trying to find out, out of that 513, how many of those 513 babies would need donor milk because the mother cannot provide it. That's all I'm trying to figure out.

DR. JEFFREY BARTLETT: A large portion of them may need it for the first days of life. I would say 30 to 40 percent of the babies that we - that we treat have moms that cannot produce enough milk in the first days of life, so they got donor breast milk for a short period of time. There's an even small percentage of those - of the overall moms that would need donor human milk for a longer period of time.

LEISL SHEEHAN: If depends on if and when the mom's milk comes in, so some babies need just donor human milk, some need - they have mom's own milk and they need human milk-based fortifiers mixed with mom's own milk and some are gonna need both, so it depends on if and when mom's milk comes in. The numbers that we have and that the CDC tracks are related to the babies that are born that would be eligible for the milk.

REP. MASTROFRANCESCO (80TH): Okay.

LEISL SHEEHAN: Not the mom that gets the milk that has her milk --.

REP. MASTROFRANCESCO (80TH): And, a lot of it - it's possible that some of these babies the mom would just take care of them and feed them and they're okay. Just doing the breast milk from the mom.
LEISL SHEEHAN: Sometimes the mom can provide milk, but the younger the baby's born the less likely the mom's gonna be able to provide milk. It depends on each mom.

REP. MASTROFRANCESCO (80TH): It does. Okay. That's just not the number I was looking for, but I certainly understand. Thank you very much.

REP. WILSON PHEANIOUS (53RD): Any further questions? Thank you very much for your testimony. Okay. I'm gonna just go out of order to accommodate some here. I'd like to call Dr. Victoria Niklas, please. Oh, I'm sorry. Excuse me. It's Martha Dawson that I need – oh. She's like well. Yeah, that was the – okay. That's too bad.

DR. VICTORIA NIKLAS: Well, thank you. Good, late afternoon, Senator Moore and Wilson Pheanious for having us today. I'm Dr. Victoria Niklas as mentioned. I am the Vice President for Medical Innovation and Communication at Prolacta BioScience. I've been in that position for three years, previously as the Chief Medical and Scientific Office. I also mentioned that, like Dr. Bartlett, I'm also a practicing neonatologist and have over 20 years of experience caring for those critically ill babies that we've spoken to.

I want to echo the gratitude I have for Representative Frey introducing this bill obviously addressing a very critical issue and thank you to the Committee for considering it. As you're all aware and has been summarized earlier that doctors and experts agree that the breast milk is the best source of nutrition. The American Academy of Pediatrics endorses it as well as the American Academy of Pediatrics states that preterm newborns
should receive a fortifier to make that milk nutritionally sufficient to allow not only growth, but also to support development. So, the low birth weight babies in the Neonatal Intensive Care Unit, human milk feeding is critically important, but the piece where Prolacta comes in is that fortified breast milk is critically important and Prolacta manufactures a human milk-derived fortifier so the diet of those babies can be exclusively human milk so that all of the important bioactives and proteins and so on can be enriched. This is important as Dr. Bartlett said because it is important in the reduction of diseases like necrotizing enterocolitis as well as reducing the time a baby has to be on parental nutrition and there were other factors mentioned. So, while I can testify at length on the benefits of those, one request that we have that the Committee consider is that this bill would require that all of the donor milk that's provided under this bill would actually be monitored by an agency other than the Human Milk Banking Association of North America, and while we all have products that are beneficial to these babies, the states that monitor human milk that were mentioned earlier use the Department of Health as that agency. We would make that recommendation. There are several banks that provide donor milk in the industry and more will be coming forward and we believe that this should be regulated by an uninvolved party.

So - and of course, Havana produces a very good and high quality product and we partner with them particularly their milk can be fortified with the human milk fortifier, but it cannot substitute for the role of a governmental agency, so I wanted to make one other presentation about the number of moms
in a Critical Care Intensive Care Unit that are able to provide breast milk, so if you look at the human milk feeding rates in the Neonatal Intensive Care Unit, it generally falls far short of that of babies in the normal nursery, and depending upon the hospital depending on the mothers that are there, rates can be as low as 10 percent, so there's a tremendous need to have a donor milk supply. I wanted to mention that.

So, I think we all share in the goal at improving and increasing the availability of human milk for Connecticut's neediest patients and the amendments that I and others have requested today would only improve that, and therefore, improve the clinical benefit of human milk, particularly by pairing it with the human milk fortifier. By taking these two key steps, I think Connecticut will be at the forefront of these vital issues nationally. So, I'd like to thank you for your time and the opportunity to testify for you and I'm happy to answer any questions that you may have. I'd also like to mention that Dr. Dawson had to leave because of a critical - not that she missed her flight and she was going to in her testimony - has been submitted and she was going to review that the National Nurses - National Black Nurses Association actually has submitted a resolution on the exclusive human milk diet and this is critically important because of the higher risk of future newborns in the minority populations, so I thank you for your time and I'll take any questions.

REP. WILSON PHEANIOUS (53RD): Thank you very much. I'm just wondering, did you say that the doctor left some materials.
DR. VICTORIA NIKLAS: That was part of her testimony. She submitted it as part of her testimony.

SENATOR MOORE (22ND): Okay. All right. So, we will review that then.

REP. WILSON PHEANIOUS (53RD): Do you have any questions? Do either of you have any questions? Okay.

SENATOR MOORE (22ND): I'm sorry. I wanted to ask you, where are you from?

DR. VICTORIA NIKLAS: Los Angeles.

SENATOR MOORE (22ND): So, you traveled here for this testimony?

DR. VICTORIA NIKLAS: Yes, I have.

SENATOR MOORE (22ND): So, I just wanna say how much - you know, three minutes is not a lot of time considering you spent that much time to come here, but I wanted to say that it doesn't matter how much time you spend. It's the fact that you did come and you believe in this means a lot and that you've come that far to give this testimony. We understand how important it is. I'm very grateful for the person who's brought this legislation to us and I think we've learned a lot, more than - I'm way past that age of worrying about breast milk for a baby [laughter], but I have - I'll probably have grandchildren - well, I have grandchildren old enough now, but I'll have grandchildren in the future that this will be really important for. I hope they don't have to use it, that they're not a preemie, but it's a great opportunity to hear so many voices come and speak so passionately and know
so much about something that we've not had a conversation about before, right?

And, so I think - you know, I think that's the great part of this that we're learning and that we're - there's a lot of things we can't change right away, but there are some things that we can work on right now and get it changed and it will affect generations, so thank you so much for coming.

