SENATOR MOORE (22ND): First, Kathleen Brennan. The first hour will be dedicated to officials and after the first hour, we'll alternate between the two.


KATHLEEN BRENNAN: Good morning, Senator Moore, Representative Abercrombie, and distinguished members of the Human Services Committee. My name is Kathleen Brennan and I am a Deputy Commissioner at the Department of Social Services and I'm here before you today to offer remarks on several of the bills on today’s agenda.

Starting with Senate Bill 1052, AN ACT EXPANDING MEDICAID COVERAGE OF TELEHEALTH SERVICES. DSS supports the purpose of this bill to expand access to telehealth services in Connecticut’s Medicaid program, and we welcome the opportunity for dialogue with legislators and other proponents of the bill to discuss how best to implement telehealth in the
Medicaid program.

DSS needs to ensure that the expansion of various telehealth services is implemented carefully. Based on our experience with covering e-consults and other telehealth services, we're considering expanding Medicaid coverage of telehealth services, in the coming months to increase access to behavioral health services (mental health and substance use disorders); to reduce the need for individuals who are homebound to travel to see their medical provider when services can be provided by telehealth; and to reduce the need for individuals who undergo a surgery in a non-contiguous state to travel to see their providers for related services before and after that surgery.

The federal Centers for Medicare and Medicaid Services (CMS) has explained that telehealth services are already coverable under any state’s Medicaid State Plan without the need for a waiver. To the extent that changes to the state plan are necessary to implement specific telehealth services, we can submit one or more state plan amendments to make those changes. Seeking a section 1115 demonstration waiver to implement telehealth services is not required to expand coverage of telehealth services.

The Department believes that the goal of this bill will be best accomplished by simply amending subsection (b) of section 17b-245e, Telehealth Services Provided Under the Medicaid Program of the General Statutes. And the written testimony provides the amended language that we would propose.
For those reasons, the Department recommends the above substitute language in lieu of the language raised in the bill. And we would certainly welcome further dialogue on this subject.

Senate Bill 1053, AN ACT EXPANDING MEDICAID AND HUSKY B COVERAGE FOR CHILDREN. We appreciate the intent of this proposed legislation which seeks to provide health care coverage to more children in Connecticut, regardless of immigration status. However, there are limitations placed on the federal funding for immigrant families in both the Children’s Health Insurance Program (HUSKY B) and Medicaid programs (HUSKY A and HUSKY C). The CHIP and Medicaid programs currently cover all lawfully residing immigrant children. And we are already taking advantage of section 214 of the Children’s Health Insurance Program Reauthorization Act (CHIPRA), which allows coverage to be extended to lawfully residing immigrant children who have been in the country less than five years. This means that all lawfully residing immigrant children who otherwise qualify for the CHIP and Medicaid programs are immediately eligible for coverage. If coverage were extended to all children regardless of status, the state would be unable to claim federal financial participation for children who are undocumented. This would result in additional program costs incurred entirely by the state. According to the Center for Children’s Advocacy, there are approximately 17,000 undocumented children and youth in Connecticut under the age of 19. Other organizations such as the Migration Policy Institute estimate the number to be around 13,000 statewide. The exact number is somewhat elusive by nature as
many individuals may not be inclined to report their status or the status of their children. It's important to consider that some children may not meet other eligibility requirements; family income is too high or families may be fearful to apply for public benefits for their children due to public charge concerns. As a result, the actual number of individuals this bill proposes to support will likely be lower.

But based on the high end of estimates and utilizing the current HUSKY A per member per month rate of $315 dollars, the annual cost to support a state-funded medical assistance program would be approximately $64 million. This does not include system implementation and other related administrative costs.

Since this proposed bill would result in additional program and administrative costs that would be borne entirely by the State and absent the availability of appropriations, the Department is unable to support this bill.

Senate Bill 1065, AN ACT CONCERNING LONG-TERM CARE SERVICES. The Department commends the Human Services Committee for its attention to the need for strategic planning for Medicaid long-term care services. This is a critical need given the strong preference of older adults and individuals with disabilities to live in home and community-based settings, the state's interest in controlling costs, and support for town-level tailoring of strategies to meet the local needs. However, we respectfully state that this legislation is not needed.
In keeping with the legislation enacted by the General Assembly, DSS developed and implemented the Strategic Plan to Rebalance Long-Term Services and Supports in 2013 which captures the data and planning strategies that are contemplated by this bill.

In addition, the Connecticut Long-Term Care Planning Committee prepares a long-term care plan every three years based on the fundamental principle that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting. The most recent plan, titled Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut, was released in January 2019. This work informs DSS' Strategic Plan to Rebalance Long-Term Services and Supports. And for these reasons, the Department respectfully believes that this legislation is not needed.

Senate Bill 1066, AN ACT PROVIDING A VOICE FOR NURSING HOME RESIDENTS SUBJECT TO TRANSFER DUE TO NURSING HOME CLOSURES OR RECEIVERSHIPS. Section 5 of this bill requires a receiver, who is appointed by a Superior Court judge to evaluate whether a nursing facility is financially viable, to hold a hearing before any involuntary transfer or discharge from a nursing home may occur after a nursing home is placed in receivership.

This change is unnecessary because a hearing process for involuntary transfers or discharges already exists.

Connecticut General Statutes 19a-535(c)(2) provides
residents the right to appeal an involuntary transfer or discharge by submitting a request to the Department. Before a nursing facility can discharge a resident, it must notify the resident and the resident’s legal representative, in writing and at least 30 days before the scheduled date of the discharge, of the right to file an appeal with the Department.

The resident’s guardian, conservator, other legally liable relative, or responsible party and the long-term care ombudsman also have the right to participate in nursing facility discharge hearings held by the Department's Administrative Hearings unit, and they often do.

For these reasons, Section 5 of the bill is unnecessary.

Senate Bill 1079, AN ACT CONCERNING NURSING HOME FACILITY MINIMUM STAFFING LEVELS. This bill requires chronic and convalescent nursing homes to maintain minimum nursing staff ratios of at least 2.3 hours of direct care per resident per day. Because the Department of Public Health is the lead agency responsible for the oversight of care provided at nursing homes, the Department of Social Services is unable to directly comment on the appropriateness of the proposed staffing levels.

However, we have concerns related to the accuracy and stability of the data that would be used to identify non-compliance of the proposed requirements and which would be used to calculate nursing home rate increases to support the additional staffing requirements. A well-defined measurement of current
staffing levels would be required to accurately estimate the fiscal impact of a change in the minimum staffing levels.

In light of these reasons, the Department is not able to support this bill.

House Bill 7335, AN ACT CONCERNING OUT-OF-STATE USE OF ELECTRONIC BENEFIT TRANSFER CARDS. This proposal would require Department to notify an EBT cardholder that continuous use of an EBT card for more than 30 days in any quarter out of state shall give rise to a presumption that the holder has moved out of state and would require the Department to end any assistance the individual is receiving. While DSS agrees that people who have moved out of state should not continue to receive state benefits, we cannot support this bill for a number of reasons.

Preliminarily, this Department notes that applicants for assistance are required to meet state residency requirements in order to receive benefits. Most types of assistance require an annual review of eligibility; short-term SAGA benefits require a review every six months. If a person has permanently moved out of state, then existing rules dictate that they would not be eligible.

We also believe that the mere use of an EBT card out of state over a 30-year [sic] period is not a sufficient reason to presume that an individual has forfeited Connecticut residency, as there are various reasons a resident may temporarily be out of state. For example, individuals may be commuting to work out of state, providing temporary care for elderly or ill family member who lives out of state,
living temporarily out of state to escape a domestic violence situation, or visiting family or friends.

We also have concerns about the proposed process which appears to require termination of benefits without adequate notice and verification. The right to a hearing pursuant to sections 17b-60 and 61 is normally available only after the Department has taken negative action on a case. In addition to the failure to account for the many reasons a person may be temporarily out of state and the structure of the proposed process, the Department is concerned that limiting the use of federally funded benefits based upon usage in other states could raise constitutional concerns related to the right of travel.

We also believe that this bill, as written, would have a disproportionately negative effect on DSS clients who live near the Massachusetts, New York, and Rhode Island borders. Those who work in and routinely visiting neighboring communities across the state line may use their EBT card there because stores are closer and more convenient.

Finally, the Department does not currently differentiate between cash benefits issued pursuant to an assistance program or cash that is routed to a client’s EBT card for a child support payment. It's not unusual for a custodial party to leave Connecticut and still be eligible to receive child support benefits. As long as Connecticut is responsible for enforcing a child support order, the custodial party does not have to reside in Connecticut to receive payments on an EBT card. This bill as written appears to propose terminating
child support payments to custodial parents who move, which the Department does not believe is good policy and may also violate the constitutional right to travel.

For these reasons, the Department is unable to support this bill.

House Bill 7336, AN ACT EXPANDING MENTAL AND BEHAVIORAL HEALTH CARE OPTIONS UNDER THE MEDICAID PROGRAM. This bill seeks to expand access to mental and behavioral health treatment and ensure rates are equitable across the state. The Medicaid program is proud to offer a robust behavioral health benefit for children and adults and the Department of Social Services is always interested in discussions on how to improve our service system for those individuals with behavioral health conditions. As the Medicaid program already meets the goals of this bill, we believe that this bill is unnecessary.

The proposal looks to ensure rates are equitable in different regions across Connecticut for the same services. In general, behavioral health services provided under Medicaid use a uniform fee schedule for all services, regardless of region, with two exceptions, psychiatric inpatient hospital services at a general hospital and methadone maintenance. In general, support making payment methodologies uniform statewide whenever possible. However, we are unable to support any change in methodology that would result in increased state expenditures for which funding is not included in the Governor’s budget.

The bill also seeks to reduce costs and increase
treatment options by expanding the types of certified and licensed providers that may provide treatment under the medical assistance program. The Department already enrolls and reimburses all licensed and certified professionals whose license and certification allows them to practice independently. Currently, this includes physicians, APRNs, physician assistants, licensed psychologists, licensed clinical social workers, licensed professional counselors, marriage and family therapists, licensed alcohol and drug counselors. For those professionals whose license or certification does not allow them to practice independently, they have the option to work at a licensed behavioral health clinic and the Medicaid program provides reimbursement for their services as long as they are properly supervised.

There are two potential certifications and/or licensures that we do not enroll as independent practitioners, certified alcohol and drug counselors and licensed master social workers. It is our understanding that both of these professions require supervision as part of their scope of practice under state law and professional guidelines and for this reason we don't enroll them as individual or group providers. Certified ADRCs may enroll as licensed alcohol and drug counselors once they receive their licensure and the licensed master social workers may enroll once they receive their license as a licensed clinical social worker.

For these reasons, we believe the bill is unnecessary.

House Bill 7337, AN ACT CONCERNING THE DEPARTMENT OF
SOCIAL SERVICES ENERGY ASSISTANCE PAYMENTS. The Department does not support this bill as it is unnecessary and, as written, could result in a significant hardship to individuals eligible for fuel assistance. Pursuant to Connecticut General Statutes 16a-41a, a community action agency that administers a fuel assistance program must make payments to vendors of deliverable fuel not later than 30 days after the CAA receives a metered fuel slip or invoice for payment from the vendor. This statutory requirement was added during the 2018 legislative session. This bill proposes to prevent community action agencies from authorizing a fuel vendor to deliver fuel unless funds for such delivery have been transferred from the Department to the CAA and are available to pay the vendor for such delivery. This would require the CAA to withhold vendor authorizations, thus preventing eligible individuals from receiving fuel until the agency has received the funds from the Department.

While we recognize the importance of ensuring timely payments to the deliverable fuel vendors and understand the community action's need to have the funds available, in the start of this federal fiscal year energy assistance program, the Department was required to execute new three-year contracts. While the contracts for some agencies were not fully executed and approved by November 14, 2018, which was the start of the fuel deliveries for this program, all of the contracts were fully approved and all of the community action agencies did receive the funds in sufficient time to make payments to the deliverable fuel vendors within the 30-businessday timeframe required by statute.
If the proposed bill had been in effect for the 2019 program year, many clients needing a fuel delivery during the first week of the program would have been unable to receive the deliveries, and would have been in jeopardy of being without heat.

We are concerned also that the prohibition on fuel delivery authorizations could potentially result in violating federal LIHEAP regulations which require the Department to provide assistance within 48 hours, or 18 hours if there is a life-threatening situation, following the receipt of an application from a household experiencing an energy crisis.

Going forward, we recognize and will ensure that our contracts are amended in a timely manner to ensure payment is made as quickly as possible. But for the reasons mentioned above, the Department is not in support of Raised Bill 7337.

7338, AN ACT INCREASING FUNDING FOR ELDERLY NUTRITION, ENSURING EQUITABLE RATES FOR PROVIDERS OF MEALS ON WHEELS AND COLLECTING DATA ON MALNUTRITION. This bill would require the Department to increase the fee schedule for the Medicaid reimbursement to Meals on Wheels by no less than the CPI. It would also allow the Department to increase fees to Meals on Wheels providers who provide evidence of extraordinary costs for delivery in sparsely populated rural areas.

We appreciate the valued service of Meals on Wheels providers to recipients of our Medicaid home and community-based services. Effective January 1st, 2019, the Department increased rates for these services by 2 percent. Prior to that, back in
October 2016, the Department also revised reimbursement guidelines for the delivery of meals under its programs to allow providers to receive reimbursements for multiple meal deliveries in a single day as appropriate. Providers can now be reimbursed for a full multiple meal delivery as long as the client is present to accept the full delivery.

Unfortunately, the Department's unable to support a provision that requires additional Medicaid rate increase at this time as the Governor's budget does not include funding for this bill. The Department must oppose this rate increase.

House Bill 7358, AN ACT CONCERNING A STUDY OF MEDICAID-FUNDED PROGRAMS. This bill requires the Commissioner to conduct a study of Medicaid programs to assess factors pertinent to the quality of care, gaps in care, and necessary actions to comply with the Affordable Care Act.

The DSS Division of Health Services is already charged with these functions on a standing basis, regularly reporting to the Commissioner on quality of care (through such means as annual reports on HEDIS measures, measures of the effectiveness of Intensive Care Management, and consumer and provider satisfaction), on access (through such means as geo-access analysis and mystery shopper surveys), and necessary actions to comply with the ACA.

Our written testimony provides links to publicly available information on HUSKY Health, to our detailed monthly reports to the Medicaid Assistance Program which is charged under statute with a broad
range of oversight activities that encompass the goals of House Bill 6171, and to report on the Medicaid network adequacy, which incorporates DSS' materials on access to care as well as other factors relevant to provider participation, including ACA Ordering, Prescribing and Referring requirement.

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

Thank you very much. I have a number of people here to support me in providing additional answers to you.

[general laughing]

SENATOR MOORE (22ND): I have a number of people here to support me too! [laughing]

KATHLEEN BRENNAN: Right. It's always good to feel supported.

SENATOR MOORE (22ND): Thank you for that testimony. Representative Case.

REP. CASE (63RD): Thank you, Madam Chair. I support you wholeheartedly. Just a couple questions. On the 7335, on the EBT card, are there both state and federal dollars on there?

KATHLEEN BRENNAN: Yes, there are. Yes.

REP. CASE (63RD): Is there state dollars on there because it's a federal match or can we do two cards and not have state and federal so that we can better
see where the state dollars?

KATHLEEN BRENNAN: Well, there's state dollars because they're state programs. So, like SAGA, CASH -- What else, guys? State supplement and then obviously we have state SNAP, too. So we don't have two cards.

REP. CASE (63RD): I think my question is, and we'll hear some testimony later, is we're just looking to see on some of the cards that are out of state for more than 30 days --

KATHLEEN BRENNAN: Mm-hmm.

REP. CASE (63RD): -- maybe up to six months for people who leave the state for that period of time, if it's state dollars, then we should be in the state. And that's where I think it's coming from, but I understand if it's federal dollars, we don't have any control over the federal dollars. But are the state dollars subsidized by the feds? Is that why they're on there together? So is the SNAP program, are those programs subsidized -- Can they be drawn out separately?

KATHLEEN BRENNAN: Can, I guess, fundamentally, they could be. I don't know, but that's not -- You know, right now, our state SNAP program, we get reimbursement from the federal government. I wouldn't say that those are the federal dollars that are on the cards.

UNKNOWN: [Off Mic]

KATHLEEN BRENNAN: I guess I'm not answering your question.
REP. CASE (63RD): No. [laughing]

KATHLEEN BRENNAN: I can tell by the look on your face, I'm not answering your question. [laughing] I'm not, yeah.

REP. CASE (63RD): Because I guess we're looking for a better way to track how federal, how state dollars are spent and where they're spent if it's within the state of Connecticut.

KATHLEEN BRENNAN: Okay.

REP. CASE (63RD): And not outside the state of Connecticut for a prolonged period of time.

KATHLEEN BRENNAN: Period of time.

REP. CASE (63RD): That is our concern --

KATHLEEN BRENNAN: Okay.

REP. CASE (63RD): -- that we just wanna, given the fiscal restraints that we're in --

KATHLEEN BRENNAN: Absolutely.

REP. CASE (63RD): -- people deserve their benefits --

KATHLEEN BRENNAN: Mm-hmm.

REP. CASE (63RD): -- they deserve what they have, but we wanna make sure that they're here in the state of Connecticut that they're using our benefits.

KATHLEEN BRENNAN: I think -- I can certainly
appreciate that and one part of the written testimony that I didn't recite indicated that we did a recent review of EBT transactions, and approximately 2.6 of those EBT transactions occurred out of state, and approximately half those transactions were made in our border states. So we understand it, but I think from we've seen, we don't see it as being a significant problem. Although I understand what your point is.

REP. CASE (63RD): Okay. And we'll move on. You talk about the CAAs and the fuel. We did a huge bill last year I think in cooperation with the Chair on getting the vendors paid within 30 days of receipt.

KATHLEEN BRENNAN: Mm-hmm.

REP. CASE (63RD): Is it that most CAAs get their dollars first? Or are they actually doing authorizations prior to the CAA getting the dollars?

KATHLEEN BRENNAN: I think, for the most part, we try to get the money out there before the start of the program year, which I think is November 14th. In this particular case, there were a few community action agencies, I think three, whose contracts took a little bit longer, so they did not have the program dollars in the CAA bank account on November 14th, but authorizations can start November 14th. Deliveries can start November, I'm sorry, deliveries can start November 14th, and within that 30-day window, all the money was there. They got their payment, so they were able to pay their vendors within that 30-day time period.