DR. VICTORIA NIKLAS: You're very welcome. Thank you.

REP. WILSON PHEANIOUS (53RD): One more question. Please go ahead.

REP. HUGHES (135TH): Thank you, Chairwoman, and would you speak a little bit more about the access to these products as you say in underserved communities that - I'm thinking about rural hospitals. I'm thinking about - well, yeah. I'm just thinking about whether this legislation would increase the availability to those that aren't the primary centers for neonatal.

DR. VICTORIA NIKLAS: Yes. So, there'd be absolutely no reason why it wouldn't and I'm sure that Dr. Bartlett can speak to some of these smaller hospitals in Connecticut, but there's absolutely no reason why the product can't be delivered to every preterm newborn born in the United States of America.

REP. HUGHES (135TH): Yeah. That's really important because I'm just thinking incidentally of several moms I knew who they weren't preterm babies, but they weren't able to - she wasn't able to produce milk for a while, so you never know, and how do we
plan on that except to have really quick access to those products for those babies and that's what I'm wondering about is getting that availability especially to underserved communities.

REP. WILSON PHEANIOUS (53RD): Okay. Hearing no further questions and I thank you very much for your testimony.

DR. VICTORIA NIKLAS: Thank you.

REP. WILSON PHEANIOUS (53RD): I'm going to go back to the officials list for Mr. Juan Candelaria briefly. Thank you, Representative.

JUAN CANDELARIA: I'll make it fairly quickly. Good afternoon. Abercrombie, Senator Moore, and Members of the Committee. I submitted written testimony so I'm not gonna read that testimony. I think you heard earlier today from the advocates in regards to the bill. I'm here in support of – sure, Representative Juan Candelaria from New Haven. [Laughter] Juan Candelaria. I'm here to testify and support S.B. 898, AN ACT ESTABLISHING HISPANIC FELLOW COMMUNITIES OF COLOR NONPROFIT STABILIZATION AND GROWTH FUND.

So, I've submitted written testimony. I'm not going into details of the testimony. I think you've heard all that from the advocates, but I think it was important for me to stand up here and really tell you in a nutshell what this – what we're trying to accomplish and basically it's to help these nonprofits build capacity, improve operational efficiencies for long-term fiscal sustainability. A lot of these nonprofits, when you look at that HRD line item, that has been flat funded for years. We have seen cuts from the recisions and holdbacks in
those line items and these agencies are really stagnant and in order for them to provide the services, the critical services for the communities that they do serve, they need additional resources and that's what we're trying to do.

It is to ensure that we have additional resources so that they can go out there, get grant writers to identify all the philanthropic dollars to bring into the agencies because our community continues to grow on a day-to-day basis. You saw the immigration that happened from Hurricane Maria, all the Puerto Ricans that came to Connecticut. In order for us to help those communities, to sustain them, we need these nonprofits who are culturally sensitive to the needs of those communities. And, that's the goal that we're trying to accomplish, nothing more. So, I'm just fairly quick, but if you have any questions, I'd be more than happy to answer them.

REP. WILSON PHEANIOUS (53RD): Are there any questions from Committee Members? [Laughter].

REP. HUGHES (135TH): Can you say --?

JUAN CANDELARIA: Juan Candelaria.

SENATOR MOORE (22ND): I do. I do.

REP. WILSON PHEANIOUS (53RD): I just like the way it sounds [laughter]. I'm sorry. Senator Moore.

SENATOR MOORE (22ND): Thank you. Representative, I just wanna say that your - this subject was well represented in here today. We're not sure how it can work, but I think they made it really quite clear about equity and I shared with them that I run a nonprofit. I know what it's like to compete with Yale New Haven Hospital for a lousy $50,000 and I
don't mean lousy, but compared to my budget and theirs, it's – to me, it's a lot of money. For them, it's a [inaudible 5:52:44] and I don't have the capacity to write a federal grant. I don't have the capacity to do searching for grants, but I know I do the work on the ground. So, I understand where you are and I just wanted to say how passionate they were and the woman from the Hispanic Federation, very passionate and very clear and she had great representation here today and we all paid attention. So, thank you.

JUAN CALENDARIA: Thank you so much.

REP. WILSON PHEANIOUS (53RD): If there are no further questions, we will excuse him. Our next person will be Dr. Maushumi Assad. I hope I haven't butchered your name too badly [laughter].

DR. MAUSHUMI ASSAD: It's a little bit easier. Maushumi Assad. Thank you, Representative Abercrombie, Senator Moore, and the Committee for allowing me to testify today. I'm an attending neonatologist at Winchester and Boston's Children's Hospital. As of recently, I completed my Neonatal/Perinatal Fellowship at the University of Connecticut and CCMC. So, perhaps the most relevant for today is that I published a clinical study that demonstrates the value of the exclusive human milk diet on very low birth weight babies which is the diet that Dr. Bartlett had mentioned, mother's own milk, or donor milk along with the fortifier. So, I'm testifying in support of the intent of H.B. 7165. So, according to the CDC, there's 55,000 very low birth weight infants born in the U.S. every year. We talked about 513 of these being in the state of Connecticut, so clinical research has shown
that this high risk population has specific nutritional needs which is why we can't provide mother's own milk or donor milk alone. So, by fortifying this milk, we're better able to manage the metabolic needs and promote optimal growth.

The most common fortifier that is currently used in NICUs is cow's milk based. It contains proteins that can cause feeding intolerance and also increase the incidence of necrotizing enterocolitis or NEC which is the devastating intestinal infection. Both of these complications are devastating in many ways. It can lead to increased length of stay and NEC in particular is an extremely costly complication. So, different studies have estimated average hospitalization costs due to NEC are as high as $216,000 per infant and it's between $500 million and one billion in the U.S. to care for these babies long term.

So, it can be quite costly. The alternative is to use, for the low birth weight infants and exclusive human milk diet which includes this fortifier that's donor-milk based. Despite the numerous benefits of this diet, NICUs aren't providing this diet due to the high associated costs, so that study that I published shows that in fact hospital costs can be decreased overall by decreasing the time to full feeds, hospital stay. In addition to that, it has the additional benefit of decreasing other significant morbidities such as retinopathy of prematurity and bronchopulmonary dysplasia and sepsis. So, despite the increased upfront cost, my research shows that providing this can actually lower overall hospital costs and improve clinical outcomes. So, providing optimal nutrition during this critical period is important for improving
their long-term outcomes, and based on this research and our findings, I strongly encourage you to recognize the benefits and further promote its use in the preterm population and amending the bill to include Medicaid reimbursement for this fortifier as well. Thank you for your time and the opportunity to testify today.