REP. CASE (63RD): So we don't, there really was,
they had their money. So there wasn't a problem with the vendors getting paid.

[crosstalk]

KATHLEEN BRENnan: Within 30 days, that's correct.

REP. CASE (63RD): Okay. So that program has worked --

KATHLEEN BRENnan: It has.

REP. CASE (63RD): -- as far as the legislation and getting everyone up to snuff?

KATHLEEN BRENnan: It is. We feel very comfortable and confident. We actually did, we reached out to all the community action agencies to see if there were, if there was any issues, any problems when we had that legislation last year, and obviously, the situation with the concerns with one of the community action agencies, we worked closely with the State Energy Marketers' Association (SEMA). We specifically asked that if they became aware during any part of the energy season of a concern by any of their deliverable fuel vendors that they let us know. I checked in with staff. I said, "Would ya' tell me? Did we hear anything?" And the answer was "no." Everything that we saw was going appropriately. TVCCA, I think is one of our organizations that actually pays within two weeks, or less than two weeks.

REP. CASE (63RD): Okay. Thank you. And to go on to the Elderly Nutrition, the collection of the data of malnutri -- Can you expand on that a little bit on what the Department -- I see that it would
require DSS to increase the fee schedule. I mean, I think it's -- We're trying to work on it on the Appropriations, although, because there is a $2-million-dollar holdback on there.

KATHLEEN BRENNAN: Mm-hmm.

REP. CASE (63RD): And to hold back dollars from Elderly Nutrition and Meals on Wheels is not the proper thing to do.

KATHLEEN BRENNAN: Mm-hmm.

REP. CASE (63RD): So can you just expand on that just a little bit for me to try to help me understand?

KATHLEEN BRENNAN: I am not sure what you're asking me, Sir, I'll be honest. On the malnutrition piece?

REP. CASE (63RD): Yes.

KATHLEEN BRENNAN: I'm sorry, I don't, I don't have any information on that. But I can certainly go back and speak to staff. Unless anybody who's support to be supporting me might actually Have something for me!

REP. CASE (63RD): I thought you said you had a bunch of support here today! It doesn't seem like anybody's coming forward!

KATHLEEN BRENNAN: [crosstalk] [laughing] It's totally inappropriate.

REP. CASE (63RD): Madam Chair, you have some more support? [laughing]
KATHLEEN BRENNAN: Yeah. What Keith is helping me out with is that it might be referring to the Older Americans Act, of which that would be more appropriate for Commissioner Porter to respond to, who is shaking her head or not looking very nicely at me right now.

REP. CASE (63RD): [laughing] Well, we'll have her up here very shortly.

KATHLEEN BRENNAN: [laughing] I'll be right behind her.

REP. CASE (63RD): We can do that and, no, I appreciate you coming forward today with a lot of information on the bills that we have in front of us. Obviously, there's a lot of things going on in this state. Number one, the Elderly Nutrition, to get the dollars that's needed there to do and implement all the programs is necessary. To see the holdback for me is concerning. The fuel assistance --

KATHLEEN BRENNAN: Mm-hmm.

REP. CASE (63RD): -- we find that to be very concerning just because we wanna make sure that everybody's getting what they need and I don't know what this 14-cent tax is gonna do to the budget, if that's going to go to the fuel assistance also. So that's gonna increase and serve less people. Other than that, we'll talk more about the EBT --

KATHLEEN BRENNAN: Sure.

REP. CASE (63RD): -- when some people come forward to testify on that and maybe we can make a consensus
so we can put something forward. It's been many years that this has come, and we just want accountability for state dollars. But thank you very much for coming forward.

KATHLEEN BRENNAN: Thank you.

REP. COOK (65TH): Thank you, Madam Chairman. And thank you, Deputy Commissioner. Nice to see you.

KATHLEEN BRENNAN: Good to see you too.

REP. COOK (65TH): I just want to address a couple of pieces of legislation. I would like to start with SB 1079, the ACT CONCERNING NURSING HOME FACILITY MINIMUM STAFFING LEVELS. In your testimony, it states that you are, the Department is unable to directly comment on the appropriateness of proposed staffing levels.

KATHLEEN BRENNAN: Mm-hmm.

REP. COOK (65TH): I take pause with that, given the fact that appropriateness and humanity kind of go hand in hand in my world.

KATHLEEN BRENNAN: Mm-hmm.

REP. COOK (65TH): And as we all age, we know that there's a level of dignity of which our elderly population or people that are in our nursing homes deserve. And that's an understatement. So appropriateness in my world means far more than what we're giving them currently. And, right now, we have nursing homes that are running at a 1.9 ratio for staffing to patient. That's in a 24-hour time period on a given day. And that means your CNAs,
your nurses, and anybody else, a cumulative 1.9, and I know that we are supposed to see a 2.3, but not every facility is doing that.

KATHLEEN BRENNAN: Mm-hmm.

REP. COOK (65TH): And if we are looking at the way that we treat our elderly, I hope by the grace of God I'm old enough to get there.

KATHLEEN BRENNAN: Mm-hmm.

REP. COOK (65TH): But I know that 1.9 or 2.3 hours of care a day is inhumane. It is not fair to the patient and it is clearly not fair to the staff. And we require a far less, or more depending on your interpretation, of a ratio to teacher to preschooler than we do for patient to staff in a nursing home.

KATHLEEN BRENNAN: Mm-hmm.

REP. COOK (65TH): So I think that for the Department to not support the legislation takes me back.

KATHLEEN BRENNAN: Mm-hmm.

REP. COOK (65TH): Because we're better than that. And there must be a way to be able to figure out how to look at the staffing level.

KATHLEEN BRENNAN: Mm-hmm.

REP. COOK (65TH): It is not something that I will let sit here. And with no disrespect to the Department, it is not something that I'm willing to compromise on, given the fact that we have people that are laying in urine for hours.
KATHLEEN BRENnan: Mm-hmm.

REP. COOK (65TH): People that are not fed for hours because they can't feed themselves --

KATHLEEN BRENnan: Mm-hmm.

REP. COOK (65TH): -- because nursing homes do not have the staff. Nor can they pay.

KATHLEEN BRENnan: Mm-hmm.

REP. COOK (65TH): So as a state who is aging at a rapid rate, we need to continue to figure this out. So I would hope that we go back --

KATHLEEN BRENnan: Mm-hmm.

REP. COOK (65TH): -- take a second look at how we can make this conversation much better.

KATHLEEN BRENnan: I totally get that.

REP. COOK (65TH): Because if we require our children --

KATHLEEN BRENnan: Mm-hmm.

REP. COOK (65TH): -- on an infantile state to have a 4 to 1, 5 to 1, 6 to 1, 10 to 1, 1.9 or 2.3 hours of care a day is just inexcusable in my world.

KATHLEEN BRENnan: Mm-hmm. No, I certainly appreciate, and by no means did we mean to offend you at all, Representative. I think our position is simply that as the Department of Public Health is the certification and licensure, it was not our, you know, place to say whether or not 2.3 hours is
appropriate. We don't know. I can't say I disagree with the fact that our elderly certainly deserve the best care. And the other reason why, of course we understand that increased staffing is costing more money which, unfortunately, if it's not in the Governor's budget, that's where we stand. But I certainly appreciate your position.

REP. COOK (65TH): Thank you for that. And then I want to take a moment on HB 7338, the Elderly Nutrition. And quite frankly, you didn't offend me as much as I think that it might have been an offense to our elderly population who are in those homes, so I really think that we have to --

KATHLEEN BRENNAN: Absolutely.

REP. COOK (65TH): -- as a collective group recognize the decisions that we make.

KATHLEEN BRENNAN: Absolutely. Mm-hmm.

REP. COOK (65TH): But on 7338, the $2.9 million, and Representative Case touched on it, that was never released. It is still being held back for the Elderly Nutrition. That was not released as of yet, to our knowledge. And it's not. There's no plan to release that money.

UNKNOWN: [Off Mic]

REP. COOK (65TH): And, by the way, that is an OPM holdback.

KATE MCEVOY: Good morning. I'm Kate McEvoy. I'm the Director of Division of Health Services. Thank you for the question, Representative. I think where
we are struggling to appropriately respond to the question is there are two distinct funding streams for, you know, for older adults in Connecticut. The Medicaid state plan does not cover meals, but we do cover home-delivered meals under our long-term --

REP. COOK (65TH): Mm-hmm.

KATE MCEVOY: -- services and supports waiver, as you're aware. So there are not constraints on our ability to pay for meals through those waivers. So that's an approved service. It can be as is dictated by an individual's need, included in a care plan for, for instance, a participant of the Home Care Program for Elders or any of the other supportive waivers. A distinct stream is funding that originates with the federal government, the Older Americans Act, and comes down through the Department of Rehabilitation Services.

So I think what Deputy Commissioner Brennan was indicating is that we would respectfully defer questions on holdback for that funding and/or associated state funding to our sister department. Just to reinforce again, there are not constraints on our ability to use Medicaid funds in support of coverage of those meals on the waivers.

REP. COOK (65TH): Thank you for that. And I understand it is a complicated process. You should've seen us trying to figure out how to draft the piece of legislation. But when the Department takes a stance and states that there was a 2 percent increase of which the increase was not released because of an OPM holdback that it had no intention on being released, I don't think that it's fair to
represent that they got the funds when they never received the funds. Although the intention might've been there, it was never put on the ground. So as you're drafting testimony to state that it was there, I do think that it is a false representation of actually what was given and completely followed through.

And I understand the complications with the funding in the disparities of pots. I think that's part of our biggest problem in government is that there's so many different -- We know it all the time. So many different silos that we can't figure out a way to merge things together just to make it less complicated. And we really need to do better at that. And I see we all smile because I think that's part of our goal.

UNKNOWN: Mm-hmm.

REP. COOK (65TH): The piece about this legislation where we talk about the rural areas versus the, you know, the population of density and not density, I think that we have to really take a step back and figure out how we do budget that. It's much easier, and I will just use because we're here, to deliver meals in Hartford when doors are much closer, than you go to the quiet corner or the northwest corner and you're driving 4 or 500 miles to deliver a meal and there's no different compensation or gas mileage and the like. That's, that is an unfair way to do this distribution, because they are going and doing yeomen's work into an area that they're not being compensated for, not even equally. And when you look at the base, and you look at the breakdown and you have some groups that are getting an $8.35-
dollar reimbursement and then others that are getting a $1.4-dollar reimbursement for the exact same meal, that is also a problem in our own state. Especially when the lower numbers are the ones that are going the farthest. And so that's part of the crux behind this. And I really hate the "steal from Peter to pay Paul" kind of a thing, but just because you live somewhere else or just because your organization is located in one place or the other does not mean that we have equal, equal access. And when it takes two hours to get to deliver one meal, and I'll use the northwest corner specifically, but you're only being reimbursed $1.4 dollars, you know, $1.4 dollars, but yet somebody somewhere else is being reimbursed at $8.3. We have to really look at how that funding stream is being put to work.

And I'm gonna steal my senior center's testimony thunder. But there was a letter, and our Chair's have not received it yet, and I just handed it to Representative Abercrombie, that this piece of legislation is on the national watchlist, which Joel will discuss. But very clearly they state that they recommend the inclusion of the language related to the collection and analysis of the patient malnutrition for the purposes of improving quality care. We know that malnutrition especially among older adults is critical in growing a health issue. Data that has been included in their national blueprint includes the fact that up to one out of two older adults in either risk, either are at risk or aremalnourished. It leads to four to six-day increase in hospital stays, and overall, the hospital costs can be up to 300 percent greater for individuals that are malnourished. It also states that the U.S. Secretary of Health and Human Services
cited the HHS data and stated that malnutrition is responsible for some $42 billion, with a "b," each year in health care spending. So if we're talking about nutrition, malnutrition, and not being able to support it, regardless of whether it's in the Governor's budget or not, we really need to figure this out. Because as much as I hate to put the cost pros and cons together, by giving elderly the nutrition that they need and by us recognizing that it is a problem, not only will it save lives, but it does save millions and millions of dollars and keeps people out of the hospital. So I just want to leave you with that and I hope you take that into consideration. Thank you, Madam Chair.

SENATOR MOORE (22ND): Representative Abercrombie.

REP ABERCROMBIE (83RD): So I'm just gonna intervene for just one second here.

SENATOR MOORE (22ND): Yes, you are.

REP ABERCROMBIE (83RD): [laughing] I wouldn't be doing my job if I didn't. So as you can hear, my colleague is very passionate about this issue. And kudos to her, and I appreciate that. But I think that clarification that we're talking about two different programs here. We're talking about meals for our seniors, which we all agree about.

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): Right? But your program is under the Connecticut Home Care Program --

KATHLEEN BRENNAN: [crosstalk]
REP ABERCROMBIE (83RD): -- where there was no cut.

KATHLEEN BRENNAN: Right.

REP ABERCROMBIE (83RD): What my colleague is referring to is the Meals on Wheels that comes under DORS, which was a holdback from the administration. So, you know, I appreciate you guys trying to respond --

[crosstalk]

REP ABERCROMBIE (83RD): -- to my colleague, but I think that people that are watching this need to understand, there was no holdback under the Connecticut Home Care Program, which is one vehicle of serving our seniors. Yes, we do have a huge issue on the other side, and the next commissioner will be up shortly [laughing]. But, just for clarification, I want people to understand that. Thank you, Madam Chair.

REP. COOK (65TH): And can I just say that I was trying to say that I know that there's two programs, but because there was testimony by the Department, it needed to be addressed. So thank you. Thank you.

REP HUGHES (135TH): Thank you, Madam Chair, and thank you, Commissioner, for coming before us. Referencing SB 1053, EXPANDING MEDICAID AND HUSKY B COVERAGE FOR CHILDREN, are any other states already covering children regardless of immigration status?

KATHLEEN BRENNAN: Yes, I believe they are, yeah. I don't know which ones. California is.
REP HUGHES (135TH): Okay. And you said there's a conservative estimate of 17,000 in Connecticut. What are these kids doing for health care now? Are they using emergency rooms as primary care, relying on school nurses, going without care? What do you think?

KATHLEEN BRENNAN: It's probably a combination of all of the above that you just mentioned.

REP HUGHES (135TH): Right. Which -- Do you have any estimates of what that's already costing us?

KATHLEEN BRENNAN: I do not.

REP HUGHES (135TH): Okay. So we're gonna look into that, because all we have is an estimate from you --

KATHLEEN BRENNAN: Sure.

REP HUGHES (135TH): -- about what that would cost to cover them.

KATHLEEN BRENNAN: Correct.

REP HUGHES (135TH): But we're clear that there's already costs being incurred that the state is covering them, you know, to these default means. So let's do an apples to apples cost analysis and see what that might look like. That's it. Thank you.

SENATOR MOORE (22ND): I have a question only on a statement in your Senate Bill 1053. I see that you used "lawfully residing immigrants" several times in your testimony. Tell me what that, what does that describe? On 1053.

KATHLEEN BRENNAN: Okay, Peter, could I ask for your
help?

PETER HAVARD: Hi. Peter Havard, DSS. I don't know all the details of all the various groups that fall under "lawfully permanent residents," but it basically includes everybody who has got some sort of a status in which they came into the country that we know with authorization. I don't know, that's a very simple answer, but I can give you more details if you'd like [crosstalk] --

SENATOR MOORE (22ND): I would. So what does it mean, "status"?

PETER HAVARD: I think what, we would, basically, we will cover anybody who is not currently falling under the term of "undocumented."

SENATOR MOORE (22ND): Thank you. Did you have questions?

UNKNOWN: [Off Mic]

SENATOR MOORE (22ND): Does anyone have questions?

REP ABERCROMBIE (83RD): [laughing] Thank you, Madam Chair. Okay. Deputy Commissioner, so nice to see you.

KATHLEEN BRENNAN: Nice to see you.

REP ABERCROMBIE (83RD): So let's start at the top --

[crosstalk]

REP ABERCROMBIE (83RD): -- and we'll work our way through some of these bills. So my first is SB
1052, EXPANDING MEDICAID COVERAGE OF TELEHEALTH SERVICES.

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): So I have to say that the area that I'm most concerned is the behavior health.

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): Right? And I think you are, too.

KATHLEEN BRENNAN: Yeah.

REP ABERCROMBIE (83RD): But I think that we have to do this in a faster way. You know, we've got way too many kids that are stuck in our ED that if we were able to do this service --

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): -- you know, they wouldn't be stuck there for as long.

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): I know that we also have an issue with capacity for them to have long-term care --

KATHLEEN BRENNAN: Right.

REP ABERCROMBIE (83RD): -- but at this point, I think that this is very underutilized and I think that we could do it faster and more efficient. You know, the e-consults, you know --
KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): -- I mean, we did the pilot through the FQHCs, right?

KATHLEEN BRENNAN: FQHCs, Mm-hmm.

REP ABERCROMBIE (83RD): Which have proven, right, that it's a very efficient way of doing the service, especially in our rural areas.

KATHLEEN BRENNAN: Exactly.

REP ABERCROMBIE (83RD): And let's talk about the kids.

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): You know, our teenagers, right, that can't get to these appointments.

KATHLEEN BRENNAN: Yeah.

REP ABERCROMBIE (83RD): You know, so there's a lot to be said for this, but I think we could do it in a better way.

KATHLEEN BRENNAN: Okay.

REP ABERCROMBIE (83RD): And in a faster way than what we're doing right now. The other one that I wanted to talk about, and I think that there's some miscommunication about it, and that's why I just wanna bring it to your attention, is the House Bill 7337, AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES ENERGY ASSISTANCE, right?

KATHLEEN BRENNAN: Yeah. Mm-hmm.
REP ABERCROMBIE (83RD): So my colleague, Representative Case, is absolutely right that a couple of years ago, we put in statute that there's a 30-day.

KATHLEEN BRENNAN: Correct.

REP ABERCROMBIE (83RD): My understanding is is that the agency was late with their contracts to the CAAs, which are the community action agencies ---

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): -- therefore, they were late getting it to the vendors. And the problem was is that the vendors start on day one.

KATHLEEN BRENNAN: Correct.

REP ABERCROMBIE (83RD): Right? And they have to hold the line of not being paid for 30 days --

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): -- and a lot of them have, were at their peak of their budgets. So I think that we need to think about, how do we do this in a more efficient way, because we all know that these providers, these vendors, are really small businesses.

KATHLEEN BRENNAN: Absolutely.

REP ABERCROMBIE (83RD): And to expect them to carry the weight of the state for 30 days, if not longer, you know, is unacceptable.

KATHLEEN BRENNAN: Mm-hmm.
REP ABERCROMBIE (83RD): So, you know, I don't know if you want to talk about why the contracts were late to the CAAs this year? Was there a glitch in the system or was it that we just didn't have the staff to do it? Because clearly there was a disconnect somewhere along the line.

KATHLEEN BRENAN: Sure. Thank you for that question. And I, it's my understanding that we started a brand-new contract for a three-year period, right. Instead of having an existing contract that just had to be amended to add the funds for this year, you had to start from the beginning. And the process is, you know, a little bit more -- We have a new core CT system that requires budgets to be put into systems. It can be a little bit more time-consuming. It's a fairly new process for not only the agency individuals who handle the contracts, but also for our contractors who have to go into those systems as well. So there was, you're absolutely right, that the contracts were not executed as timely as we would like. But I am not aware of anyone's payment being delayed to a vendor. We specifically asked each of the community action agencies to let us know. We certainly didn't get money out the door on November 14th, but when authorization, when delivery first started, but all the money was in the CAAs hands before December, the end of December, which, you know, when you're looking at business days, was within that 30 days. And we were not aware that anybody was asked to, did not have the money to pay the vendors in a timely period. If that's the case, I'd like to know, because we just don't have that information.

REP ABERCROMBIE (83RD): So I think what the issue
is is that, yes, we have a 30-day window --

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): -- but most times, the CAAs are able to do it in a more timely manner.

KATHLEEN BRENNAN: That's correct.

REP ABERCROMBIE (83RD): So they get it within the two weeks.

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): This, because the contracts were late, really expanded it right up to the clock of the 30-day.

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): Which hurt these vendors.

KATHLEEN BRENNAN: Sure.

REP ABERCROMBIE (83RD): So I think that's what the issue was. So I, what I would hope is because of anytime we have new systems or new contracts --

KATHLEEN BRENNAN: It takes a while.

REP ABERCROMBIE (83RD): -- that while -- And you guys take that into consideration.

KATHLEEN BRENNAN: Absolutely.

REP ABERCROMBIE (83RD): Because we -- Listen, we don't wanna be here every time having to put things in statute because you're not doing it in a timely manner.
KATHLEEN BRENNAN: Sure.

REP ABERCROMBIE (83RD): And we know that this is an area, no offense, that we've had issues for years on. So, come on, let's try and get that --

KATHLEEN BRENNAN: Absolutely.

REP ABERCROMBIE (83RD): -- that done right. Okay?

KATHLEEN BRENNAN: I can tell you now that the contracts are in place. You know, the next year coming up, it will be nothing more than adding dollars and, again, the other thing though you have to recognize too is that in some cases, we don't have the dollars. Right? I mean, this is money that comes from the federal government. And so there are times that delays, didn't happen this year, but that we don't have the funds to us to give to the community action agencies. We do have a carry forward that we have to use. We've been blessed enough to have that going forward, and let's -- We just certainly hope that that happens, so.

REP ABERCROMBIE (83RD): Yeah, but with all due respect, either do our small businesses --

KATHLEEN BRENNAN: Right. Oh, we know.

REP ABERCROMBIE (83RD): -- that are doing this job for us!

KATHLEEN BRENNAN: No, absolutely.

REP ABERCROMBIE (83RD): So it's sort of, you know, a catch-22.
KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): On one hand, right, I get what you're saying, right.

KATHLEEN BRENNAN: Right.

REP ABERCROMBIE (83RD): Because we're at the mercy of the federal government, but the reality is --

KATHLEEN BRENNAN: Right.

REP ABERCROMBIE (83RD): -- right, we can't do this without these vendors.

KATHLEEN BRENNAN: Correct. Mm-hmm.

REP ABERCROMBIE (83RD): So if we're not gonna do it in a timely manner to these small businesses, what's the incentive for them to do it?

KATHLEEN BRENNAN: Sure.

REP ABERCROMBIE (83RD): You know, so --

KATHLEEN BRENNAN: Yeah. I understand.

REP ABERCROMBIE (83RD): You know, we have to consider that.

KATHLEEN BRENNAN: Absolutely.

REP ABERCROMBIE (83RD): Moving on to 7335, which is AN ACT CONCERNING OUT OF STATE USE OF ELECTRONIC BENEFIT TRANSFER CARDS, under that, the policy, because a lot of this is schedule, are we totally in compliance with everything we do under our electronic cards?
KATHLEEN BRENNAN: Yes.

REP ABERCROMBIE (83RD): Okay. Second question is, what is our fraud percentage under these cards?

KATHLEEN BRENNAN: I don't know that.

REP ABERCROMBIE (83RD): Because I know we get monitored.

KATHLEEN BRENNAN: I can go back. Certainly, I will certainly go back and get that information to you, absolutely.

REP ABERCROMBIE (83RD): I think that would be helpful.

KATHLEEN BRENNAN: Absolutely. [Crosstalk]

REP ABERCROMBIE (83RD): My understanding is the last time that I looked at the data, we were between 1 and 3 percent, which was probably one of the lowest in the state.

KATHLEEN BRENNAN: [Crosstalk]

REP ABERCROMBIE (83RD): So I just wanna state that I don't believe that there's a problem with these cards.

KATHLEEN BRENNAN: Sure.

REP ABERCROMBIE (83RD): And so, you know, I don't see any action needed.

KATHLEEN BRENNAN: Okay.

REP ABERCROMBIE (83RD): But out of a courtesy to
our colleagues, we did --

KATHLEEN BRENNAN: Sure.

REP ABERCROMBIE (83RD): -- have a hearing on that portion of it. The behavior health, so one of the things I'd like to -- The other bill that we're talking about is 7336 --

KATHLEEN BRENNAN: Yeah.

REP ABERCROMBIE (83RD): -- EXPANDING MENTAL HEALTH AND BEHAVIORAL HEALTH OPTIONS UNDER MEDICAID. So under DCF, right now, one of the things that they're doing, which I think is really something that we should all take a look at, so under Voluntary Services and Differential Response, they're gonna be contracting with providers that do the behavioral health portion so that individuals that come through DCF -- So differential responses for individuals before they go into the DCF system, right?

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): So what they're doing is sort of like no wrong door. Right.

KATHLEEN BRENNAN: Mm-hmm.

REP ABERCROMBIE (83RD): And I think that we, under the DSS, 'cuz they're different hats, right? We under the DSS need to look at that also, right, because behavioral health --

KATHLEEN BRENNAN: Yeah.

REP ABERCROMBIE (83RD): -- is right here, guys, right in front of us.
KATHLEEN BRENnan: Mm-hmm.

REP ABERCROMBIE (83RD): And we could be doing this in a much better way. You know, we know what's going on in the school districts. In the urban district, they have behavioral, behavioral therapists that now are working, because these kids are not at the point where they have a full diagnosis.

KATHLEEN BRENnan: Mm-hmm. Right.

REP ABERCROMBIE (83RD): So I think that it's an area that we really need to, as a state, not just you -- I'm happy about what DCF is doing.

KATHLEEN BRENnan: Of course.

REP ABERCROMBIE (83RD): But it's really an area that we all have a responsibility and it's something that I think we can do in a more efficient way and we really need to think about how do we spend our Medicaid dollars, because the reality is this. If we don't do it up front, it's exactly what my colleague was saying about some of the Medicaid kids that don't, I mean, some of the kids that don't get services under the Medicaid program --

KATHLEEN BRENnan: Pay for it [Crosstalk]

REP ABERCROMBIE (83RD): -- you pay on the back end, right?

KATHLEEN BRENnan: Absolutely.

REP ABERCROMBIE (83RD): So, especially in the mental health field.
KATHLEEN BRENnan: [crosstalk]

REP ABERCROMBIE (83RD): So I would like you to just consider that as we --

KATHLEEN BRENnan: Certainly.

REP ABERCROMBIE (83RD): -- go forward. Is there a more efficient way that we can do that? And with that, that's all I have, Madam Chair. Thank you.

SENATOR MOORE (22ND): I have, would like to ask you something about Senate Bill 1079, the nursing home facility. So in the second paragraph, you said a well-defined measurement of current staffing will be required to accurately estimate the fiscal impact of the change of the minimum staffing level. My question to you would be, what would that look like? What type of report would you look for to do that and is there a possibility for you to work with DPH to address those issues?

KATHLEEN BRENnan: Of course. I'm gonna call Chris Levine, who's our resident nursing home expert.

UNKNOWN: [Off Mic]

CHRIS LEVINE: Good morning. Chris Levine from DSS. We looked at the CMS data and we believe it has some serious limitations. I think to get a clearer look, we would have to do a Request for Information from every nursing home, have them attest to the information they're providing, and then audit that information on the back end once you determine the rate increase that would be required to support the additional staffing.
SENATOR MOORE (22ND): Could you do a sampling of nursing homes, instead of doing all of them? Some of them that have high usage or high volume?

CHRIS LEVINE: Yeah. I, I don't think so because the acuity varies widely between the nursing homes. And the current reimbursement varies widely between the nursing homes. And then the staffing ratio related to that acuity, there's a large variance with that. So I don't think you could take a statistic from a sample and apply it unilaterally or even within some tiers and get a good result.

SENATOR MOORE (22ND): The follow-up to that is would you be working, willing to work with DPH to make this happen? I mean, at some point, we've got to shift, you know, that -- We just have to shift. There's more people aging. There possibly could be more people who need these services. So what are you building toward to try and figure out how do we start to address this?

KATHLEEN BRENNAN: Short answer is, yes, we would certainly work with DPH.

SENATOR MOORE (22ND): So we don't have to create legislation for everything that we need to do when we can see what the future brings.

KATHLEEN BRENNAN: Of course.

SENATOR MOORE (22ND): And what needs to happen. I don’t like the idea that we have to put something into legislation to get people to do what they should be doing when we look toward the future.

KATHLEEN BRENNAN: Mm-hmm.
SENATOR MOORE (22ND): Right? So I'll believe that, with all good intentions --

KATHLEEN BRENNAN: Mm-hmm.

SENATOR MOORE (22ND): -- and with your posse, you will be able to [laughing], you will be able to work with DPH to address this.

KATHLEEN BRENNAN: Mm-hmm.

SENATOR MOORE (22ND): Well, thank you.

UNKNOWN: [Off Mic]

SENATOR MOORE (22ND): Oh, no.

REP HUGHES (135TH): Thank you, Madam Chair. I was just gonna suggest, we can develop an app for this! Come on!

UNKNOWN: [laughing]

REP HUGHES (135TH): I'll add to your posse of support. I've got some young app developers. This is a great application. We can get this data. Thank you.

UNKNOWN: Thank you very much.

SENATOR MOORE (22ND): Thanks very much. So Amy Porter, you just got under the hour. So [laughing].

UNKNOWN: [Off Mic] Come on up!

SENATOR MOORE (22ND): Come on up.

AMY PORTER: Timing is everything. Good morning, Senator Moore, Representative Abercrombie, and
distinguished members of the Human Services Committee. My name is Amy Porter and I'm the Commissioner for the Department of Rehabilitation Services. I wanna thank you for the opportunity to offer testimony on House Bill 7338, AN ACT INCREASING FUNDING FOR ELDERLY NUTRITION, ENSURING EQUITABLE RATES FOR PROVIDERS OF MEALS ON WHEELS AND COLLECTING DATA ON MALNUTRITION.

While we believe we understand the underlying motivations behind the bill, for several reasons we can't offer our support for Section 2 of the bill, which addresses the role of the Department of Rehabilitation Services.

First, Section 2 seeks to place elderly nutrition providers or ENPs on an equal footing with area agencies on aging in the process that we use when we design our formulas for funding. The five Connecticut Area Agencies on Aging, or the AAAs, are fixed in statute. We currently work collaboratively with them to provide important services to older adults across the state. The AAAs are also an explicit part of the federal framework for the service delivery and design. ENPs, on the other hand, are valued service providers, but they're also parties to a competitive bidding process. We can't presume that a particular ENP or group of ENPs will always be the provider because we can't know in advance who will win a competitive bidding award. Also, if the current ENPs are given an elevated position in the formula design process, others that might bid for future contracts may feel that they have been placed at a disadvantage to another bidder that was on the “inside” of the process. And our role is to avoid any potential conflict of interest.
We also don't know the full universe of elderly nutrition providers and who might decide to become one in the future. Tomorrow's ENP could be an entity that is completely unknown to us today. There are also ENPs that work with DSS’ Connecticut Home Care Program for Elders, so it's unclear whether the legislation means to include those folks in this proposal as well.

Second, while we sympathize with the burden placed on some AAAs and ENPs in delivering meals to rural and less densely populated areas, this is one of several factors that we take into account when we determine the formula for distribution of funds. To be specific, the federal Older Americans Act, which controls our federal funding and our programming, requires consideration of the geographical distribution of older individuals as well as older individuals with greatest economic and social need, with particular attention to low-income minority individuals. With this guidance, Connecticut’s State Plan on Aging lays out six criteria in evaluating need: the total number of individuals 60 and older, and from that group we look at minority status, disability status, low-income status, rural area, and the number of low-income minority individuals 60 and older. As you can see, these criteria already include a consideration for the demands of a rural population.

If Connecticut were to single out and elevate the “rural” factor, for the first time in state statute, it could disrupt the careful balancing of the factors that are required of us under federal law. Also, any advantage or added weight given to rural factors in our formula might have to come at the
expense of the other factors, namely, disability, minority, and low-income status.

There are a few other concerns. As noted, the bill would insert the ENPs into a more prominent position in the formula development process. However, the formula that we develop affects more programs than just Elderly Nutrition; it also affects disbursements of several other federally-funded programs including Supportive Services, Health Promotion, and Family Caregiver Support. There is no necessary connection between the elderly nutrition providers and these other programs and therefore no programmatic justification for providing them with a role with such broad potential impact.

On a more technical level, we note that the bill requires us to use 2020 Census data, but that data is not yet ready for use. It also doesn’t provide for later years when the baseline data will come from the 2030 Census or 2040 Census.

Also, while “meals on wheels” is a very common usage to describe our service, it's also used to refer to the similar service provided by DSS and so it's not clear if it's our program alone that's being discussed in the bill. And we heard some of that confusion a few minutes ago.

Lastly, under federal law, when our agency develops these formulas for disbursement, we solicit and accept input from interested parties. This is an official and an important part of our planning and it's a process where we could happily accept input from the elderly nutrition providers. It's already
built into our processes. We believe strongly in the value of listening to the community we serve and our partners in that work and we'll continue this practice in the future.

I want to thank you for your attention and for allowing me the opportunity to offer this testimony. I look forward to continuing to work with this Committee on this important matter and I'm happy to answer any questions you may have.

UNKNOWN: [Off Mic]

REP. COOK (65TH): Thank you, Madam Chairman, and thank you, Amy, very much. And thank you for the participation and ability to have the elderly nutrition forum that we had at the end of the fall last year. I just can't believe it was last year. I know that you were in the room, so you heard the things that I had stated and I do recognize that there is some, not confusion, for us, but I think it does get pretty wonky when we talk about how funding streams and the like are distributed and what have you. The reason why the 2020 Census was put in there, I'm about being proactive, not reactive. So I'm trying to plan for the future to figure out what we need to do moving forward. And obviously, if we base things [coughing], excuse me, on things that were from the 2010 Census, it's obviously going to be outdated by the time we get something implemented. You heard my comments on the national recognition in, you know, attention to this.

And the only one other thing that I do wanna say is as you had stated in your testimony that this was about input and you all are willing to listen. I
agree with you. You all are very willing to listen. This legislation proposal did come from those groups that are out in the field trying to figure out a way to make this work and work better. So as much as I understand that certain things are taken into consideration, especially rural and what have you, as we recognize that the, even in our own job, that the consideration for mileage fluctuates from year to year, and it goes up and down, we don't do that when we talk about the reimbursement. We do it, we fix it, and it typically does not go back and change until the next assignment. We really need to look at this, because as much as we are doing a good job, we can do a much better job.

And we also recognize, as I had stated earlier, that on the front end, if we invest, then on the back end, the need is less.

AMY PORTER: Right.

REP. COOK (65TH): And our elderly that we have done yeoman's work to try to allow to stay home, money follows the person, you know, aging in place, and you fill in all those other great programs that we have, there are still people out there that are malnourished. And that the meals are just not getting everywhere that they need to be and people are scrimping and saving to try to do as much as they can with as little as they get. And I believe that this is an investment in an area that we must, not try, but we must figure out how to improve. And that is not a disrespect to you or your agency and the good work that you're doing. But it is a cry for help knowing that the programs that are out there that are doing this job are going to leave
because they cannot make ends meet. And this is probably, this is the biggest fear that I have. So I just wanted to say that and thank you very much.

SENATOR MOORE (22ND): Thank you very much.

AMY PORTER: Thank you.

SENATOR MOORE (22ND): We'll now go to the public portion. Ann Pratt. Is she here?

UNKNOWN: [Off Mic] She was here.

SENATOR MOORE (22ND): Okay. Tom Swan.

UNKNOWN: [Off Mic]

SENATOR MOORE (22ND): Rosana Ferraro. Hi Rosana.

ROSANA FERRARO: Hi.

SENATOR MOORE (22ND): Please state your name. Thank you.

ROSANA FERRARO: Absolutely. I'm Rosana Garcia Ferraro. I'm the Policy and Program Officer from Universal Health Care Foundation of Connecticut.

SENATOR MOORE (22ND): Have you testified before?

ROSANA FERRARO: Not in front of this committee.

SENATOR MOORE (22ND): All right. So you have three minutes. Give us your best.

ROSANA FERRARO: Yes. Absolutely.

[general laughing]
ROSANA FERRARO: Not, none at all. So Chairs and members of the Human Services Committee, thank you for the opportunity to testify in support of Raised Bill 7339, AN ACT CONCERNING A PUBLIC INSURANCE OPTION.

The Foundation envisions a health system that is accountable and responsive to the people it serves, that supports our health, and takes excellent care of all of us when we are sick, at a cost that doesn’t threaten our financial security. I’m testifying today because we believe a public option for our state would take a major leap forward to help Connecticut achieve this vision.

Ten years ago, in this very building, the Foundation testified in favor of SustiNet, which was a public option that proposed to expand coverage to the uninsured while bending the cost curve and improving the health of all state residents. Despite gains since then, people in the state continue to struggle with access to quality, affordable, equitable health care.