REP. ABERCROMBIE (83RD): Can you – do you know how other states – so OLR had told us that there was about six states that were able to get I assume either a state plan amendment or waiver to include this as a Medicaid reimbursement. Do you know anything about that?

DR. MAUSHUMI ASSAD: I don't. I know the states that Dr. Bartlett had mentioned that are covering, but I don't know how exactly that happens.

REP. ABERCROMBIE (83RD): Okay. And, then – and then, the second question is, for the fortifier, right? So, what is the cost of the breast milk and then what is the cost for the fortifier that goes in it?

DR. MAUSHUMI ASSAD: So, per baby, it can be about $1,000 for the fortifier.

REP. ABERCROMBIE (83RD): Per what, hon? Per what? Per – is it?

DR. MAUSHUMI ASSAD: I don't know the actual --.

REP. ABERCROMBIE (83RD): Like how do you measure? Is it formula for a week, a month, a year? How – how do you do that?

DR. MAUSHUMI ASSAD: Sorry, $10,000 per baby for the entire course, so that would be their time from
admission to discharge which usually you're not— sorry, let me go back a little bit. So, they're not on the fortifier their entire length of stay. It's just 'til they're a few months old basically. Once they get to full feeds at about 34 to 36 weeks, they're transitioned to formula and not necessarily still on that donor milk-derived fortifier.

REP. ABERCROMBIE (83RD): Okay. So, let me just—let me say back what I think you said, okay? "Cause I'm not a doctor. I don't play one on TV. Okay? [Laughter]. So, Gale, wait. Wait 'til you see these late nights. This is just early for us. So, what you're saying is, is a preemie baby is born, right? Depending on how preemie the baby is— I apologize for not using the right terminology, right? They decide that the breast milk is the best procedure to go forward. They decide that because of the condition, of the nature of the baby, what's going on with the baby's body, you have to do a fortifier, right? So, you're saying that if you do that for say four weeks, right, that that's the amount of money that you're saying for the fortifier for that amount of time. When a baby gets discharged, right, so you go by is it weight or a number of weeks or both, is the measure you use to see when the baby doesn't need that anymore?

DR. MAUSHUMI ASSAD: Usually weight and age of the baby.

REP. ABERCROMBIE (83RD): So, it's both?

DR. MAUSHUMI ASSAD: Gestational age. It's both, yeah.

REP. ABERCROMBIE (83RD): Oh. Okay. All right. You gotta talk in layman terms.

REP. ABERCROMBIE (83RD): Don't laugh over there in the corner [laughing]. Okay. So, then - so then, once you stop - so, do these babies stay on the breast milk without a fortifier at some point, so say you do reach, right, the weight or the number of weeks, right? Are some of these babies staying on breast milk and then do any of these babies go home continuing to use breast milk or do you - do most of them get transferred on to a formula?

DR. MAUSHUMI ASSAD: So, they will continue on breast milk, but in addition, will have a formula that will supplement the extra calories and increased calcium and phosphorus that they need for bone growth.

REP. ABERCROMBIE (83RD): So, -- so. Oh, you mix them together or how do you --?

DR. MAUSHUMI ASSAD: You can. You can mix it together. You can also have them exclusive breastfeeding if mom's are able to breastfeed and then just have a couple bottles of formula in order to make a good amount of their daily intake in order for good growth.

REP. ABERCROMBIE (83RD): Oh, so you can do - so you can - and, listen, I find this really fascinating, so thanking you for taking the time. These guys know I was like so anxious in this. So, you can have a mother that gets donor milk through the hospital, right, and then her milk comes in and she can transition when she brings the baby home to her own milk.

DR. MAUSHUMI ASSAD: Yes.
REP. ABERCROMBIE (83RD): Interesting. They're agreeing. Okay. Thank you. Thank you for that. I really appreciate it.

REP. WILSON PHEANIOUS (53RD): Are there any other questions? Senator Moore. Oh, I'm sorry. We'll let Senator Moore go first and then --.

SENATOR MOORE (22ND): So, just out of curiosity, have you seen an increase in the need of – for this because of the opiate crisis that those babies might be preemie and there might be a greater need?

DR. MAUSHUMI ASSAD: That's good question. I don't – I can't speak from – but, yeah.

REP. WILSON PHEANIOUS (53RD): Are there any other further questions? Oh, I'm sorry. Yes. Thank you.

REP. MASTROFRANCESCO (80TH): I wanted to touch up on followup on what Representative Abercrombie was talking about, the cost. And, I guess I'm a little confused like the Representative – this is a learning process for me as well, certainly not an area that – I'm far too old for breast milk, but anyway [laughter], so the donor breast milk, there's two components. You have the donor breast milk and then you have the fortifier, correct, which is Prolacta?

DR. MAUSHUMI ASSAD: Yes.

REP. MASTROFRANCESCO (80TH): Is that the brand name?

DR. MAUSHUMI ASSAD: That is the brand name.

REP. MASTROFRANCESCO (80TH): Of the --.

DR. MAUSHUMI ASSAD: Of the fortifier.
REP. MASTROFRANCESCO (80TH): Of the fortifier, okay. So, you had mentioned something about a cost of approximately $10,000. Is that for the donor milk or is that for the fortifier?

DR. MAUSHUMI ASSAD: Yes.

REP. MASTROFRANCESCO (80TH): And, $10,000 will get you how long and how much?

LIESEL SHEEHAN: Sure. Renegotiating with Prolacta for the record, so $10,000 is the average course of treatment for the fortifier and that course of treatment, of course, depends on how premature the baby is, how long it need the fortifier, but I think it's around $230 a day for the fortifier. That does not include donor milk. Most of the time our fortifier is mixed. The ideal situation is that it's mixed with mom's own milk as she can pump. If she can't, most often it's mixed with donor milk which comes from HMBANA the vast majority of the time and I know HMBANA gets --.

REP. MASTROFRANCESCO (80TH): I'm sorry, comes from where?

LIESEL SHEEHAN: The Human Milk Banking Association of North America, one of their milk bands and I know Amy will testify on their behalf shortly so she can talk about their milk. Prolacta has a very small donor milk business that only certain hospitals use. That donor milk is around $9 an ounce. It is a higher cost because of the processing that Prolacta does and they do extra testing and quality measures. Normally, I think you're talking about $4 or $5 an ounce, but I know the name and I can clarify that for you. The fortifier is the bigger cost, right. We would say that's where you see a lot of the cost
savings as well and that's what Dr. Assad's study
talks about. That's where you see the $10,000.