A survey conducted in Connecticut last year found that 82 percent of people who buy their own insurance are worried about affording coverage. That same survey found that 50 percent of adults faced affordability challenges last year.

We support Raised Bill 7339 in the context of our support for House Bill 7267: AN ACT CONCERNING PUBLIC OPTIONS FOR HEALTH CARE IN CONNECTICUT, which is a bill in the Insurance and Real Estate Committee that, while inclusive of the concept raised in RB 7339, also includes a public option for small groups
in this state and a public option for individuals.

RB 7339 is aligned with Phase 3 of HB 7267 in that it calls for a process to find ways to expand coverage even further. The public options offered in HB 7267 address the challenges of small groups and some individuals, but may not necessarily provide a solution for low-income state residents who struggle with health care costs.

One policy solution to help low-income residents would be to expand Medicaid/HUSKY eligibility, while preserving the existing benefit structure. This would certainly help low-income people access health care and coverage.

But with the current fiscal realities being what they are, this is an unlikely solution at this time. But still, those whose incomes are too high to qualify for Medicaid struggle with health care costs, even those with access to financial help on Access Health CT.

People who qualify for subsidies, those who have low or moderate incomes, are increasingly turning to bronze tier plans on the exchange. In 2017, 18 percent of subsidized individuals chose a bronze plan. In 2019, that was up to 32.5 percent. The bronze standard plan has a deductible of $6,000 dollars and an out-of-pocket maximum of $7,900. And how can someone who qualifies for subsidies afford to get sick with coverage like that?

According to the Connecticut United Ways recent report, an estimated 30 percent of Connecticut households are above the federal poverty level, but below the basic cost of living. This means that
there are many -- So I'll wrap up. -- many who do not qualify for Medicaid and still face these high health care costs.

So we support examining ways for everyone in the state to access quality, affordable, equitable coverage and we urge that this bill, 7339, be enacted as part of a broader effort to bring public options to Connecticut. Thank you.


MAIREAD PAINTER: Good after, yeah, good afternoon. Good afternoon, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Mairead Painter, and I'm the State Long-term Care Ombudsman. Thank you for this opportunity to testify before you this morning, or this afternoon, on two bills.

The first bill is bill number 1066, AN ACT PROVIDING A VOICE FOR NURSING HOME RESIDENTS SUBJECT TO TRANSFER DUE TO NURSING HOME CLOSURE OR RECEIVERSHIP. Although very well intended, and we all are very concerned about individuals when there is the potential closure of a nursing home and how difficult it is, not only for residents, family
members, and staff in the nursing home. But this bill, respectfully, feels more like a one-size-fits-all, and there's very different circumstances in every closure. Closures can happen due to federal bankruptcy, state bankruptcy. It could be that there's not enough money to run the building and the owners may go to the Department of Social Services and they put a receiver in. There could also be a request for closure where there's not receiver put in place. And because of those differences, the way that we approach them can be different, and the types of public hearings and the types of forums that are offered are different. We've had a lot of feedback from residents, families, and nursing homes regarding public forums. In some cases, there's been a great deal of support for them and people have wanted to be heard, even in cases where we weren't able to make that happen for them. And then in other cases, residents have sometimes felt that it prolonged a process that was happening anyhow and made it more challenging and more difficult, because until the decision is made, there are some protections that are in place that aren't afforded to them until that decision is made. And it made it a long period of time where they were left uncomfortable.

We think it's really important to always represent the residents in these cases. I wanna make it clear that Connecticut's one of the very few states that has a process and a team in place that is multi-department. We speak regularly. There are meetings held at the nursing homes. Every resident is encouraged to have an individualized, person-centered care plan where they can have members from different departments talk to them about what their
options are. They can have a assessment done to say what's available to them, and so that we can offer the opportunity to reduce any trauma to the individual. There's no way to totally reduce trauma. And one of the other concerns that I have is that in some cases, we have had nursing homes that are running at such a low quality where it is traumatic for the individuals in the building and they're looking to have the opportunity to be accepted and live in a home where they have the highest quality of care and are treated in a dignified manner. I understand how emotional this can be for individuals. But I just wanna caution that putting one standard in place is difficult because of the different types of processes that take place.

The second bill that I'd like to speak to you about today and testify on is Bill 1079, AN ACT CONCERNING NURSING HOME FACILITIES AND MINIMUM STAFFING LEVELS. You've heard me testify before on this. And I would prefer a much higher level. I did hear Representative Cook earlier, and I truly feel that it needs to be closer to four hours per day per resident. However, I also want to recommend that we look at the federal guidelines related to individualized care and need in buildings and meeting, I believe when DSS testified earlier in talking about what an individual needs and accommodating that need, that is our federal requirement. Now, however, it is difficult to apply. It's hard to know exactly when residents change, and there's different people in the building and different people on a unit, what that acuity might be at any given time and how you measure that and how you make sure that there's enough staff to
meet the acuity for all of those individuals. Our program feels very strongly that we do need some mechanism in order to measure and hold accountable the staff that is actually in a nursing home. I have testified before to the fact that we do have, through Medicare or CMS, the ability to look by payroll-based journaling who is in the building at what time. However, that's about a quarter later. You see that about a quarter out. But having access to that and knowing that individuals are receiving the quality care that they deserve is very important. We do see that the staffing lists that are supposed to be reported every day in every building often are, they meet the minimum level or a higher than. However, the concern is some points with callouts, if people don't restaff, that's not actually who is on the floor at the time, although they may struggle and they may try to fill those hours, it doesn't always happen. So although we're seeing the staffing levels, that's not always what we're finding out is happening day to day.

I thank you for this opportunity to testify before you this morning and I'm open for any questions.

REP ABERCROMBIE (83RD): Thank you. And as our Long-term Ombudsman, I just wanna thank you for your work. I know you're new to this position and it's been a pleasure working with you this session. And thank you for your leadership on these issues. It's nice to know that we have somebody to call to try and figure out, you know, the devil's always in the details --

MAIREAD PAINTER: Mm-hmm.
REP ABERCROMBIE (83RD): -- to try and figure out what's the best way for us to move, what direction is best for us to move as a state. With that, Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman. And thank you so very much. I'm sorry I missed the very first portion of your testimony. As we talk about nursing home staffing levels, specifically, we recognize that it is lumped in together. Right, that a 2.3 is the accumulation of anybody that's gonna walk in that room and care for a patient in a given day. That is the minimum requirement. We also recognize that traditionally the head nurse or the charge nurse would do the medication and maybe some of the paperwork, but then the CNAs, in theory, are doing the grunt work. I mean, and that's not any disrespect to any, anybody that's caring for our patients. So, please, I want that to be made very clear. Is there a possibility, as we're moving forward, to try to figure out a way to address staffing levels? That we separate out the CNA work versus the medication, you know, administration and what have you? I know that you were sitting in here when I was talking earlier and comparing this to the levels of care for our children that are in preschools. And we have a much different threshold, and we could be feasibly talking about patients that are in sometimes very childlike states. So if we have a level of standard of care and a much more responsible and respectful level for our children, why are we not holding it for our elderly? But do we have that ability to separate out nursing hours of care versus CNA hours of care, versus OT or PT, which we also understand it could fluctuate between patients. But by lumping everybody in --
MAIREAD PAINTER: Mm-hmm.

REP. COOK (65TH): -- really does not give us the true crux of what's happening in a nursing home.

MAIREAD PAINTER: We can. And so one of the ways to do that is by defining what is "direct care." If you define "direct care staff," and by that definition apply the hours required, you would solve that problem. Right now, we have administrative staffing, nursing staffing that's administrative, and then we have nursing staffing that is direct care staff. And I would be happy to show, through that payroll-based journal, it actually breaks it down by license, by the type of care that's done in each home, whether they're a nurse, an LPN, an RN, if they're the charge nurse, they're the CNA, and it breaks it down by hour. I think that would be helpful to use.

But I also see the need on the acuity side to look at as the acuity in nursing homes has gone up -- Right, we have individuals that require more hands-on care. Their needs are different than they may have been 10, 15 years ago. That we also look at, what are the actual needs related to the individuals that are there. So if it is a nursing home that has a higher acuity, that we look at those staffing needs, versus a lower acuity. What is the population that they are directing their services and their best practices towards? And that we look at that, a home that had a lower acuity maybe has different needs. Maybe they have a higher population of individuals who experience mental health concerns. They may have individuals that have more physical disabilities that are rehabbing
in a different way and may need more PT/OT. And so we'd wanna look at that, the staff that are required for the individuals they're serving meet those needs, that we're not prescribing exactly what that is.

REP. COOK (65TH): I appreciate that. And I think it's, you know, as we're having this conversation, and it is a hard one to realize that we're not doing, we understand that we're not doing it right, but it's very difficult to swallow that this isn't being done at --

MAIREAD PAINTER: Right.

REP. COOK (65TH): -- at a level that's above the minimum requirements. And I think that when we start putting a number like a 1.9 or a 2.3, if we all just sat back and recognized how many times we cared for our own self in a given day, whether that be lunch, or going to the ladies' room or the men's room, or grooming yourselves, or all of those things, that is far beyond a 1.9 or a 2.3 hours of care for our own individual person. And that's because we can do it for ourselves. And so, as we're talking about numbers and dollars and cents, it's gotta be I think exactly what you were saying, and separate these things out. Because one level or one type of care is not the same as another. And each person does have a variance in needs. And so I really look forward to working with you and trying to figure out how to make this work and bettering the facilities and the quality of care that we do get for our patients and the great work that you do. So thank you. Thank you, Madam.
MAIREAD PAINTER: Thank you.

REP ABERCROMBIE (83RD): Further questions? I just have one.

MAIREAD PAINTER: Sure.

REP ABERCROMBIE (83RD): So I'd like to talk a little bit about 1066, AN ACT PROVIDING A VOICE FOR NURSING HOME RESIDENTS SUBJECT TO TRANSFER DUE TO NURSING HOME CLOSURES OR RECEIVERSHIPS. What role does your office play at this point when there is a receivership or closure?

MAIREAD PAINTER: We're notified as soon as there is a request or there is a bankruptcy. In some cases, we are the patient care ombudsman appointed by the court to oversee, to make sure that services and care in the home maintain throughout the bankruptcy hearing. In other cases, in all cases, we have a meeting at the nursing home right after the announcement. It is open to all residents and families to go over what their rights are, the right to an appeal. We work directly with DSS, The Money Follows the Person Program, we meet together that night, explain who people are who they'll see, and really encourage every resident and every family member to have an individual consultation to go over what their rights are, what to expect, the appeal process, have an assessment done, to truly understand what's covered by their insurance, whatever their insurance may be. We then follow up with the resident council. We meet with them on a regular basis. Department of Public Health meets with us as well with the residents to ensure that safety. And then there's weekly meetings in the
building a representative from my office, as well as DSS and most of the time DPH, are there as well to meet with the residents.

REP ABERCROMBIE (83RD): And do you send a notice to the residents or family members that might be on record as to what's going on with the nursing home?

MAIREAD PAINTER: Yes. That goes out simultaneously. There was, that was passed two years ago, that there was actually a notice received from our office that goes with the notice from the nursing home.

REP ABERCROMBIE (83RD): And on that notice, it states that the nursing home is either going into closure or receivership and what next steps are, and then you also set up a meeting with the residents to talk about their options?

MAIREAD PAINTER: Yes, we set up the meeting that -- That meeting is no, at this point, described in that notice. We're working on that. But that is the process that happens. Sometimes it's different when it is a bankruptcy. So federal bankruptcies run different than state bankruptcies in the process. And the different types of bankruptcy. One may be to restructure. And we're not sure what's gonna happen yet. So we, that may not be the process that we're talking to residents about, even though that process is starting.

We recently had two nursing homes this year that were in bankruptcy at a federal level, and they were able to restructure and the homes were able to maintain themselves and stay open and came out of bankruptcy. So we wouldn't want -- We're just
making sure that we're fully informing the resident councils, we're meeting with them. There was another receivership where -- There's been two, where it looks like there may be the option for a potential buyer, and one actually did sell. And so we just made sure we were meeting with those resident councils, meeting with the families, making sure that we're keeping them up to date as their representatives, knowing what's going on and what to expect.

REP ABERCROMBIE (83RD): So why do you think the proponents want to add another layer of having a public hearing? I mean, if you just had to think because you meet with the residents, you know this industry much better than, I'll just speak for myself, than I do. Why do you think that people would like a public hearing? What's the purpose of that?

MAIREAD PAINTER: The public hearing is the opportunity for resident family members and members of the public to have a voice, which I totally understand. I do think in some cases, there's been recent cases where there were bankruptcy court hearings where representatives from the Long-term Care Ombudsman program requested that the judge hear what the residents had to say, to hear to what some family members had to say, and members of the town, and the judge denied that. The judge denied that because under their guidance, they were only able to hear matters that pertained to the bankruptcy and that they felt it was inappropriate at that time, and that judge wouldn't allow the state ombudsman to move forward. That was a, the first time that had happened, but it was extremely stressful. It was
upsetting to residents and family members. They felt like they lost their voice on that. That was what reported to us. Although we were able to advocate for that, it's a different setting where the judge really felt that she needed to only hear matters that were pertaining to the bankruptcy of that case.

REP ABERCROMBIE (83RD): So even if we pushed, even if we moved this bill forward, we still can't change that process. We don’t supersede what the judge decision is about a public hearing.

MAIREAD PAINTER: Correct. And so that was my concern and what I wanted to make sure that you guys, we're all aware, that the Committee was all aware of, that whenever possible, we 100 percent represent the right and the, the rights and the voice of individual residents as it is their home. In some cases, we are just not able to fully apply that.

REP ABERCROMBIE (83RD): Thank you. I think that's very helpful for this Committee to understand what the process is and how this changes that. So thank you. Any further questions or comments? No? Thank you so much. We appreciate it.

MAIREAD PAINTER: Thank you and have a good day.

REP ABERCROMBIE (83RD): We're gonna go back to the public, and up first is Ann Pratt.

ANN PRATT: Good afternoon, members of the Human Service Committee. My name is Ann Pratt. I'm Director of Organizing of Connecticut Citizen Research Group and I am testifying on behalf of
7339, AN ACT CONCERNING PUBLIC INSURANCE OPTION.

CCRG strongly supports commonsense solutions that will address the disturbing increase in uninsured individuals, and ever-rising and increasing health insurance cost, out-of-pocket, prescription drugs, and premiums. The increase in uninsured individuals and the rising costs are in part due to the state's decision/need to reduce eligibility levels for HUSKY A parents from 2001 percent down to 155 percent in 2015. We believe it's really important that the state figure out a way to address the needs of those income level people who are struggling under these costs.

I wanna share with you a story of a neighbor of my parents who lives in Bridgewater, Connecticut. She was and is an individual single mom who was on HUSKY, helping her and to have really important access to care for an autoimmune problem/issue that she had. She then lost the HUSKY A coverage when they reduced the eligibility requirements, and she was without health insurance. She worked very hard and she was able to get a higher paying job matching her degree and her qualification. It was a great success story. However, the employer did not offer quality health insurance, so she took that health insurance, and now, just recently, she is saying that the gains that she had in the increase in income is being eaten up by the health insurance costs. She just went to a primary care physician for a regular visit for her autoimmune health concern. She paid $500 dollars for that single one-hour visit, plus another $500 dollars for blood work and prescription drugs. She is now basically faced with additional visits to the, for health care, and
she sees that there's zero sum gain for her in terms of this health care. And those are the kinds of things that a study of this insurance option would help.

We also just wanna add, however, some guardrails that we really think should be included in this bill. One is to strengthen significantly the language around appointing of Medicaid advocates. The bill that was considered last year, House Bill 5463, had much stronger provisions for Medicaid advocates to be appointed to this study group. We feel that that's very important. We also, obviously, stress the need to focus on that population of 2001 and below who are not eligible. We do not believe that the Office of Health Care Strategy should lead this study because of their role in SIM and sort of providing or suggesting that risk be put on to providers and patients. We just feel like it would be more appropriate to have a different entity leading this charge, and in specific, we call for specific protections on existing Medicaid recipients, no reduction in current eligibility, no reduction in current benefits, no change in cost-sharing protections, no reduction in current provider networks, and no change to the basic current manage fee for service payment in the Medicaid. We believe that those are what make this program strong and feel that that's very important to protect those things.

SENATOR MOORE (22ND): Thank you, Ann. Did you provide a written testimony?

ANN PRATT: Yes.
SENATOR MOORE (22ND): You submitted it?

ANN PRATT: Yes.

SENATOR MOORE (22ND): Thank you very much.
Questions? Representative Wood.

REP. WOOD (141ST): Thank you, Madam Chair. And thank you for your testimony. Can you tell me again the details of the $500 dollars? What kind of health policy is this woman on?

ANN PRATT: She's on a health policy that was provided through her work. So it was just a standard offer that her job provided. I don't know the details of what exactly the plan was, but this was what she had stated to me just this morning in terms of the costs on a regular primary care visit and blood work.

REP. WOOD (141ST): So it's something she pays a premium.

ANN PRATT: It's a private insurance. Yes, correct.

REP. WOOD (141ST): So it's not even on Access Health Connecticut, private insurance.

ANN PRATT: Mm-hmm.

REP. WOOD (141ST): Five hundred dollars for a doctor visit. Five hundred dollars for follow-up blood work.

ANN PRATT: Correct. Out of her pocket.

REP. WOOD (141ST): That, that just doesn't seem --
ANN PRATT: I mean, I can ask her to provide you more details if you think that's out of -- But, you know, the stories that we hear on a daily basis are, that is not out of line. As a matter of fact, we hear many times even worse. So I don't, I was not surprised by that. In terms of what I'm hearing from the field.

REP. WOOD (141ST): And no idea what she's paying in monthly premiums.

ANN PRATT: I think it was something like $300 a month. Approximately.

REP. WOOD (141ST): Okay. Thank you very much.

UNKNOWN: [Off Mic]

REP. WOOD (141ST): Thank you very much.

SENATOR MOORE (22ND): We're going to shift. We have someone with special needs that we're going to take right now. All right, her name is Gislene Batista.

TRANSLATOR: [inaudible 01:31:34]the Committee, so I just don't know if I'm going to be translating anything, because she only speaks Portuguese.

UNKNOWN: So you can sit to the left and just turn on your mic so you don't have to try and do that mic.

GISLENE BATISTA: (Through Translator) Hi, thank you for hearing me today, members of the Committee. My name is Gislene Batista. I am a mother, an immigrant, and I'm here today to speak in support of SB 1053, which is the ACT EXPANDING MEDICAID
COVERAGE HUSKY B FOR CHILDREN.

SENATOR MOORE (22ND): Thank you.

GISLENE BATISTA: (Through Translator) Being a mother of a child with cerebral palsy is not easy, but rather a privilege for the few, because they are children sent by God to make us better people.

My daughter's my heroine. Her name is Emily Batista. She is 11 years old. And for 11 years, I have been searching for a suitable wheelchair and good health care for her, but I have not been to and this has created more health problems for my daughter.

My daughter does not have a lot of movement, but she does have a lot of strength, a lot of will, and power. Emily is a very intelligent child, and this has helped our daily communication. I know Emily has wishes and dreams just like any other child her age, and I know she could be in better health and achieve those dreams if she could have better medical insurance and health care.

But these things do not work well for us undocumented immigrants, and this primarily affects and hurts our children.

These children, like my daughter, expect to have the minimum of dignity and care that they need to survive in this country, where health and education are rights that should be available and accessible to all.

I wholeheartedly hope that before you vote for or against this bill, please remember that these
undocumented children could be your child, your grandchild, or a loved one.

I ask that you reflect and look at all undocumented children as not one more in a crowd. I ask that you to allow these children to have the minimum rights they need so that their lives can have less suffering, and more respect and dignity. They are children, and as the word of God says, they deserve to receive all love and care.

As Jesus said, "Let the children come to me and do not hinder them, for the kingdom of heaven belongs to those who are like them," Matthew 19:14

Remember that one day, these children could be the pride of this nation.

Thank you.

SENATOR MOORE (22ND): And a child shall lead the way. Thank you for your testimony. Thank you for taking the time to come here. We appreciate that. Representative Hughes.

REP HUGHES (135TH): Thank you, Madam Chair. I'd like to ask Emily what she would like to be when she grows up.

GISLENE BATISTA: (Through Translator) She loves to dance. Maybe a ballerina, but she loves to move and dance.

REP HUGHES (135TH): And one more question for Emily. Who is her hero? Who does she admire?

GISLENE BATISTA: (Through Translator) Her father.
REP HUGHES (135TH): Thank you.

SENATOR MOORE (22ND): Thank you very much. Any other -- Thank you, dear. Next is Representative Perillo.

REP. PERILLO (113TH): Good afternoon, Senator Moore, Representative Abercrombie, Senator Logan, members of the Human Services Committee. I thank you for the opportunity to testify on, in support of House Bill 7335, AN ACT CONCERNING OUT-OF-STATE USE OF EBT CARDS. As you may know, this is a House Republican proposal and I'm proud to speak on behalf of the caucus in favor of it.

The bill obviously is intended to ensure, or at least minimize, fraud and abuse in our EBT system, in our Social Services system, specifically, in this case. It would require a individual who uses a card for 30 days consistently out of state, outside of Connecticut, without any other Connecticut charges, it would require that individual be assumed to be no longer living in the state of Connecticut, but then give, of course, that individual an opportunity to prove otherwise that they do still live in the state of Connecticut. There are a number of reasons, and I think it was mentioned by the Deputy Commissioner, there are a number of reasons why that individual could justifiably be using that card out of state and still in live in Connecticut. But as we know, there are also situations where they would not be doing so, and they would be using that card inappropriately.

I think it's important to know that this bill does not eliminate benefits, as I said, for those
individuals who are legitimately using their card out of state. It does not eliminate those benefits. It gives individuals the opportunity to illustrate that they do still live in Connecticut. And that's only, that only makes sense.

The other thing it does not do is it does not prohibit the use of the card out of state in any way, shape, or form. It is natural that individuals who live out of state, or who live in Connecticut, will use their card out of state. You have specifically in our border states of Massachusetts, Rhode Island, New York, we see that in the data and we would certainly expect that. But what this bill is designed to ensure is that individuals who clearly do not live in the state of Connecticut any longer no longer receive benefits from the state of Connecticut. This, as I said, this is a priority proposal for our caucus. And again, I appreciate the opportunity to testify in favor of it and would certainly entertain any questions or thoughts from the Committee.

SENATOR MOORE (22ND): Representative Hughes.

REP HUGHES (135TH): Why, thank you, Madam Chair. Thank you for testifying on our behalf. So what is your data on the amount of fraud that you know is going on that this bill hopes to address?

REP. PERILLO (113TH): Well, what we know is where funds are spent. And DSS, to their credit, was able to give us data from 2016 -

REP HUGHES (135TH): Mm-hmm.

REP. PERILLO (113TH): -- showing that money is
spent in other states and showing us which states in which that money is spent. No surprise, Massachusetts and New York are the states in which most money is spent outside of Connecticut. Interestingly, though, the third most common state where money is spent outside of Connecticut is Florida, which is kind of a surprise. Now, we don't have any more specific data than that here in Connecticut. But Massachusetts does. In Massachusetts, which actually has already tasked legislation to this effect, limiting out-of-state, inappropriate out-of-state spending, in Massachusetts, where I had said was very high, but they were actually able to drill down a little bit more deeply than just which state. In Massachusetts, they drilled down to the zip code. And ironically, they determined that the majority of Florida money spent by Massachusetts recipients, the majority of that money spent in Florida was spent in Orlando. There's only one thing in Orlando. Now, can we correlate that directly to the state of Connecticut? Certainly, we cannot. But rest assured, we will get the data to determine whether or not spending by Connecticut recipients in Florida is spent on vacation.

REP HUGHES (135TH): So this bill is an attempt -- Through you, Madam Chair. So this bill is attempting to create a barrier for families going on vacation to spend their EBT cards? Is that correct? Because it sort of sounded like you were saying that we are trying to find people who have moved out of the state.

REP. PERILLO (113TH): Representative, I believe that if you are a recipient of benefits from the
taxpayers of the state of Connecticut, and you can afford to go on vacation with that money, that's inappropriate.

REP HUGHES (135TH): So, the intent of the bill is really to capture that?

REP. PERILLO (113TH): No, actually, the intent of the bill is to ensure that funding is spent in Connecticut. Let me rephrase, funding is spent by true Connecticut residents for the things that they need. And I think that is the, certainly the intent of most people. We all want to see, in this room, we all wanna see the individuals who need services get those services. And we, this Committee has heard today, for years, and will hear today, again in the future from individuals who need benefits. And the intention of this is to ensure that those individuals get those benefits.

REP HUGHES (135TH): 'Cuz -- Through you, Madam Chair. I was really confused about the 30-day timeframe, because as one who takes a hell of a lot longer than that to move myself, I can't imagine that people who spend, you know, really moving their entire household, that can happen even within 30 days. So I am concerned that day-to-day people do a lot of business in bordering states, care for a lot of family, care for, you know, have all kinds of reasons, getting medical care in different places that we are requiring people to restrict their living to Connecticut when actually their needs may be beyond that.

REP. PERILLO (113TH): That's an absolutely accurate statement. What the bill proposes is that if
spending occurs out of state for 30 days without any other spending in Connecticut, that would trigger a presumption that the individual no longer lives in Connecticut. Obviously, if you live in Connecticut, you're spending money in Connecticut, you've got a doctor out of state, you have family out of state, your normal course of life takes you out of state and you have to spend money there, that that's not what this is focused on at all. This is focused on individuals who have not spent money in Connecticut for 30 days. And that's what would trigger the presumption. And again, also give that individual the opportunity to say to DSS, no, no, actually, I still live in Connecticut. And they can prove it and that's fine. We don't want to deprive individuals the ability to spend out of state when they need to spend out of state, assuming they still live in Connecticut. But that's a very, very good question.

REP HUGHES (135TH): And do you have data on that of what we heard from the Commissioner, I believe, that there was like 2.3 percent that they're looking at that's spent out of state and I don't know if you have any data on what's over 30 days?

REP. PERILLO (113TH): I'm sorry. Would you rephrase that question?

REP HUGHES (135TH): In terms, you said that you would like no, you know, 30 days, consecutively. Do you have any data on how much money is being spent out of state for 30 days consecutively by Connecticut EBT users?

REP. PERILLO (113TH): The only data I have is how
much money is spent out of state. I don't have data showing how much is spent 30 days consecutively without spending money in state.

REP HUGHES (135TH): Conversely, are you aware of how many Connecticut residents don't pay income tax because they maintain a residence in Florida for less than six months and a day?

REP. PERILLO (113TH): No, I don't. But, obviously, if individuals receiving these benefits live out of state for six months and a day, this bill would identify them. Because if they're spending money out of state for six months and receiving Connecticut benefits, this bill would effectively indicate that they no longer should be receiving Connecticut services.

REP HUGHES (135TH): I'm aware of that. But I'm just saying that we actually have a very high population of residents that don't pay any income tax because they live out of state largely in Florida or South Carolina or other places where there's no income tax. And that's fine. That's, we, we, you know, we give that a pass. But we're not giving a pass to people who are spending 30 days outside of Connecticut in their normal living pattern to receive EBT benefits, but we are actually giving those benefits to residents that don't pay income tax.

REP. PERILLO (113TH): We're not giving, this bill would prohibit -- I'm trying to follow. This bill would prohibit those individuals who are out of state for six months to receive those EBT benefits.

REP HUGHES (135TH): Right. I'm talking about
another counterpart of Connecticut residents that routinely don't pay any income tax because they live out of state for six months and one day.

REP. PERILLO (113TH): Yes, I understand that. So you're talking about the taxes themselves. That would be under the purview of the Finance, Revenue, and Bonding Committee.

REP HUGHES (135TH): Yeah, I'm just saying that it's not acceptable for you if anybody's receiving EBT to be out of state for longer than a month, but it's clearly completely acceptable for other Connecticut residents to not pay any income tax if they're out of state for six months and one day.

REP. PERILLO (113TH): What is not acceptable to me is that individuals who do not live here are receiving benefits from taxpayers in the state of Connecticut that could otherwise go towards purposes here in the state of Connecticut. It could be money for schools, it could be money spent elsewhere within the Social Service system for individuals who live here and need help. That is the focus of this.

REP HUGHES (135TH): Right. And we already give that --

SENATOR MOORE (22ND): Excuse me. Representative Hughes, through the Chair, please [crosstalk]

REP HUGHES (135TH): Yes, yes, I'm sorry. Through the chair, yes. Yes. I hear you. But we already, through you, Madam Chair, I'm just making the point that we already give that pass to people that don't live here for six months at a time and it's quite a generous subsidy that could be used on services in
Connecticut as well. Just making that point. I have a lot of problems with this bill and the premise behind it. And I'll just state that for the record. Thank you.

UNKNOWN: [Off Mic]

REP. MASTROFRANCESCO (80TH): Thank you, Madam Chair. Just a question, but first a comment. I understand that obviously there are people that live here six months and a day and they don't pay income tax, but most of those people pay property taxes. And they live in their respective towns, and they are contributing to our state by, you know, paying their property taxes. So I would respectfully disagree with my good colleague. They do pay taxes. Representative Perillo, do you know in other states like in Massachusetts, are they allowed to use their EBT card, I don't know what they call it in Connecticut, do they have something similar? Do you, does any, do you know that?

REP. PERILLO (113TH): Yes, they do.

REP. MASTROFRANCESCO (80TH): Through you, Madam Chair.

REP. PERILLO (113TH): Oh, I'm sorry. Massachusetts recognizes, as does the state of Connecticut, that individuals may be inclined to use their cards out of state. In fact, no surprise, Connecticut is one of the, has one of the highest incidences of Massachusetts recipients using benefits. The -- And Massachusetts has passed this legislation. The difference being that, as proposed here, the number of days is 30; in Massachusetts, it's 60. And,
quite frankly, I find 60 to be a reasonable number as well, so if it were, if there were a compromise position, maybe 60 would be it. I don't know if there is a compromise position, but I throw that out. [laughing]

REP HUGHES (135TH): You know my position.

REP. PERILLO (113TH): I do indeed, Representative.

REP. MASTROFRANCESCO (80TH): Thank you. Through you, Madam Chair. I agree. I don't think 60 days is certainly unreasonable and I, you know, I do think that there are people out there that probably don't live in Connecticut and they're still using their cards in other states. And I personally believe that you need to be a resident of the state and contribute something to society here in Connecticut to be afforded that. So I couldn't agree with you more. But thank you very much for your testimony.

REP. PERILLO (113TH): Thank you.

REP. MASTROFRANCESCO (80TH): Thank you, Madam Chair.

SENATOR MOORE (22ND): Representative Case.

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

REP. PERILLO (113TH): Good afternoon, sir.

REP. CASE (63RD): Just to follow up, a quick question. If somebody is moving, or lives out of the state for six months and a day, most likely they're not on state benefits. Is that a fair
assumption?

REP. PERILLO (113TH): I can't answer that question, Representative.

REP. CASE (63RD): So basically, what we're trying to drill down on, and the number is 2.6 percent that is used out of the state of Connecticut on the EBT cards. And for your -- Are you aware this is a cash card. Correct?

REP. PERILLO (113TH): Correct. This is, these are cash expenditures that I'm referring to.

REP. CASE (63RD): Okay. So I guess I just wanted to talk on, briefly, what we're trying, what the bill is trying to look at is not penalize anybody, but try to find where other dollars are being spent so that we can better service more people within the state of Connecticut. I don't think it's an assumption of people who decide to move down south for six months and a day, those aren't the people that we're looking at. It's more of people that actually don't live in the state of Connecticut that still have Connecticut benefits that DSS and others probably should be looking at and maybe are looking at, but we need to find an avenue and have a bill and a way to push to locate that and to stop it. Is that --

REP. PERILLO (113TH): Yeah, and you actually, Representative, used the word "penalty." And actually, there's not any sort of penalty in this bill. Some would argue there probably should be. But what this is simply designed to do is to identify folks who don't live here anymore and ensure that they're not continuing to receive
benefits.

REP. CASE (63RD): Thank you. And just, you know, Connecticut is very good at working with people with benefits and we wanna help as many people as possible. And I think we see that in, you know, some concerns that a lot of us have in the present Governor's budget that we're working on with some Social Service programs, you know, with the cut to MSP and other things. But we wanna make sure that we're servicing and using Connecticut state dollars to the best ability to make sure that we can impact the most people, and I think that's one of the crux and one of the reasons for this bill being brought forward. Am I not correct?

REP. PERILLO (113TH): That is absolutely correct, Representative. The singular goal of this bill is to ensure that Social Service dollars, specifically for EBT cards, which is the point here, are utilized by Connecticut residents, true Connecticut residents who need the benefits. That is the singular goal of this piece of legislation.

REP. CASE (63RD): I thank you for your time, and I thank you, Madam Chair.

SENATOR MOORE (22ND): Representative Wilson Pheanious.

REP. WILSON PHEANIOUS (53RD): Yes, if I may. The bill impresses me as being extraordinarily punitive toward the poor. That's my concern about it. Because it's making the assumption that people who receive EBT or who have, are receiving state benefits don't perhaps deserve to be out of state in the ordinary course of business. Their aunt,
grandmother, someone can't get sick in another state where they may need to go and attend to that person. We have eligibility requirements for getting on this program. We have redetermination that goes on on a regular basis. Of course, there may be somebody somewhere that's committing fraud. I don't doubt it, in any program in the world. But there's also a U.S. Constitution that protects people, gives them freedom of association, freedom of travel, and this bill would seem to constrain those people to whatever business they might have out of state, it better take place within a 30-day period or you will begin to try to remove them for benefits. And it just seems extraordinarily punitive. I understand the issues that Representative Hughes was raising about the difference in the way we treat people according to whether they're rich or poor. And my concern is that while of course we all wanna keep, we wanna get the most we can from Connecticut benefits for Connecticut residents, in this bill, it would appear that you are restricting the travel and the basic rights of individuals on EBT to exercise the freedom of their lives like every other citizen. I think the Constitution protects that. I think that's the reason why you can, why every state has, why you would have to be able to allow people to use benefits in any state that they travel in, and I think that's just a basic human right. Given that you don't have statistics for Connecticut that show that there are extreme abuses in this area, I just wonder what the genesis of this is, if not what I'm assessing it as.

REP. PERILLO (113TH):  Representative, I think actually you have a very legitimate concern. But I want to address it.
REP. WILSON PHEANIOUS (53RD):  Mm-hmm.

REP. PERILLO (113TH):  Again, the bill does not prohibit anyone from traveling out of state, and I think --

REP. WILSON PHEANIOUS (53RD):  It can though.

REP. PERILLO (113TH):  -- the example you give of somebody who has to care for a family member --

REP. WILSON PHEANIOUS (53RD):  Mm-hmm.

REP. PERILLO (113TH):  -- is an excellent one. The bill provides for an individual to illustrate that they still live in the state. You'll also note that the bill as currently worded is not specific as to what information should have to be provided to prove that somebody is still a legitimate Connecticut resident. I think that should be open to discussion. I think the input of the agency should be involved in that as well, and I know the agency testified in opposition. I respect that. But we, we also, we know what we don't know. And I think that, I speak for myself in this matter, I think any discussion about what should trigger someone's ability to continue to receive those benefits because they do legitimately live in Connecticut, I think that should be discussed. Because the intention of this bill, nor of anybody in this building, I believe, is to cut somebody out because they have to legitimately tend to affairs, be it family or business or otherwise, outside the state of Connecticut. But I, again, Representative, I thank you for the question. I think it's a very fair concern.
REP. WILSON PHEANIOUS (53RD): Right. Well, because my concern is that we are placing these constraints only on one class of people, on those that are poor enough to receive these benefits, that we're trying to constrain this particular group, make sure they stay in Connecticut, can't, you know, use these dollars -- I mean, can use these dollars out of state, but somehow, it just feels punitive and wrong to me. And I guess I'll be voting on that basis. But I thank you for your --

REP. PERILLO (113TH): Thank you very much.

SENATOR MOORE (22ND): Representative Abercrombie.

REP ABERCROMBIE (83RD): Good afternoon, Representative.

REP. PERILLO (113TH): Good afternoon, ma'am.

REP ABERCROMBIE (83RD): So I just, I just wanna make sure that people understand, when we talk about these cash cards, it's not just the cash assistance. All child support, which is considered cash, goes on these cards also. And under state and federal law, those recipients do not have to live in this state, so there's also some consequences to not just the cash assistance under this legislation before us. And I just wanna make sure that people understand that. Right. We do a lot to make sure that child support is paid. Right. And part of it is, it goes on these cards. Right, because it's more of a safety issue that way. So you can't, there isn't a differential in the system that talks about cash, that's cash assistance like SAGA and in cash that's child support. So I just wanna red-flag, you know, that that's my biggest concern about this at this
point. Thank you, Madam Chair.