REP. MASTROFRANCESCO (80TH): So, the fortifier is
about $230 a day?

LIESEL SHEEHAN: Correct.

REP. MASTROFRANCESCO (80TH): And, the donor milk is
about how much a day average?

LIESEL SHEEHAN: It depends on the baby growth,
right, because as the baby grows they need more, so
it's priced by ounce, so that's a little harder to
say how - by day, so there you'd measure it by
ounce. So, it varies.

REP. MASTROFRANCESCO (80TH): How much is it per
ounce?

LIESEL SHEEHAN: Again, it depends on where you
obtain the donor milk, so Prolacta's is about $9 an
ounce. The HMBANA donor milk is about half of that.
We can clarify.

REP. MASTROFRANCESCO (80TH): I'm sorry. Can you
say that brand again, what is it?

LIESEL SHEEHAN: It's the Human Milk Banking
Association of North America.

REP. MASTROFRANCESCO (80TH): Okay. So, it's about
$9 an ounce.

LIESEL SHEEHAN: That's Prolacta's - Prolacta is $9
an ounce.

REP. MASTROFRANCESCO (80TH): Okay. So, I'm just
trying to figure out cost-wise, so the goal here is
to have the Medicare pay for the donor milk or the
fortifier? Or Medicaid, sorry. Excuse me. I keep
saying that – Medicare. Medicare, clearly we don't need any breast milk [laughter]. Medicaid.

LIESEL SHEEHAN: We would like for Medicaid to cover both. Not every baby that needs donor milk needs fortifier, only some, and we would like for the bill to cover the donor milk and the fortifier so that babies that need this exclusively human milk diet, such as the donor milk and fortifier, can receive exclusively the human milk diet. That allows the physician to make the decision if they need just the fortifier – I mean, sorry. I mean just the donor milk or [inaudible 6:6:16].

REP. MASTROFRANCESCO (80TH): And, I think you mentioned that for the average time that the baby is on the fortifier, and average I know every baby is different, but they're --.

LIESEL SHEEHAN: Probably three to four weeks.

REP. MASTROFRANCESCO (80TH): Oh, three to four weeks. I thought it was longer 'cause you said the cost would be approximately $10,000 and at $250 a day that wouldn't --.

LIESEL SHEEHAN: The smaller the baby, the longer the baby would be on it, so it's by --.

REP. MASTROFRANCESCO (80TH): It's about an average, though. Okay. Thank you very much. I feel much more educated now on the topic.

REP. ABERCROMBIE (83RD): So, Representative, I will send you – so I reached out to Yale to find out the measures that they use, how they pay for it, and how many – what they average. So, I've got the information, the criteria that's used. I haven't gotten the information as to how many moms that they
normally do within a year, but I'll make sure that we send that information around for the whole Committee. Yeah. Representative Hughes.

REP. HUGHES (135TH): Thank you, Madam Chair. Just - just for cost comparison for the Committee and you may or may not know this, but do you know how much it costs for instance for a - for a children with hemophilia to have the - well, the medication, the injection every other day? Do you know how much that is?

DR. MAUSHUMI ASSAD: No.

REP. HUGHES (135TH): It's $3,000 for - per dose, so just to give it in terms of comparison, in terms of what we're talking about for the life of a baby to get back on track versus a lifetime of life-saving dose that's equitable, so yeah.

DR. MAUSHUMI ASSAD: Thank you for that.

REP. HUGHES (135TH): FYI. Thank you.

REP. ABERCROMBIE (83RD): Thank you. Okay. So, I just wanna make sure. So, Dr. Victoria is not testifying or is she? You already did. So, now we're on to Dr. Martha Dawson. Okay. Dr. Jim Moore. So, this is the guy that's got the answers 'cause I saw him shaking his head over there. Thank you for sticking around to testify today. We do appreciate it.

DR. JIM MOORE: My pleasure. Senator Moore, Representative Abercrombie, and Members of the Human Services Committee, I want to thank you for the opportunity to share my thoughts on H.B. 7165, THE ACT CONCERNING MEDICAID COVERAGE FOR DONOR MILK. My name is Dr. James Moore. I'm the Division Chief for
Neonatology for Connecticut Children's Medical Center and that includes the University of Connecticut as well and that we are submitting this testimony in support of the proposed legislation because of the significant health benefits, many of which you've already heard for our neonatal patients. In addition to the reduction and cost of care of these neonates that comes directly from the use of human donor milk.

Before I comment on the bill, I do want to mention that our statewide newborn services network allows our neonatologists, our neonatal nurse practitioners, our PAs, to share their expertise with families and care for babies at 11 different hospitals within the state of Connecticut from Putnam to Hartford to Norwalk. Specifically, I'd like to now address donor human milk which is obviously extremely important in the field of newborn care. Increasing human milk usage has become a focus in pediatrics and neonatology based on substantial positive literature-based evidence and in a textbook of neonatal nutrition and in policy statements from the American Academy of Pediatrics, it is clear that human milk should be used for preterm babies as best practice because it improves health outcomes.

Human milk, and this may address the Representative's question, is much more than nutrition. It is living tissue and actually in Australia and in Europe it is treated as a tissue rather than nutrition or a food product. This living tissue, in addition to the sugars and proteins and fats that most of us think about for human milk, is actually made up of hundreds of components that are vital to newborn health. Some
of these include immunologic factors such as antibodies, leukocytes, and proteins that together actually prevent infections.

Human milk also contains hormones that promote organ growth and development. None of this is present in formula. The full array of proteins, hormones, and cellular signals that are contained in human donor milk are too extensive to list here, but the key message that I'd like to get across is that human milk or human donor milk is actually specifically designed for human babies and that we have - it has many more benefits than just getting them to grow. Human donor milk, when used in the Newborn Intensive Care Unit, you heard some of this already from Dr. Bartlett, improves tolerance to oral feeds and has been shown to reduce NICU stays anywhere between one to four days. In fact, there are more than 53 literature-based studies in just the last 11 years that have either shown improved tolerance, reduced length of stay, or reduced instances of a catastrophic GI tract infection called necrotizing enterocolitis which we've now heard about a couple of times. NEC affects up to 10 percent of all babies admitted to NICUs that have weights of less than 1,500 gm. Of those babies that develop NEC, mortality can approach 50 percent in infants that require surgery.