REP. PERILLO (113TH): Representative, thank you.

REP ABERCROMBIE (83RD): Yeah.

REP. PERILLO (113TH): And actually, I had noted that from the agency's testimony. That was one of their concerns as well. And certainly, none of us in this building want to prohibit funding being spent for child support, absolutely not. But in this day in age, with the data systems we have, I would have to imagine and I would defer to the agency, they would know probably better than me, but if we -- We know whose cards, I would imagine, are also making child support payments, having child support benefits. So I see no reason why we couldn't carve that population out.

REP ABERCROMBIE (83RD): Well, actually, I don't think that our system is set up that way. So it also includes SNAP benefits, which would be considered cash, cash under SAGA, right, and then child support. So I don't believe that our system under DSS is set up, that they're separated in the system. So I think it's a little bit more complicated than saying cash assistance spent out of state over 30 days, we're looking at those individuals. The other thing is is that state, federal law allows this, which means suit could be brought against the state for not being in compliance with federal law, right. The other piece of this is that there is a certain period of time, and I think in DSS, I'm sorry, I'm trying to look at their testimony, but if residency, there are some precautions in here around residency. It is more
than 30 days. But there are some precautions in here around that, which I think is what you're trying to get at.

REP. PERILLO (113TH): Yeah, and, you are expert in this area. And you know the rules. But I admit what's frustrating is, I heard, especially from the agency, I heard a lot of reasons why we can't, we can't, we can't, we can't. You know, again, I would reference Massachusetts where this was an issue. It was identified and it was dealt with in Massachusetts. And the commissioner there of the sister agency, I was doing some research on this, said something that I think a lot of Connecticut residents would agree with. The comment was, "There is no amount of fraud or waste or abuse I will tolerate. One dollar is too much." So I find it very hard to believe that here in the state of Connecticut, we can't implement a few data monitoring systems that can make, or at least help to minimize that. Again, the goal of this piece of legislation is to ensure that services and benefits are provided to individuals who need those services and benefits and who live in the state of Connecticut. And does allow for folks to leave for certain business, as the representative mentioned.

REP ABERCROMBIE (83RD): Through you, Madam Chair, but this isn't fraud, so I think that we, so I would wanna see what Massachusetts is classifying as or clarifying as fraud, right. Under federal law, these individuals are allowed to use these cards out of state. Under child support payments, there is no requirement for them to live in the state, so I would, I understand what you're saying about looking at Massachusetts, but I would wanna know what the
criteria is that they're using under these cards. And maybe their system isn't as complicated as ours in the sense of, we use this card in all different programs under DSS. Maybe in Massachusetts, and I don't know, 'cuz that was your research, you know, maybe their cards, they have individual cards for the services. So you might have a card if you're SNAP, you might have a card if your cash assistance, and, oh, by the way, you might have a different card which is all in their computer that identifies what program you're on. We don't. We have one card that everything is put on. So I think it's a little bit more complicated than what Massachusetts is doing at this point. But I do appreciate the caucus bringing this forward. I understand what you're getting at, but I, you know, I have some concerns of the consequences of where this is going.

REP. PERILLO (113TH): I appreciate those concerns. I, if you want Massachusetts data, I can certainly gather it for you and get it for you. I do want to say, Madam Chair, I appreciate that we have these discussions in this Committee from time to time, and I also appreciate that we disagree, but those disagreements are not disagreeable. And I appreciate it very much.

SENATOR MOORE (22ND): Thank you. I have a concern. Trying to understand, where does your concern come from if you don't have data that proves that this is being abused in Connecticut? If we believe it's between 1 and 3 percent fraud, where is your concern that you think we can do better than that?

REP. PERILLO (113TH): Well, our concern, largely, I mean, a) we know that money is being spent out of
state. We also know that that's not necessarily improper or fraud. We know that in other states, it was identified as fraud. We also know that bills like this are a marathon and not a sprint. So we need to start the dialogue somewhere. I think this is a good place to start it. As I said, I and the House Republican caucus will be working with the agency to dive a little bit deeper into this data so we can draw some clearer conclusions. I think at the end of the day, regardless of on which side of the aisle we sit, I think we all want to make sure that funds go to the folks who need it.

SENATOR MOORE (22ND): So then I wanna respond to a comment you made about low-income people in Florida having a vacation. I'm disturbed by that comment. Because I could pay for someone to go to Florida and have a vacation, and I would want them to eat while they're there, so use some of their benefits while they're there, the same benefits they would have used if they were in Connecticut. So I wouldn't want to deprive someone of an opportunity to have a vacation. And I would doubt very seriously -- I've been to Disney in California and Florida. I can't afford to, as a working-class person, I can't afford to go inside any of those places more than three days when the ticket is $100 dollars a person. So I doubt very seriously that low-income people are going to Florida, staying for more than 30 days. I don't know anybody who could afford to stay there for 30 days and visit. So I also don't appreciate the idea that low-income people don't deserve a break or how they may get there, or that they go to Florida and stay for 30 days, and they're misusing their benefits. That's just a comment. I don't need a response from that. But I take offense to
that comment on behalf of low-income people who deserve to enjoy their lives and have that right under the Constitution.

REP. PERILLO (113TH): I very much respect your thoughts on that, sincerely, Senator.

SENATOR MOORE (22ND): Next up is Tom Swan.

UNKNOWN: [Off Mic]

SENATOR MOORE (22ND): You're my leader.

TOM SWAN: Senator Moore, Representative Abercrombie, other members of the Committee, my name's Tom Swan. I'm the Executive Director of the Connecticut Citizen Action Group. First, I wanna thank those of you that weighed in during the last discussion. I think you showed what some of the best of humanity, along with the earlier speakers that came up, and what this Committee is all about.

On behalf of our thousands of members statewide I want to thank you for hearing today H.B. 7339, AN ACT CONCERNING A PUBLIC OPTION. There's a lot of momentum for this this year. In the next hour, there's gonna be two bills voted on in the Insurance Committee, a public option. The Labor Committee voted in bipartisan manner 11 to 3 a public option bill out of there. What makes this important is this Committee is recognizing the central role that Medicaid plays in health care in Connecticut. And this bill also recognizes the importance of Medicaid in creating a more rational and fair health care system for the future. The high deductible plans that earlier speakers spoke about aren't working for anybody. Everybody hates them. A public option
building off, not necessarily part of Medicaid, has to be considered a central component of building a universal health care system that works for everyone. For anyone to argue otherwise is just wrong. Individuals should be able to benefit from the state's ability to control cost, people should not have to decide whether to take a new job or keep their health care, and a public option done right will build even more support to protect Medicaid.

While we appreciate you raising this bill, we recommend several changes:

We do not believe that any proposals that come out of this working group will really be able to address the issue unless we have a partner at the federal level. We do not believe this administration, with their hostility to people's health care will be a good partner within this; so, therefore, we're proposing you change the deadline for the working group to report back to the committees of cognizance in January 2021 and where then we can determine whether to engage CMS and the Department of Social Services nationally.

We also believe that the Office of Health Care Strategy should help staff this process and probably not lead it due to its role in pushing a scheme that would have put more risk on patients and providers as part of the SIM process. We believe in the office, but for this to gain the buy-in of key stakeholders, we should consider co-chairs from the membership of the working group. If this is just about rehashing that fight, it is a doomed to failure.
The legislation should make clear that current enrollees are to be held harmless.

Government officials currently in the legislation as being part of the working group should be non-voting ex-officios. And we should be more explicit with giving the Governor and legislative leaders appointing authorities similar to what other working groups have had.

And I also want to make clear that insurers should not be on this work group. It's a built-in conflict of interest. It's something that's looking to --

And then, I think if we're gonna be looking towards 2021 and building towards there as part of this work group, building off the stuff that other places, we need to figure out how to maximize what we're getting in terms of federal funds from Medicaid. Part of that, we think we should restore benefits up to 201 percent of the federal poverty level, particularly since it looks very likely that we will be raising the minimum wage this year.

And finally, we should also look to increase some provider payment rates so that there's not as much of a cost shift till we have more money if we're looking to potential a waiver in 2021.

Thank you very much for everything you do and for hearing me today.

SENATOR MOORE (22ND): Thank you, Mr. Swan. Any questions, comments? Is, did you submit --

TOM SWAN: I did. I did not till the Committee started, but I've got my reply saying, thank you for
submitting.

SENATOR MOORE (22ND): Thank you. I'll read through it to look for your recommendations.

TOM SWAN: Okay. Forgive the run-ons, please.

SENATOR MOORE (22ND): Anyone else? Thank you. Appreciate it.

TOM SWAN: Thank you.

SENATOR MOORE (22ND): I don't see Senator Kissel. I see Senator Kushner.

SENATOR KUSHNER (24TH): Senator Moore and Representative Abercrombie, it's so nice to be here today to testify before you, and I admire your leadership and the way you've been conducting this hearing. I've been watching it on T.V. And I do wanna be here to introduce Daniel Bustillo, and he's going to be speaking on House Bill 1051, AN ACT STRENGTHENING HOME CARE SERVICES. And he is the Executive Director for Health Care Career Advancement Program and he can address some of the issues around, in this still around training. So, I will yield my time to Daniel.

DANIEL BUSTILLO: Thank you, Senator. Good afternoon, Senator Moore, Representative Abercrombie, and members of the Committee. As was mentioned, my name is Daniel Bustillo and I'm the Executive Director of the Healthcare Career Advancement Program (H-CAP), a national labor/management organization that promotes innovation and quality in healthcare career education. H-CAP works closely with state
governments, employers, labor unions, and other stakeholders involved with health care career education in many states, including Connecticut.

Today, I am speaking in support of Senate Bill 1051, an Act Strengthening Home Care Services. Please note that in my testimony, I’ll be using the term “homecare worker,” which is an umbrella term. However, this bill only includes employees of private homemaker-companion agencies.

I have a personal background as a research worker and social worker in health care, as do some of my family members as homecare workers and nurse aides. Over the years, access to training allowed me to increase my job-related knowledge and skills, which helped provide better services to the clients I worked with. It has also facilitated my progress on a career path toward my present position to help support quality training opportunities for health care workers across the country.

Homecare workers are the unsung heroes of the medical profession in many ways. Yet many of these workers struggle to earn a living wage while working long and unpredictable hours at tasks that are physically, mentally, and emotionally challenging. The domestic roots of homecare render it often invisible, isolated, and unappreciated. Long considered traditional “women’s work,” home care is overwhelmingly done by poor women, and often women of color and immigrants.

High-quality homecare is integral to helping older adults and people with disabilities stay in their homes and communities and avoid unnecessary
institutional care, yet there have not been appropriate training systems set up for this workforce. As the health care industry undergoes rapid and unprecedented changes in the coming years, it is vital that homecare workers have the skills and resources they need to provide high-quality patient care in this new environment.

This bill would allow policymakers to begin to understand the current state of the workforce, gaps in training, and help the state plan for long-term care needs that will continue to increase throughout Connecticut in the next decade. The bill’s requirement of 16 hours of paid training within 60 days of hiring is in line with many other states; in fact, some states require significantly more training.

Massachusetts has standards at different levels for homecare workers, which are referred to as a career ladder for these workers. The Massachusetts title of personal care homemaker is comparable to that described in the Connecticut legislation, and Massachusetts requires 40 hours of training, plus 20 hours of personal care training by an RN, 3 hours of which is a practicum, along with 6 hours of annual in-service training.

New York State has had standards in place since the 1980s for personal care aides, which include 40 hours of training, plus a one-day practicum, before being hired, along with 6 hours of annual in-services.

The State of Washington has required 70 hours of “basic training” for all homecare workers since
2012, both independent providers and agency-based, which must be completed within 150 days of beginning their work, along with 12 hours on annual continuing education. Washington also has additional training requirements if the client has more than one “special needs” area.

This training does not take anything away from the self-direction that homecare clients give to their homecare workers. The client will continue to give direction to the homecare worker, and professional training will only improve the quality of care that is delivered.

I applaud you for considering this legislation. Ultimately, if we want to elevate this workforce for the benefit of the client and the worker, we will need to invest in training and education standards, as well as be able to look at the long-term care trends of the industry so we can better anticipate the needs of the industry. I hope that this bill will be a start of a journey towards fully professionalizing this workforce in ways that will create quality careers in the homecare industry and improve the quality of care that clients deserve.

Thank you for your time.

SENATOR MOORE (22ND): Thank you for your testimony. It was very thorough. Any questions? Thank you. Thank you, Senator.

DANIEL BUSTILLO: Thank you.

SENATOR MOORE (22ND): Karen Siegel.

KAREN SIEGEL: Good afternoon, Representative
Abercrombie, esteemed members of the Human Services Committee. My name is Karen Siegel and I am testifying today on behalf of Connecticut Voices for Children. We are a research-based child advocacy organization working to ensure that all Connecticut children have an equitable opportunity to achieve their full potential. I thank you for this opportunity to testify regarding HB 7339. We did also submit written testimony supporting SB 1053, about which I'm happy to answer questions.

We strongly support efforts to address rising rates of uninsurance in Connecticut and to make insurance affordable. Yet, how health insurance options are designed and implemented can have serious life-altering consequences. To that end, we respectfully submit recommendations for amending this proposal to address who the public option will benefit, how it will be structured, and how it will guard against unintended harm to enrollees in existing public health plans.

Specifically, we recommend requiring that the work group’s recommendations protect Medicaid eligibility, access, and quality; considering affordability for the lowest income families ineligible for Medicaid; including input from consumer advocates who are diverse in needs by both age and disability status, and racial and ethnic background, among other factors; that the working group’s output should address who the public option will aim to enroll, since a public option designed to reach low-income families would need to address different barriers than one intending to reach higher income families who are ineligible for cost-sharing subsidies on the state marketplace; that the
working group be required to detail how offering would be structured and implemented, and that's because plan administration can have a significant impact on both the network of providers and the administrative costs; and we also recommend clarifying, in section 1.c., how stakeholder input will be gathered and included and specifying that that input will include perspectives of families with young children, people with disabilities, and people of color.

So while striving to ensure that all Connecticut residents have access to health insurance, it is crucial to protect the dramatic success of our state’s unique Medicaid program.

Thank you all for your time, and I'm happy to answer any questions.


REP HUGHES (135TH): Thank you. Through you, Madam Chair. Thank you for your testimony. So can you describe a little more fully what the drop-off concern is of people losing eligibility under this, in terms of --

KAREN SIEGEL: In terms of whether or not people would lose access to Medicaid?

REP HUGHES (135TH): Yes. In terms of that cliff, with income eligibility.

KAREN SIEGEL: I think in terms of this specific bill, there isn’t necessarily a threat to income eligibility except that any time we open up the
Medicaid program to change, that becomes a recommendation that is heard and discussed.

REP HUGHES (135TH): Right.

KAREN SIEGEL: There are some concerns around getting these lowest income family members who lost their access in 2015 --

REP HUGHES (135TH): Right.

KAREN SIEGEL: -- access to health insurance and whether or not any public option would be affordable to them, or really whether or not an actuarial analysis would show that it makes more sense to restore Medicaid eligibility for them.

REP HUGHES (135TH): Right, that's what I was getting at is where your recommendations fall in that spectrum.

KAREN SIEGEL: I think we would really have to do an actuarial analysis. I think at a minimum restoration to 201 percent makes sense because it's aligned with child eligibility.

REP HUGHES (135TH): Okay.

KAREN SIEGEL: And we know that when parents have coverage, children have coverage too.

REP HUGHES (135TH): Right.

KAREN SIEGEL: And it's confusing to families when the thresholds are different.

REP HUGHES (135TH): Right. Okay, great. Thanks for clarifying that. That's all.

KAREN SIEGEL: Thank you.

REP ABERCROMBIE (83RD): Sarah Eagan, Office of -- Oh, shoot! I was gonna say, she was there a minute ago. [laughing] I didn't see you bend down. Sorry. Office of the Child Advocate, sorry. Good afternoon.

SARAH EAGAN: Good afternoon. Good afternoon to the Committee, Representative Abercrombie, distinguished members of the Human Services Committee. My name is Sarah Eagan and I run the state's Office of the Child Advocate, and I'm here to testify on behalf of Bills 7339, 7336, and 1053, which are all bills to ensure people have access to meaningful health care. I really thought about -- I did supply written testimony for the Committee, but I really thought about what it was that I wanted to communicate, that I felt it was important to communicate on the record here today. And I thought about all the fiscal arguments in favor of extending health care to all people, which I believe that almost everybody on the Committee and I'm sure most people working in this building want to do. And then the answer always becomes, you know, well, what does it cost to do that? Right? These are conversations we have in meetings in this building all the time.

But I think it's, and I think it's, I think it's well acknowledged at this point that the ancillary costs of not providing health care to children dramatically outweigh the costs of providing it. And I do have a list of things that I want to talk
about with regard to that. But I think in my role as the child advocate, and not role as the state's chief health care economist, which would be a good role for the state to have, I think the most important reason we heard from the family that was here earlier today, you know, with their, the mom whose daughter was here with cerebral palsy, and her testimony is more powerful than anything that I can offer. And I think, yes, there are financial arguments for offering. There are economic arguments for having a public option. Right, I mean, we've all heard these. Our initiatives here in Connecticut don't exist in a vacuum. But at the end of the day, the phone at the Office of the Child Advocate rings all the time, and whether it's about special education, whether it's about benefits, whether it's about a kid in the hospital, whether the call comes from CCMC and a pediatrician, or it comes from mom or grandma, it is 90 percent of the time about a child who has special needs that are unmet. And you know what? I had a call like this just the other day. A call came to my office. And another person in the office took it, and she was talking to me about the call and it's a parent with a child who can't leave the house and has all these problems. And I started coaching the person in my office through the call. And I said, well, we have to figure out, you know, do they have insurance and what kind of insurance they have or do they have HUSKY or do they have nothing and have they called the state agency. And I said to this person in my office, unfortunately, every call we get like this, the first thing we have to figure out is not what the child needs, but what payer they have access to. Right, that's the world we live in. It's not about
what your 11-year-old needs, but who the identified payer is.

And at the end of the day, if the 11-year-old can't access primary care, if the family can't access what they need, they'll access it in an emergency room, which is expensive, not only for the hospital and for the state, but anything you can get outpatient primary care is three times as expensive to get in an emergency room. And all of those costs are passed off to the state either through higher, in health insurance premiums or in other ways. Right? There's no getting around that.