For survivors and this gets to the long-term point, is that they often have lifelong problems, and most importantly, neurodevelopmental disabilities that often require and become a burden to the families. Using human milk instead of formula can reduce the rate of NEC by up to 50 to 80 percent. This impact can lead to immediate savings that you heard about that can total into the hundreds of thousands and
that otherwise would've been babies that had developed it, and more importantly to me, it improves their long-term health outcomes.

I'd like to conclude with a very personal story. A number of years ago, I did take care of a family and that mother had a baby that was born 13 weeks early at 27-weeks' gestational age. This little boy transitioned from mom's milk to formula because mom was unable to keep up. Her supply was inadequate. One week later, this baby developed necrotizing enterocolitis and died of complications of this intestinal infection. Two years almost to the day, this mother delivered a second 27-weeker. This time, it was a girl. She was able to actually get mom's milk for a period of time, and when mom's milk became insufficient, the hospital that they were at was able to use donor milk. Unfortunately, their policy said that they had to stop at a month. Unfortunately, within two days after this baby was transitioned to formula, this baby developed NEC and almost died. Each time this mother presented to us, and I happened to be actually the physician for both times, that on the second time this mother asked how could this happen again?

I will be transparent. NEC is a very complex disease, and while we don't fully understand all the contributing factors, what we do understand is that human milk is the only intervention we have in neonatology to reduce the incidence of it. It is best practice to supply preterm babies with mother's own milk, or if not available, to use human donor milk when mom's milk is not available. Unfortunately, and this was I think another question earlier, we still have families in our state that could benefit from this therapy - human donor milk,
unfortunately, is not offered in all the NICUs across Connecticut because of the cost and I would urge you to approve H.B. 7165 so that we can extend this vital intervention to all babies that need it. And, I want to thank you for your consideration of our position. And, to the question of how other states did it, I most recently before I became Division Chief at Connecticut Children's, I was actually the Medical Director at Dallas Children's in Texas. They passed this law because of it being a living tissue as opposed to nutrition.

REP. ABERCROMBIE (83RD): So, they were able to get Medicaid to pay for it under a different definition?

DR. JIM MOORE: Correct.

REP. ABERCROMBIE (83RD): Interesting. Okay. So, my second question to you – thank you so much for your testimony. So, currently private insurance doesn't pay for this either. Is that correct?

DR. JIM MOORE: I believe that's correct.

REP. ABERCROMBIE (83RD): So, at CCMC, what measure do you use to decide if you're going to - 'cause I would assume what we're talking about it you're donating, right, this product for these babies. So, how do you determine which babies get this breast milk and which don't? How do you make that determination, and then the second part of that question is, how do you pay for it?

DR. JIM MOORE: Exactly. First, we do not discriminate. All preemies get either mom's own milk or have the donor milk offered. On rare occasion, there is a couple of the moms here and there that may actually decline, but we use donor
milk or human milk for all of her our preemies that are essentially less than 34-weeks' gestation. As far as how we pay for it, Connecticut Children's, as I'm sure you're aware, takes care of maybe more than 15 percent of all kids in Connecticut covered by Medicaid, and that we have spent nearly $90 million on free and uncompensated care. To your exact question of Connecticut Children's Unit and the NICU here, we spend somewhere between $60 and $75,000 a year on donor milk alone. We do not use the fortifier for the simple case of that we cannot afford it. But, we do use donor milk because we believe whatever we can offer, we will. Many of our families come from inner city Hartford and other areas as well. We believe that it is best practice and we try to adhere to the American Academy of Pediatrics policy.

REP. ABERCROMBIE (83RD): So, I would assume that Yale and Yukon probably do the same thing.

DR. JIM MOORE: Yale I believe does do the same thing. Yukon is actually – the NICU is actually Connecticut Children's. They're one and the same.

REP. ABERCROMBIE (83RD): Oh, they are?

DR. JIM MOORE: Yes, they are.


REP. HUGHES (135TH): Thank you, Madam Chair, and Thank you for your testimony. This really broadens like we said our learning curve very much and I love as I suspected the redefinition of mother's milk and fortifier as tissue which indeed, of course, it is
biologically. Do you – and again, I think it's just really important to put this into perspective in terms of cost. So, are you aware that when like tissue is donated that the recipient usually has to take some kind of injection for antirejection? So, do you know how much [inaudible 6:19:12] is as an injection?

DR. JIM MOORE: I do not know.

REP. HUGHES (135TH): It's $10,000 per injection. And, that is required so that the recipient doesn't reject the donated tissue especially in the early stages. So again, I think this is really cost-effective to provide when we think about.

DR. JIM MOORE: I want to state that you do not need antirejection medication for human donor milk.

REP. HUGHES (135TH): Right. Even more cost effective. Right? It's a win-win. I think it's a bargain. So, can you send, and we'll give you a card, can you send our clerk a total amount of what you average a year for the donor milk and then how often you have to use a fortifier? I mean, it is automatic for you, and if you don't, could you just give us those numbers because this is the challenge that we face, right? So, the way we do our appropriations budget and the way we pay for things is that we don't take into consideration what it costs to not do the right thing. We can only work with what's in front of us. So, if it's gonna be 100,000 a year, we have to put 100,000 in the budget. So, I need, and I've asked the same thing from Yale and I haven't gotten it yet, we need solid numbers what we're talking about 'cause I can't get this bill out of this Committee, right? It's gonna have to go to appropriations without any background
information, so please if you could send me that, I would really appreciate it.

DR. JIM MOORE: To answer the second part which was the fortifier, all preterm babies require fortifier, all. They are not able to sustain themselves on breast milk alone. In addition to the additional calories, they need the additional calcium and phosphorus for bone growth and others that breast milk in and of itself is not capable of doing with the volumes that these babies can tolerate.

REP. ABERCROMBIE (83RD): Sort of like giving an elderly person Ensure.

DR. JIM MOORE: Exactly.