But more than the fiscal argument for ensuring that that 11-year-old has what they need is that what do we force parents into? What is the experience of raising a child and feeding them and caring for them and sending them to school, all the same things they want for their child that I want for my children? And for them to have needs that that family can't meet. Or to not be able to take your child to the doctor, to be afraid to take them to the hospital and what the implications are for you. To be forced to call offices like mine or to be too afraid to call an office like mine, to be too afraid to call the state to ask for help. It is, I think, a fiscal necessity to provide health care for all people in equitable and affordable ways. But it is a moral imperative. It is a moral imperative that we do this.

I have a new baby at home. I have three children. I have one child who has extensive specialized needs, is a walking set of pre-existing conditions. I think about how I provide health care for my
family. I think about how we provide it for all the children in this state. I have a five-month-old baby at home, and I think all the time, I think every time I go to the grocery store, every time I take her to the doctor, I think how lucky I am that I have the capacity to meet her needs thoughtlessly and relatively effortlessly. And to have this mom and her family come in not speaking our language. You know, coming in to talk this committee about her experience, and really asking that her child be treated with dignity, that her family be treated with dignity.

I am confident, I am confident that we have the capacity as a committee, as a state, as legislators with different ideas about how to solve problems, that we have the capacity to help families and children like that. I know that we can. And I, in my role as the head of the state's Office of the Child Advocate, I look forward to being part of that problem-solving in whatever ways that I can. We support all of those bills that are in front of the Committee today.

One quick record clarification I wanted to make. The Committee asked a question earlier about how many other states provide health insurance coverage for all children regardless of immigration status. I think the answer provided to the Committee was just one, California. It's actually six. And the District of Columbia, and that includes California, I have the list, Illinois, New York, Washington state, Oregon, District of Columbia, and to some extent Massachusetts. So states are finding a way to meet that need, right.
And I can't resist, my last comments will be on the financial piece of it which is, you know, the Connecticut Hospital Association has data on what hospitals face in terms of uncompensated and unreimbursable care, which is over a billion dollars in unreimbursed care for 2017. Connecticut children's medical centers' unreimbursable costs for 2017 rose 88 percent. All right, that's, that somebody in my office hears from on a regular basis about kids that languish in an emergency room, coverage, or no coverage, because they can't access the care they need in the community. And we know that that's the most expensive. The cheapest care is primary care. That's why there are mandates around pre-deductible coverage for vaccinations, for physicals, that's why we have requirements about mammograms, cholesterol checks, et cetera, to some degree, because those cost benefit analyses have already been made. They're present in Medicare, they're present in the Affordable Care Act, they're present all throughout our current insurance system, because decisions have been made both by insurers and policymakers that providing that level of primary care is essential to not only controlling cost but insuring healthy children and adults. So to me on all levels, moral, equitable, spiritual, which we heard about too. I won't make those arguments, but I'm glad somebody did. It's work that has to be done. And I'm excited to see all these bills under consideration by the Committee and I'm grateful for the opportunity and the privilege of testifying on it today.

REP ABERCROMBIE (83RD): Thank you. And thank you for your work. And I think the thing that is the saddest that I see as a state and as a nation is
people that have what they thought was good insurance and still cannot provide for their children, especially individuals with special needs. I refer families to your office and to the health care advocate's office all the time to be able to go after these insurance companies. So when people say there's options out there, sure, if you want a $10,000-dollar hospital deductible. If you want a $1,000-dollar deductible to go to the doctors, sure, there's options out there, but what we're talking about is affordable options. And I think, I agree with you. People have the right to be healthy. People have the right to insurance. And we as government have an obligation to provide this.

So I agree with you. You know, there's gonna be a lot of conversations around what does that look like. You know, Medicaid is an option. States are looking at it. It's not unique to Connecticut. And so there's gonna be a lot of conversations around this. But I think the biggest thing is, people are scared to death about what's gonna happen under the Affordable Care Act and how families are gonna go forward with that. Especially with pre-existing conditions. Right?

So I thank you for your work. I thank you for your leadership. It's always a pleasure to work with you, especially since we work on the DD work group together, and you're right, we hear from the hospitals all the time. You know, CCMC is really the only designated children's hospital in the state. Right? They take all of our Medicaid kids, and we know we don't pay enough under Medicaid either. And then we wonder why they're in a deficit. Right?
SARAH EAGAN: Right.

REP ABERCROMBIE (83RD): So I agree. Representative Hughes. Oh, I think Jay was first.

UNKNOWN: [Off Mic]

REP. CASE (63RD): Thank you, Madam Chair. And I just wanna echo some of your things, you know, Sarah. If we could clone you into so many things, 'cuz as Representative Abercrombie, I do send a lot of people to your office. And I think that a lot of it too is, a lot of the people have difficulties maneuvering the system. You have a way of getting people to the system and to figure out what is best for them. And a lot of people are scared on how the system works, and I don't know how we get that out there more and get that to people, you know. A father of a 16-week-old right now. I mean, I'm scared for his future. Growing up with special needs in my family, my brother, you know, people don't realize what that medical costs for a special needs. You know, it was almost $5,000 dollars a month in medication for my brother, you know. And luckily my family was able to do most of that until a passing of a parent, but, you know, keep advocating. We'll work on it. I know Kathy, we talk about it quite often upstairs, and somehow, we'll get there. But you're right, you know, the children and all people of Connecticut, we deserve, and people deserve what is right. And we just need to get there. But thank you for coming forward with everything and we will do our best on this Committee.

REP HUGHES (135TH): Thank you, Madam Chair, and
thank you so much for your spontaneous and heartfelt testimony, and I just really, really applaud the Office of Child Care Advocate for unequivocally saying that all children deserve basic health care and basic needs, and that not to qualify that with their parents' status or anything else. Or socioeconomic status or zip code or where they live or what their color is, all children. And we, as a state, have a responsibility to our state's children that live with, within our state, regardless of who they are or what their name is or what their language is. And I just really appreciate it. And thank you for that advocacy.

SARAH EAGAN: Thank you.

REP ABERCROMBIE (83RD): Further questions or comments? Thank you, Sarah. Have a great day. We'll see you soon.

SARAH EAGAN: Thank you.


ELLEN ANDREWS: Hi. I'm Ellen Andrews from the Connecticut Health Policy Project. We are a nonprofit, nonpartisan organization, and we're gonna have our 20th anniversary coming up this year.

UNKNOWN: [Off Mic]

ELLEN ANDREWS: Very proud of it. We were created 20 years ago because of the kind of stories that you're hearing right now. We heard that from people, and we get that every day, about people who cannot afford insurance, and I completely agree with
everything that's been said about the need and that health care is a right. It is an absolute right.

Unfortunately, I've also been around, maybe fortunately, I don't know, I think I'm in a rut. I've been around for even longer working on Medicaid in Connecticut. I staffed the Medicaid Council, what's called something different -- And we're not getting a new staffer, but ever since I left, I've been on the Medicaid council. So I was around for times in Medicaid that were, you know, as challenging as the program looks now, it was way worse. It was way worse. And anyway, we have gone leaps and bounds in improving it.

There are many good ideas floating around the capitol to address the fact that the uninsured rate went up by 22,000 people last year. That's reversed a four-year trend of going down with the Affordable Care Act. So we need to do something about it. And, but a public option based on Medicaid is not the right way to go, in my opinion. We tried this in the past. And at first glance, Medicaid's appeal as a public option is understandable. Since 2012 when Connecticut fired private insurance companies, for the second time, from our program, per person costs are down. We are saving $968 million dollars a year now, compared to other states, from 2011 till now, we are not saving that much because they've been going up, and ours are going down. And after a year, that gap, years, that gap gets really big. So that's a lot of money. We do not want to go back there.

But despite spending less money, we've also improved quality of care, ED visits are down, hospital visits
are down. The first year after we fired the HMOs, we had 32 percent more providers coming in to the program. They hated the HMOs, almost as much as we did. So it, but, and so I can understand from a perspective of, you know, jumping on Medicaid, using Medicaid as a foundation for a public option. But it, the juice just isn't worth the squeeze, let's say. I have a friend who's an advocate from Texas and she uses that phrase all the time, and that's all I think of when I look at this.

We heard these same stories in 2008. Governor Rell, to her credit, created the Charter Oak Plan as an affordable coverage, bills piggybacking on the Medicaid program in 2008. And at first it was affordable, but that didn't last very long. And it ended up attracting higher-cost members for a variety of reasons that I can't get to in three minutes, but it's in my testimony. It ended in a death spiral. And so that was never available to more than 14,000 people, a tiny fraction of the number of people who were uninsured at the time, and it also harmed the underlying Medicaid program in two ways. They linked participation for providers in the Charter Oak program to participation in the Medicaid program, for which providers get paid for an average adult sick visit $46 dollars; under a commercial plan, they get paid $100, $110. So it's, the doctors who are doing this are doing it out of the goodness of their heart. They're not making, getting rich on Medicaid patients. But when they were asked to take on an even larger group of people, that was just too much for many of them, and we lost providers from the Medicaid program. The other problem --
REP ABERCROMBIE (83RD): Can you summarize, Ellen, can summarize? The three minutes went off, thank you.

ELLEN ANDREWS: Okay. Oh, that went off. Okay. We also lost because we had gotten rid of the insurers in 2008 and they came back because the Governor wanted Charter Oak. No other state has implemented this buy-in option yet. Other states are looking at it, but they're very different than Connecticut. So I really think that, while I understand why a Medicaid buy-in is attractive, there's lots of good ideas to make affordable, to make premiums affordable and, that won't risk and harm to the Medicaid program.


ELLEN ANDREWS: Thank you.


SHELDON TOUBMAN: Good afternoon, Representative Abercrombie, other members of the Committee. My name is Sheldon Toubman. I'm an attorney with New Haven Legal Assistance. I am here to testify in opposition to HB 7339, to the extent it would build off of the Medicaid program.

We obviously support affordable health coverage for those who are not able to afford insurance and who are higher than the Medicaid limits. But we don't think that this is the right way to go. We have a very efficient Medicaid program, as Ellen just
testified to. Nobody wants to go back to a capitated system, which was expensive and produced poor quality.

We support a public option, but there's grave dangers in using specifically Medicaid. And there was a question by Representative Hughes about what the dangers are. One is that we would be forcing 800,000 Medicaid folks back into capitation because that's what happened under Charter Oak that Ellen just referred to, where in order to entice the insurers to run Medicaid, they, to run Charter Oak, they were given all the Medicaid folks. So that's a major concern. Second thing is the provider networks were linked in the two cases. And then, even if the legislature didn't say we'll contract with MCOs, capitated MCOs, and took the risk, the state took a risk itself, then the risk is that while it starts looking expensive, if the premiums don't cover costs and then we have to cut Medicaid, because it all looks like Medicaid, even though the rest, that the real Medicaid program's still very efficient. So those are some of the concerns.

Attached to my testimony in the back are requests to -- If this is going to get passed anyway, please put in basic protections. It's not there. The language right now is basically, no offense, but it's useless. It's just says that the work group will study Medicaid protections for existing Medicaid recipients. It has to be explicit. The most important things to say that all existing Medicaid coverage groups, right in the bill, it should say, will see no reduction in current eligibility, no reduction in current benefits, in cost-sharing protections, no reduction to the
current provider network, and perhaps most important, no change to the basic current managed fee for service payment model. It has to be in the bill.

Other things are take on a mandatory start date. Include Medicaid advocates. The bill last year at least had that, three Medicaid advocates; this bill doesn't even provide for them at all. To ensure broad representation, we'd recommend also in the language we gave to you attached to my testimony is the suggestion that legislative leaders appoint the unnamed people.

Require the work group to focus most on lower-income folks. And we wanna point out that you can look at restoring HUSKY A. That's building on Medicaid, but it's actual Medicaid. And so we can just increase the income limits, and we can cover more people. And it should be looked at, what's more cost-effective.

We also recommend that the final report produced should go to the committees of cognizance which should then decide, you know, hold a hearing, decide which of the recommendations, if any, to adopt.

And lastly, I've already said at the beginning, which it's so important to specify what protections shall be in there. So it's not up for the work group, whoever these people are, to come up with it. It's said that these protections, which I think everybody would agree with, that we wanna make sure those things don't happen to the existing Medicaid coverage group. Should be in there, again, if this bill's nevertheless going to pass in terms of
building on Medicaid. Thank you very much.


I'm just gonna one more time ask if Susan Kelly is here. Seeing none.

We're gonna move on to House Bill 7335, OUT OF STATE USE OF ELECTRONIC BENEFIT TRANSFER CARDS. Kathy Flaherty. I saw her someplace, but I don't see her now. No Kathy Flaherty? Okay. Moving on to House Bill 7336, EXPANDING MENTAL AND BEHAVIORAL HEALTH. Kathy Flaherty again. Okay. Maybe she'll be floating in. House Bill 7337, DEPARTMENT OF SOCIAL SERVICES ENERGY ASSISTANCE PAYMENTS. Rosemarie Vinci?

UNKNOWN: [Off Mic] She had to leave.


STEVE SACK: Good afternoon. Thank you. My name is Steve Sack. I am a wholesale heating oil dealer in West Hartford, Connecticut, and I cover the entire state of Connecticut with terminals that supply heating oil to fuel oil dealers that deliver to homes.

I wanna talk about HB 773, that I'm in favor of it. The issue on my end that I've seen with this is that when payments are not made on time, it can shut down a heating oil dealer who's making deliveries to houses. They only have so much of a credit line with either me or my competitors. Just like anybody
has on their credit card, you hit your maximum and it shuts down. It doesn’t let you charge anymore. I can only go so far with the dealers to let them build up so much credit before I say, okay, I need a payment. Normally, they pay most of their bills in ten days or less, sometimes three to ten, depending on their credit. I, myself, as a major wholesaler, I'm either paying in advance or within two or three days of receipt of product. It is an expensive product. It is a large cash outlay. And it makes it very difficult for some of the smaller mom and pop dealers who participate in this program to help out the citizens to continue to run their business when they're completely strapped with the money being tied up in this program and can't get paid at all. And some have either had to leave the program, because they don't have $50,000, 100, 200,000 dollars to support the program. Most of their business, a lot of these people are getting paid COD on delivery for their current paying customers, but this, they have to float for 30 days. And it can be very difficult on them. It's no different than you have a credit card, you have a limit, you don't pay it at the end of the month because you don't have the funds, it gets shut down. ATM card, you don't have any money in it, you can't use it, you don't get to buy food or anything. Just like these dealers can't keep their business running without getting the money for the products they've delivered and had to pay their wholesaler, and wholesalers have had to pay the manufacturers, all the way up the line. Thank you for giving me the time. If you have questions?

REP ABERCROMBIE (83RD): Thank you for your testimony. So this year was unusual though, right?
I mean, since we put in the 30 days two years ago, we didn't have this issue last year. Correct?

STEVE SACK: Of the slow payments?

REP ABERCROMBIE (83RD): Yeah.

STEVE SACK: We've had slow payments for as long as I've been in the business, you know, with my clients.

REP ABERCROMBIE (83RD): Yeah, but, well, so let's go back a little bit. Two years ago, we put in a 30-day requirement under the CAP agencies to pay once they get the receipts from the oil vendors. My understanding is that there wasn't a problem until this year, which was due to the contracts with the CAP agency.

STEVE SACK: Yes, it made it much more difficult and they were getting delayed this year very much so, because when they went to the agencies to get funded to get reimbursed for their deliveries, there was no money there.

REP ABERCROMBIE (83RD): Right, because it was a delay in the system.

STEVE SACK: Correct.

REP ABERCROMBIE (83RD): But it was an unusual situation. I'm not justifying it. DSS should've known if they were doing new contracts, they should've put a cushion of time in there. Totally agree with you. But since we, as a legislative body, put in the 30-day requirement for payment, it really hasn't been an issue.
STEVE SACK: It's been much better, yes. But if there's no money in there to pay, then it makes it very difficult for them to --

REP ABERCROMBIE (83RD): Totally agree. And you heard me when I, when the commissioner was here, the deputy commissioner --

STEVE SACK: Yes.

REP ABERCROMBIE (83RD): I agree, you guys are small businesses and we really appreciate what you do in this program, so we know. We don't wanna hurt you guys and we don't wanna see you walk away from the program. So I totally agree.

STEVE SACK: Thank you.

REP ABERCROMBIE (83RD): Questions? Representative Case.

REP. CASE (63RD): Just a comment. Thanks, Steve, for coming up. So as Representative Abercrombie spoke about, we worked pretty hard on this two years ago to make sure. And there was a lot of language going around on the 30 days and the 30 days is of receipt or receipt of an invoice. And I think that, we heard from the deputy commissioner, once again, as the representative said, in regards to the contracts. But are you still seeing issues with yourself getting paid from these contractors or do we think we've pretty much put this to bed, other than the contract issues?

STEVE SACKS: In the beginning of the season, it put a pretty hard strain on everybody, because they were delayed in getting their payments. Especially in
the beginning of the season, it kicks in. Everybody needs a delivery the first, day one. Day one, it's crazy. We know, in our shop, order extra oil, bring extra supplies in because it's gonna go out the door. And it does put a huge strain on these, on most of the dealers, day one when the program starts having to outlay that much cash and waiting to come in, and then all of a sudden, some came to me and said, "Can you help me? I can't get money. They haven't paid me." So I then turned to my good friend, Chris, there behind me, makes a few phone calls and helps get some cash flow to these guys.

REP. CASE (63RD): Well, in -- Hopefully, we don't have this going forward after this legislation goes, but not to belabor any longer, but most of these people who are these small companies that deliver, when they deliver on the state contract, it's at a much less, lower margin than a normal customer would be. So the cash layout is that much more important because you're not making, you're doing it, a lot of these small companies do it to help out the state of Connecticut and to get these deliveries to the people. But the margins there barely make enough to cover the cost for that delivery to get to the house.

STEVE SACK: Yes, we, most of my customers, I mean, most dealers in the state of Connecticut deliver this at a much lower margin than they normally would get. For a multitude of reasons, they do it. For some reason, it's been going back since I've started here in the early 90s. You know, we seem to be the only industry that helps out, that participates in these programs. We go out day and night nonstop, and we get, we get to do it at a discount. You
know, when food assistance goes to Stop & Shop, people on food assistance, they go to Stop & Shop and they buy whatever, a loaf of bread and it's $2 dollars, Stop & Shop gets the $2 dollars. We only get, you know, if our price is $2 dollars, we only get, really, $1.75. So we do it for less. You know, everybody else that participates in different types of programs gets usually 100 cents per dollar; the oil industry does it for less.