REP. MASTROFRANCESCO (80TH): Thank you, Madam Chair. I was trying to get figure numbers before, basically how many premature babies are born in Connecticut and I think the number I got – was it 515? There's approximately 515. Do you have any further numbers knowing like how many of those out of the 515, to Representative Abercrombie's point, trying to get some numbers together – how many of those babies born premature would be Medicare – Medicaid. Jeez. I keep saying Medicare. I'm so far beyond that for this topic. How many of the 515 would be Medicaid eligible? Just trying to get some cost figures in your head and you did mention as well that insurances do not pay, correct? Or they'll pay for the first 30 days, the private --.
DR. JIM MOORE: The – the – I think – sorry. Let me be clear. I am not aware that private insurance pays. That doesn't mean that they don't. I'm just – I'm in the background, but in other states it does. I'm just not aware of Connecticut at this point. Fortunately, being in an academic center, I'm not necessarily involved in counting the money, but I do know that was being Medical Director of Connecticut Children's NICU as well that we do offer donor milk to all comers either way and we look it as essentially eating that cost because it is the best thing for these children.

REP. MASTROFRANCESCO (80TH): Right, yeah. In my mind, it doesn't really matter whether they're on Medicaid or if they're a private insurance. A baby is a baby and we need to do what we can to take care of them. That's why I was just curious because this one specifically was for Medicaid, so just curious.

DR. JIM MOORE: Yeah. Realistically, obviously the numbers vary by county. In our own population, we actually here in Hartford have a fairly high rate of Medicaid where some of the other hospitals around the state have lower. There's also big discrepancies. In the rates of prematurity between whites and African-Americans, it's almost twice as common for prematurity to occur in African-Americans, so there is a variety of different things to consider, but the total of medication, it would be something I would have to look up and then I could give you the numbers for what the cost would probably be.

REP. MASTROFRANCESCO (80TH): That'd be great. Thank you very much for your testimony.

DR. JIM MOORE: Thank you.
REP. ABERCROMBIE (83RD): Thank you so much. I look forward to getting that information from you. Dr. Naomi Bar-Yam. Thank you. You know what happened, they separated, so I'm not sure how many of there -- if it's two words or one. Thank you for being here.

DR. NAOMI BAR-YAM: Okay. Thank you. I'm gonna try to keep this short 'cause I know everybody wants to go home. So, thank you to all the Members of the Committee for this opportunity to share my thoughts in support of H.B. 7165. My name is Naomi Bar-Yam. I'm the Executive Director of Mother's Milk Bank Northeast and I'm the immediate past President of the Human Milk Bank Association of North America and we would strongly encourage Connecticut to join with the seven other states and Washington, D.C., that currently provide Medicaid funding for donor milk.

And, each of those laws is different. I'm happy to send you the legislation. I mean, I have them in my files for each of those states, so I'm happy to send that to you. Medicaid coverage for donor milk in Connecticut will save both lives and healthcare dollars. Mother's Milk Bank Northeast is a nonprofit community milk bank operating under the safety guidelines of the Human Milk Banking Association of North America. We are Connecticut's primary milk bank and we serve eight Connecticut hospitals.

On a community level, we have five milk depots which are drop off locations throughout the state, and since 2011, we have nearly 700 Connecticut mothers who have been screened to be milk donors. Babies born as we have heard weighing less than 1,500 gm, which is about 3.4 pounds, are at the highest risk for developing NEC. About one-third of the babies
with NEC can be treated medically, about one-third requires surgery to remove part of their intestines that have died, and about one-third do not survive. Multiple research studies over decades as we have heard tell us that human milk is important in preventing and mitigating the severity of NEC. Between 5 percent and 7 percent, although someone just said about 10 percent, of premature babies will develop NEC, so in Connecticut each year, an estimated between 500 and 600 babies are born at less than 1,500 gm. Of those, between 30 and 35 or so will develop NEC.

Our research indicates that providing donor milk to babies until they reach 1,500 mg would cost between $300,000 and $350,000 per year and I have a little bit more details in the written testimony. This assumes that babies do not receive any of their own mother's milk which is rarely the case. Often mothers are able to provide something. If one conservatively estimates that the human milk diet reduces NEC by 50 percent, and as before it can be higher than that, this measure would prevent 15 to 18 cases of NEC per year. NEC treatments average $225,000 per patient, so to add that all up, an investment of $300,000 to $350,000 for donor human milk will save $3.3 to $4 million dollars to treat NEC.

These calculations are NICU costs only, do not measure the long-term effect, and costs of the developmental delays and short gut syndrome which we've heard often affect NEC patients. It has been well documented, and I don't have the exact numbers - we're still working on getting those as other people are, that low income and families of color have much higher rates of premature birth, NEC, and
infant mortality. They're also more likely to be treated in safety net hospitals as we've heard which in turn are less likely to use donor milk because it is not covered by Medicaid. So, Medicaid coverage for pasteurized donor human milk will save lives and money and ensure more equitable access to quality care in Connecticut.

Mother's Milk Bank Northeast is eager to work closely with the Human Services Committee and other committees that become involved on really refining the details of this bill, so please call upon us. We have us and at the milk bank we have the expertise of a large and very dedicated and wonderful Research and Medical Advisory Board, some of whom are here in Connecticut really in the service of the citizens of Connecticut. Thank you.

REP. ABERCROMBIE (83RD): Thank you for your testimony. Questions? Thank you for waiting to testify. We really do appreciate it. Ann Marie. She's not here either? So, that concludes everyone that has signed up to testify. If there's any -- . Okay. So you must've signed up late because I have the list of earlier, so Kaley, you wanna get the list, please? So, why don't we do this. Do you guys wanna come up together? Are you friends or --? Okay. Okay. That's fine. Just checking.

SENATOR MOORE (22ND): So, I met you all very earlier in the day. You were looking for the room, right? I'm the one who told you go look for the table, but it was - I thought you - but, I thought you said you were going to be meeting in a room later. I thought maybe you thought there was something after this, so I am the one that gave you
the directions, all right? But, you've been here quite a while.

REP. ABERCROMBIE (83RD): Okay. So, Stephanie DiMarco is first. Where's Stephanie? Okay. And, then Natalie and then Marissa.

STEPHANIE DIMARCO: Hi. Good afternoon, Madam Chair and Members of the Committee. My name is Stephanie DiMarco and I'm speaking in support of H.B. 7165. I am a mother to two beautiful children and a milk donor. This is my daughter, Willamina. Sorry. She was born two years ago at only 24-weeks' gestation, so she's one of those 515 babies that was born in 2017 weighing less than 1,500 gm. While waiting to see my daughter for the first time and recovering from childbirth, I was encouraged to start trying to pump milk. Since she was born so early, the nursing staff wasn't sure if and when my body would start producing milk.

They did stress how important it was that I try. I was incredibly fortunate that my milk came in right away. On my first trip to the NICU, I was so, so proud that I had a few drops of precious colostrum to bring with me. I continued pumping religiously every two hours and I brought progressively larger containers of milk with me to the NICU. After I was discharged, I drove back and forth from New Britain to St. Francis multiple times a day to see my first born child and bring little bottles of milk with me. On her seventh day of life, the amazing nursing team told me that I could start freezing my milk at home because I had already brought in so much milk to the NICU. I was the champion of milk at the St. Francis NICU.
Sadly, Mina's lungs were too weak to survive the infection that she developed and we made a devastating decision to remove her from life support at 12 days old. And, my story could end here. I could've asked the NICU to dispose of that milk. I could've emptied out my freezer and I could've worked to let my milk dry up. And, I almost did. I woke up that first night after my daughter died covered in tears and milk and I didn't know what to do. I pumped a little bit to relieve some of that pressure and I poured the milk down the drain. And, then I sat on my kitchen floor and I sobbed because it felt like I was pouring away the only thing that I was able to do right for my daughter. I was pouring away our connection. I was pouring away my motherhood.

The next morning I found a little hope. When you leave a hospital for the last time without a baby, you get a tiny box of memories and a folder with some pamphlets on grieving. In that folder, there was also a card for Mother's Milk Bank Northeast and I thought, maybe they'll want some of this frozen milk. I spoke to the wonderfully kind and supportive intake coordinators at the milk bank and they told me how incredibly important human milk is for premature babies and I chose to donate the frozen milk I already had and continue pumping through my daughter's due date. For 16 weeks, I faithfully pumped. I got up multiple times a night. I sat wait for what was probably days of my life making milk for babies that I'll never meet.

My husband washed all those tiny pump parts for me multiple times a day. It was an incredibly large part of our grieving process and it is something that I will be proud of for the rest of my life.
You've heard from earlier speakers on the statistics on breast milk and necrotizing enterocolitis in preemies. You know that it is medicine for these tiny fighters, but I want you to really understand what the statistics about breast milk and NEC really mean. A premature baby that receives breast milk, whether from their mom or a donor like me, is 79 percent less likely to develop necrotizing enterocolitis. They are 79 percent less likely to develop a condition that can easily kill them. Their parents are 79 percent less likely to have to pick a funeral home. They're 79 percent less likely to decide if their child should be buried or cremated. They're 79 percent less likely to only be able to introduce their child with a picture. They're 79 percent less likely to spend the rest of their lives grieving their precious baby.

I was able to donate over 1,000 ounces of breast milk because my daughter, Willamina, was here and made me a mom. I donated because with each ounce given to another baby, her legacy lives on. I donated because her life, no matter how brief, matters. My son, Octavius, was born four months ago full term and I'm proud to say that for his big sister's second birthday, we sent in our first donation of 150 ounces. Between my two babies, I have donated over 10 gallons of breast milk and done my part to help other babies live. I'm asking you to please do your part and ensure that Medicaid covers donor breast milk. Thank you. Sorry to bring the room down.

SENATOR MOORE (22ND): I appreciate your courage to bring this to us with such passion. And, I'm considering Willamina as an angel for all those other babies that you were able to – but, I think it
was quite generous 'cause you could've waddled, you could've felt sorry, you could've said why me, you could've just stayed in your bedroom, thrown the pillow over your head, and just stayed there, but you didn't. You did something and you do hold us to that standard of you want us to do something also. So, I thank you for doing that and I gotta tell you, we're on board. We're just gonna figure out how we do this. You've built a really great case of why this is important. I mean, when I consider we knew - most of us - didn't know a thing about this and that you've come here with this information and built a really strong case of why we need to do this. I'm quite sure everybody here is gonna try to do the best they can to make this happen. We just have to tweak it to figure out how we - how we get it done. All right?

STEPHANIE DIMARCO: Thank you.

SENATOR MOORE (22ND): So, thank you. And, so Natalie. I don't know how you follow that. I'm sorry. I'm sorry.

SENATOR HASKELL (26TH): I just wanted to very briefly thank you so much for sharing your story and for your patience. These hearings can be exceptionally long and it is I think clarifying, at least for those of us like myself who don't know very much about this issue, to hear your story.

STEPHANIE DIMARCO: You're not a huge lactator? [Laughter]

SENATOR HASKELL (26TH): No. Not exactly. So, I really am so grateful for not only your service to the community, but also your service here today in - -.
STEPHANIE DIMARCO: Thank you so much.

SENATOR HASKELL (26TH): -- helping us understand the impressive importance of this issue.

STEPHANIE DIMARCO: Thank you.

SENATOR MOORE (22ND): Thank you. Natalie. Thank you.

NATALIE MARTIN: I don't know how I follow that, but hi. Members of the Committee, thank you for giving us all the time to speak today on this important bill. I know it's been a long day and I don't know how to follow that really, so I will be brief. My name is Natalie Martin. I live in West Hartford. I'm here today in support of bill 7165. I am also a proud former donor of breast milk to the Mother's Milk Bank Northeast. After having my first healthy baby daughter, I began to educate myself on the many life-saving benefits of breast milk which you've heard about so far today.

A few years later after my second daughter was born, I sought out the Milk Bank Northeast in Newton, Massachusetts, to donate my over-supply because I know how important it is for medically fragile and premature babies to receive this breast milk. I'm fortunate enough to sit here today and say that if either of my daughters had needed donor breast milk, my husband I would have been able to afford it, but we know that that's simply not the case for so many. As referenced in my written testimony, low income and families of color have a greater risk of having a baby born prematurely and these are the babies that are going to benefit the most from this bill.
Years ago, I was proud to send my ounces of milk to the milk bank and today I'm proud to sit before you and advocate for our babies who need access to this life-saving liquid gold as badly. And, being a milk donor was actually only the beginning of my journey with the Mother's Milk Bank Northeast. Last summer, along with Marissa, we were instrumental in bringing a milk depot to our very own Yukon Health right in Farmington. This milk depot is making it easier for our greater Hartford donating moms to get their milk to the bank and joins five other depots across our state.

This only furthers our reach and our awareness on this - on the incredible benefits of donor milk and I'm grateful now to have joined the Board of Directors for the Milk Bank to continue to give a voice here in Connecticut for our most fragile babies. So, thank you for listening to me and everybody else and for your time.


MARISSA MERLO: It started as good morning and then went to good afternoon. Now, it's good evening, Members of the Human Service Committee. My name is Marissa Merlo and I'm from Wethersfield, Connecticut. I'm here in support of Bill No. 7165, AN ACT CONCERNING MEDICAID COVERAGE OF DONOR BREAST MILK. I am the Lactation Consultant at Yukon Health in Farmington with a background in neonatal nursing stemming back to 2003. Along with Natalie Martin who just spoke, we worked over the summer to bring a milk depot to Yukon Health. Since its opening, which we coincidentally opened during world
breastfeeding month, I'm thrilled to share that we have collected and shipped out just shy of 10,000 ounces of breast milk, an incredible feat, and shows that there is a clear need and interest in our area for donor milk.

Every day throughout my nursing career, I encountered and worked closely with babies and families who would directly benefit from donor breast milk and specifically the coverage applied through this bill. As a Lactation Consultant, I'm aware of the benefits of breast milk. That goes without saying. Breast milk can increase neurological function. It drastically decreases the risk of ear infections and GI disturbances during the first year of life just to name a few. And, those are really the benefits of a term baby receiving breast milk. To reference the written testimony that Naomi spoke of earlier, one-third of babies who develop NEC will die. Research has shown that human breast milk can prevent these deaths. During my time as a NICU bedside nurse, I personally cared for a number of babies who, unfortunately, did not have access to donor milk. As a result, I have attended more than one infant funeral due to complications of NEC.

Breast milk truly does save lives. These deaths could have been prevented if only a donor milk program had existed at the time. Unfortunately, many hospital budgets, especially those in urban communities, simply cannot take on these costs. This is why I'm here supporting this bill. Thank you so much for your time.
REP. ABERCROMBIE (83RD): Thank you. Thank you for what you do. So, the milk bank that you talked about that you have now at Yukon, right --.

MARISSA MERLO: Depot.

REP. ABERCROMBIE (83RD): So it's depot—sorry. So, do you distribute that to CCMC and Yale or does it say—is it—the amount that you have just cover what you have?

MARISSA MERLO: No. That milk actually can circulate back to CCMC and Yale, but the milk we collect actually has to go to the milk bank, the Mother's Milk Bank in Boston, right outside of Boston to be pasteurized and processed and then it's shipped to over 80 hospitals throughout northeast.

REP. ABERCROMBIE (83RD): Oh, so it doesn't come right back in to the district even though you're --.

MARISSA MERLO: Not necessarily. It goes everywhere.

REP. ABERCROMBIE (83RD): Okay. So, there isn't a system in place that says if you donate it, somehow you get X amount back. It's just a gesture of donating it?

MARISSA MERLO: It's all good will.


SENATOR MOORE (22ND): Thank you. So, we're just trying to figure out. So, people are donating it, but there must be a cost in the shipping and sending it and getting it processed.
MARISSA MERLO: Absolutely. That's covered by the Mother's Milk Bank Northeast.

SENATOR MOORE (22ND): So, then I'm gonna wait - I'm gonna ask Dr. Moore to come back up just so I can ask a question about that.

MARISSA MERLO: Do you want Dr. Moore? Do you - you probably want Naomi.

SENATOR MOORE (22ND): No. Yes. So, thank you very much.

MARISSA MERLO: You're welcome.

SENATOR MOORE (22ND): I think I just like hearing Dr. Moore. Dr. Moore. [Laughter] I think that's - that's what it was. Dr. Moore? You know, some people get elected and they think it makes them smarter than everybody else, but I come up here and I pick up a doctorate, you know? [Laughter] So, my question - we're just trying to figure out how much - what we need to ask for in the way of budget-wise for bringing this out and Representative Abercrombie just said maybe we just need to pay for the fortifier. And, but now - but I'm hearing.

DR. NAOMI BAR-YAM: No. The milk - hospitals that use it do cover it, but as you heard from Dr. Moore and others, there are hospitals who just cannot cover those costs.

SENATOR MOORE (22ND): But are - but ours do. But, I did hear it at the end of your - at the end of the previous testimony that some hospitals wouldn't be able to take on the cost of it. Is that correct?

DR. NAOMI BAR-YAM: Exactly.
SENATOR MOORE (22ND): So, but I also heard that it was covered in the hospital bill.

DR. NAOMI BAR-YAM: Some hospitals do. Each - my experience working with a lot of hospitals is that each hospital finds their own way to cover it, but it also sometimes forces them to really limit what they can cover and how long they can give these babies donor milk and so you end up cutting the babies before what would be ideally from a medical perspective.


REP. MASTROFRANCESCO (80TH): I was just concerned when the last person testified said that hospitals cannot afford it. Do you know if any hospital has refused and a baby has died because of not getting the --?

DR. NAOMI BAR-YAM: We hear about the hospitals that use donor milk 'cause they come to us. We talk to hospitals and some of them do not - say they just can't cover the cost or they can only cover minimal costs for a short amount of time and we've heard that there are babies who do die because of not getting the --.

REP. MASTROFRANCESCO (80TH): Because the hospital would not --.

DR. NAOMI BAR-YAM: Because they can't. Hospitals are pretty stretched financially and the hospitals - the safety net hospitals, which are hospitals that - that serve higher populations of Medicaid and uninsured, are even on tighter budgets than other hospitals and so they are the ones that are - we know from CDC data that about 75 percent of the
hospitals in the country use donor milk under some circumstances. Of the 25 percent less, a disproportionate number of them are safety net hospitals that just – that have – that have a higher population of those premature babies, higher mortality rates, have higher morbidity rates, have higher prematurity and NEC rates, but they – they don't have the wherewithal to cover the costs of the donor milk.

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

DR. NAOMI BAR-YAM: Thank you.

REP. ABERCROMBIE (83RD): You're welcome. Thank you so much for your presentation and thank you again to all of you for staying all day. No. We understand. It's a long day and I'll be honest, this is a short day compared to some of our hearings, so we do appreciate you being here. That concludes every --. So, first, before she says something let's include everyone that signed up [laughter]. Did I miss anybody? No. Senator Moore.

SENATOR MOORE (22ND): We have to do a better job of scheduling because the physicians usually have a reception outside this door at 5:00, right? And, it would have been great, especially for people who traveled here to meet other people who are here today, but I just want to say from the bottom of my heart, I so much appreciate your expertise and the work that you're doing and coming here bringing this to us. I think I have got a lot more to learn, but I think that we have a lot of information to work through. So, thank you.
REP. ABERCROMBIE (83RD): So, this concludes the public hearing for today. Thank you everyone.