REP. CASE (63RD): Okay. Well, I thank you for coming up. I think we've made some big strides in the past, was it last year or the year before, two years ago, and hopefully, we can keep moving forward and you can keep that guy behind you happy. Or he can keep you happy.

STEVE SACK: [laughing] Yes.

REP. CASE (63RD): Thank you.

STEVE SACK: Thank you.

REP ABERCROMBIE (83RD): Thank you. Have a great day. Chris.

CHRIS HERB: Good afternoon. My name is Chris Herb. I'm the president of the Connecticut Energy Marketers Association. We represent about 600 home heating oil and propane dealers in Connecticut and supply the state with about 500 million gallons of fuel every year.

We really appreciate you bringing this bill forward to focus on it, because it's a problem and the issues that we had a couple of years ago, and I agree with -- Your comments are absolutely correct
and your line of questionings of the deputy commissioner was right on. This was a one-time problem, but it's complicated because the trust in the program by small family businesses who rely, just on the testimony you just heard, who rely on credit lines to be able to not only be able to supply participants in the Energy Assistance Program, but their regular customers. When you compound what happened in New Haven just a, two years prior with what happened this year, the confidence in the department's ability to make sure that funds are, ultimately pay for these deliveries is being questioned and is not being questioned by one or two anymore. It's being questioned by larger companies who don't have as high of a percentage of customers that participate. And our concern and what we're managing for the department literally every day throughout the season is the questions that dealers have. Should we remain in this program in the future? I'm taking a 60 to 80-percent discount on my normal margin to participate because Mrs. Smith was, Mr. and Mrs. Smith were great customers for 30 years. Mr. Smith passed away. Mrs. Smith became eligible, and I, and we want to make sure that we're gonna reward their years of loyalty by remaining in this program. And to put family-owned businesses in a position where they're trying to decide whether or not they wanna, they need to continue to be in this program is a much bigger problem than what actually happened this year. I think, isolated, we would've never been here.

I'm a member of the State Low-Income Energy Advisory Board where I made a motion to ask that the department address this issue and the department was
the first one to resist and I was not able to get a second. I sat around a room with 20 other board members, and no one would even second the motion. And now I have to come to this Committee to ask for this to be addressed. I don't think we're asking for a big stretch. I think the commissioner responded to you when you asked the question regarding the impact that this might have and there was some testimony given by her about a federal rule that requires deliveries to be made within 48 hours of authorization. And although that is true, this bill, the authorization would never be generated unless the department issued that contract and those dollars were available. I mean, let's just get down to what happened is that small family-owned businesses were told, go make deliveries. They ran up hundreds of thousands of dollars of bills with their suppliers, like the previous testimony you heard, and then every year, and we've worked this out a decade-and-a-half ago when I first started, DSS and the community action agencies have worked out a system where we make the phone call and say, "Listen, this dealer is going to get cut off. They will not be able to make any deliveries to Energy Assistance recipients or to their regular customers unless you can cut an early check." The terms say 30 days, but in practice, we've been able to work out, especially those first few weeks, that they would get cash flow early on. We make the phone call, the check's ready, the dealer picks it up, they pay their supplier, everybody's fine.

This year, that wasn’t able to happen, because after three years advance notice, the department didn't have a contract prepared and distributed to some of the community action agencies. This is just, like I
said, I think it's tragic that family-owned businesses are being asked to question whether or not they should continue to participate in a program that is needed in these communities. We believe in this program. We've been partners with DSS, the community action agencies have made huge strides in working with us to get those payments made, but when the money isn't available even though the federal government's forwarded it to the state, it's unacceptable. And that's why we believe this bill needs to get passed.

REP ABERCROMBIE (83RD): Thank you, and thank you for bringing it to my attention when we were talking about legislation for this year. So I do appreciate that. So let me just ask you this. So the oil industry is a little different than gas and electric, right? Because our, your rate is determined on the price in New Haven Harbor, right? At the beginning of the season?

CHRIS HERB: Actually, actually daily. So --

REP ABERCROMBIE (83RD): Oh, it's daily!

CHRIS HERB: Yes, the New Haven rack average is established on a daily basis and then there is a discount off of that price. So it's actually the New Haven rack average plus a margin, and that margin is a discount off of our normal margin.

REP ABERCROMBIE (83RD): And how do we do gas?

CHRIS HERB: Gas, they're, natural gas and electric utilities are paid their full amount. They, it's, they get -- If gas is $2.00 dollars a gallon today, the utility, Yankee Gas gets paid $2.00 dollars.

REP. CASE (63RD): Thank you, Chris. So, basically, the bottom line is, and yes, it does go up to daily, but I guess your concern or your industry's concern is by the state of Connecticut not coming up with these funds right away, it's putting small business in jeopardy because they're buying product for other customers, not just the ones that are on this program.

CHRIS HERB: Correct. Yes, absolutely.

REP. CASE (63RD): So it's putting their credit line in jeopardy and no company, no company wants to put their credit line in jeopardy for a multitude of reasons.

CHRIS HERB: Non-energy energy assistance customers are typically given 30-day terms. But when your margin is that much higher, you're able to float them a little bit longer. When your margin has been reduced by 60 to 80 percent, and there's some percentage of your customers, a large percentage of your customers that may have received these deliveries, especially in those first couple weeks of the program, it draws down their ability to access fuel because that credit line is, ends up closing up because so many gallons are delivered early on. This is a problem that typically would not happen in January, but it always happens in November.

REP. CASE (63RD): And so, just for clarification, I'll enter this. There are territories within this pricing agreement that the state has with the oil
company. So it depends on where the deliveries are being made, what margin is being put on this.

CHRIS HERB: That's correct. I'm not sure, I think it's county by county, and every county has a different discounted margin based on their delivery tickets that they submit to the department, and it's recalculated periodically to determine what that margin will be.

REP. CASE (63RD): Well, I thank you. I think we have this nipped in the bud about 97 percent. We have about 3 percent to go, so thank you, Chris, for coming forward.

REP. ABERCROMBIE (83RD): Chris, we couldn't change the timeline of when we start to distribute the funds because we're held to a, we're held to the amount that we get from the feds every year. And it's dictated by their timeline. Is that correct?

CHRIS HERB: That is correct, but I wouldn't want you to have the impression -- There, every year, there are carry-forward dollars that were not spent in the previous year. So there's always start-up cash there. What happened this year had nothing to do with the timing of the federal dollars that were forwarded to the state. It was solely that contract problem. And I don't anticipate that happening three years from now. It's just, we, I need to be able to go back to these family-owned businesses and say, "You don't have any problems. The issues that occurred in New Haven where it took a year to pay you guys all the money a couple of years ago, we fixed that legislatively." And dealers returned to the program because you addressed it. This, again,
further eroded confidence in the program, and I wanna be able to go back to them to say, "You don't need to question your participation in the program. You don't need to worry about not being paid, because the legislature addressed that."

REP ABERCROMBIE (83RD): Thank you. Further questions? No? Thank you so much. We appreciate it.

CHRIS HERB: Thank you.

REP ABERCROMBIE (83RD): We're gonna move on to House Bill 7338, INCREASING FUNDING FOR ELDERLY NUTRITION. Joel, you're up first, followed by Erin Harkrader? Oh, good. Good afternoon. Representative Cook sends her apologies. She had to be in district for a family issue.

JOEL SEKORSKI: Thank you, and thank you for having me today, and thanks for raising this bill 7338. It addresses a couple things that are very important to the elderly nutrition. One is it highlights the two different funding streams that we have, and the other is that it addresses malnutrition, which is another major function that we provide.

The first piece of the bill is the COLA, and that's through the Connecticut Home Care program. It's been a long time that we've had to go with level funding with that program. I do realize that funds are an issue, but the minimal amount that a COLA, based on the CPI, would give us every year would put us in a great position. For an example, if you went back to 2007, we've gotten a total of 3 percent increase, which we're very thankful to have. But if we had just gotten 1.5 percent, which is the average
CPI, we would be at about 13 percent increase right now, which would be $2 dollars higher than we are right now in the average, which is about our average cost, for one. And two, it's still 5 percent less than what the average cost of living was over that period of time. So I think it's a justifiable ask. To nutrition, it would be very helpful.

The other thing that COLA would be very important to do for us moving forward is if the state is successful with increasing the minimum wage to $15 dollars, which we would all support. As elderly nutrition programs, we would love to pay more, but we don’t have the money. We would need some mechanism in there to help us balance that out if that is successful, like I said. In my program alone, I did a graph which was submitted with our testimony that shows it would be $68,000 dollars by 2023 in addition that we would need. And we're already losing about $80,000 a year, presently, in the program total. So you can see where that would be a major concern. Although we want to raise the wage, and we support that, it would be very difficult for us to do so being Social Service since we're already running at a deficit.

The COLA isn’t as important to our Older Americans Act funding because by contract, we go out to bid every several, every couple years -- It'll be a couple more years and we'll go out and we adjust the rate through the Older Americans Act at that time through our contract process with the AAAs.

I'd also like to say in the second piece where we're looking to go to the 2020 Census and have ENP participation, I don't think that the language says,
like the commissioner of DORS had mentioned, that
the ENPs have to be there. I think it just asks for
our input. I'm not a language expert, but certainly
any language that needed to be changed that just
required our input, which she agreed to -- She
thought that that was already in place. This is the
first year that she has been involved with the
meals, so I'm sure she's getting that information
from DSS. To my knowledge, in my 15 years, we
weren't included in that process. Or maybe we were.
You know, it's hard. We'd have to get together and
talk about that, so I do appreciate her concerns on
that and they're legitimate. As far as the 2020
Census, I think Representative Cook said it best
earlier today that we need something in there that
looks at rebalancing funds. There are areas that
are underserving and there's areas that are
overserving, and it's just merely, I think the
language says to take a look at it so that we're
aware of any imbalances that may or may not be
there. And again, I don't understand the whole
system. I know my little piece of it pretty well.
I certainly wouldn't want to unbalance nursing homes
or assisted living facilities or something like that
if that ended up getting tied to that, then that's
just something that needs to be addressed.

The final thing Erin will talk about is the
malnutrition piece. I think it would be great to
try to collect some data and have that used. It's
certainly gotten attention nationally to this bill
already because of that, and we're gonna read that
into testimony after. The ENPs in total do a great
job of reporting on how people are doing at home.
The drivers, you know, we've been over this a lot of
times in my past testimonies. I don't think I need
to say it today, but Meals on Wheels drivers see their people every day, and that's really important for collecting data, reporting data, and making sure the people are safe in their homes. So if you have any questions, I'd be happy to answer them. But thank you for the opportunity today and thanks for raising this bill.

REP ABERCROMBIE (83RD): Thank you, Joel. Thank you for coming up and thank you for your leadership on this issue. It was really wonderful to have you at the forum that we did in the fall to try and understand all of the different funding sources and who's providing them, so thank you. Representative Case.

REP. CASE (63RD): Thank you, Joel. Thank you for coming up and -- So, we always talk about these two funding sources. And when I visited your place, as I do often, if you were able to get the same dollar amount for the two funding sources, would that be a cost-effective savings to you? Because you're delivering two different meals.

JOEL SEKORSKI: Well, we're certainly delivering two separately funded meals. Right now, the one that's not working for us is the standard meal price; the one that is working for us is the one that we negotiate with the AAAs per region. So if Bill 7072 is successful, which increases the Connecticut Home Care Program by 10 percent, which would bring us back in line as I started off my testimony with, then, yes, that would be great. But the significant difference in that is that the Connecticut Home Care Program funded meals, we do not ask a donation from the client, and the Older Americans Act we do, so we
can afford to get a little less from the Older Americans Act funded meals.

It's about 60:40 in our region, 60 percent Older Americans Act, 40 percent Connecticut Home Care Program meals. They're blended within all of our programs that are doing both. The cost for us is synonymous, so it still costs us $12.50 to make that one meal that day, regardless of how we're funded for it because we have to look at the program as a whole. They use the same menu, they use the same trucks, they use the same drivers to deliver. So that's a difficult question to ask, because one is the AAAs and one the Department of Social Services, and I certainly am not in a position to fight both of those entities and wouldn't want to get at either of their, them, say the wrong thing.

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


ERIN HARKRADER: Good afternoon. I'm Erin Harkrader and I'm the director of the Elderly Nutrition Program for the Greater New Haven Area through LifeBridge Community Services. And I'm actually going to summarize a letter sent on behalf of our programs from the National Association and Defeat Malnutrition Today, their coalition, in support of this bill. And Bob Blancato, who is the national coordinator, wrote a letter which should be part of our packet, saying that the Defeat Malnutrition Today Coalition is strongly supportive of HB 7338 to increase funding for elderly nutrition, ensure
equitable rates for providers of meals, and collect and analyze data on malnutrition. They are, of course, especially focused on malnutrition and how our programs help affect the malnutrition of seniors.

So they're very keen on the fact that this bill does include data collection and language related to that data collection and how we quantify malnutrition in their seniors. And data included in the national blueprint includes the fact that up to one out of two older adults is either at risk of becoming or is malnourished. It leads to a four to six-day increase in hospital stays, and overall hospital costs can be up to 300 percent greater for individuals who are malnourished. I will note it does also increase the likelihood of somebody having a re-admission to the hospital if they are malnourished and they are not receiving proper nutrition, which as we know, a lot of seniors who get out of the hospital aren't able to cook themselves meals because they're frail, they don't know how, they don't wanna use the stove. There's a lot of different reasons. But it's a very easy issue to combat with the Elderly Nutrition programs and Meals on Wheels.

Recently, U.S. Secretary of Health and Human Services, Alex Azar, discussed malnutrition and cited HHS data, which found that Americans with malnutrition are twice as costly to treat at the hospital than those who come in well-nourished. He also estimated that malnutrition is responsible for some $42 billion dollars each year in health care spending.
So Defeat Malnutrition Today says that HB 7338 takes an important first step for the state of Connecticut with this language for data collection and analysis on patient nutrition. Better data can help the state to determine where resources may be needed and better data collection can also help advance a greater focus on prevention. As the bill notes, data collection analysis is for the purpose of improving quality of care and it should be universally supported.


ERIN HARKRADER: Thank you.

REP ABERCROMBIE (83RD): Thank you so much. We appreciate you being here.

Moving on to SB 1053, EXPANDING MEDICAID AND HUSKY B COVERAGE FOR CHILDREN. Adolfo Guzman. Good afternoon.

Good afternoon.

TRANSLATOR: Buenas tardes.

ADOLFO GUZMAN: (Through Translator) My name is Adolfo. I'm an immigrant. And I'm here today for the Bill 1053.

My opinion today is that it will be great if you guys can approve and support this bill. It would be extremely beneficial for all of the immigrant youth.

Also, you all know that it's very difficult for those who don't have medical insurance because in some locations, they are not taking care of you if
you don't have medical insurance. Like an example, when I attend a private clinic because I got a cut by an accident in my hand, they didn't take care of me because I didn't have medical insurance. And I ended in emergency room in a hospital and I didn't care if they're going to bill me a lot of money. However, since that day that I attended the emergency room, I still have a large bill that I'm not able to pay.

That will be very different if you guys can help us. If I had medical insurance, it would be great, because I didn't have to be worried about paying large bills and don't be worried and if I ever get sick, I can go to any hospital or any clinic. And I'm here today to ask you to please support this bill. Thank you.

SENATOR MOORE (22ND): Thank you for your testimony. So how is his hand? Was he able to get some type of treatment someplace?

TRANSLATOR: He finally got help in a emergency room, but again, the bill is astronomic.

SENATOR MOORE (22ND): All right. Well, thank you for your testimony.

TRANSLATOR: Gracias por la testimony.

SENATOR MOORE (22ND): Kathy Flaherty.

KATHY FLAHERTY: Okay. Yes.

SENATOR MOORE (22ND): Before you sit down. You have a couple of bills, Kathy?

KATHY FLAHERTY: Yes. Thank you, Senator Moore and
members of the Human Services Committee. I apologize for not being here earlier when you called my name. But I'm here now. My name is Kathy Flaherty. I'm the executive director of the Connecticut Legal Rights Project and I'm here to testify in opposition to two of the bills on your agenda and in support of two.

In opposition to the bill concerning out-of-state use of electronic benefit transfer cards and an act concerning Department of Social Services energy assistance payments, because really both of those bills don't reflect the reality of the lives of poor people and punish poor people for in the case of DSS not making the payments to the fuel vendors who deserve to get paid in a timely manner. You'll have people being cold. And that's just not acceptable, and shouldn't be acceptable in this state. And in terms of the act concerning out-of-state use of electronic benefit transfer cards, you heard even the department itself testify that people who live in border towns may shop in a town, closer store that happens to be over the state line. I do think it potentially interferes with Constitutional right to travel.

And I also just don't think we should be punishing poor people or making assumptions about their lives because of the fact that they happen to be poor and eligible for programs. I'm really disturbed at some of the testimony I heard by members of the Republican caucus who are proposing this bill, and I think especially when at the federal level, we just see policy after policy after policy that really is targeted towards hurting poor people in the name of saving government money when there is no
similar analysis of tax breaks that are given to large corporations or to really rich people. And I think we need to draw a line and hopefully you will just reject that bill.

In terms of HB 7336, AN ACT EXPANDING MENTAL AND BEHAVIORAL HEALTH CARE OPTIONS UNDER THE MEDICAID PROGRAM, I do think it's possible we don't really need that bill. But I know there are other bills in front of this legislature addressing parity, so I think making sure that Medicaid covers necessary behavioral health care options is good.

And expanding Medicaid coverage of telehealth services, the reality is is that there are reasons why we need expanded access to treatment. Telehealth would eliminate some of the problems that we see in the nonemergency medical transportation if people don't have to get transported to the doctor but can still access the doctor and get some services remotely, that probably would be a good thing and I'd encourage this legislature to do what they could to move that forward. I appreciate you calling me out of order and that's all I have unless anybody has questions for me.

UNKNOWN: [Off Mic]

KATHY FLAHERTY: Before, but it's on -- That covered all four, the two I like and the two I don't, so. [laughing]

UNKNOWN: [Off Mic]

SENATOR MOORE (22ND): Thank you, Madam Chair. And thank you very much for your testimony. I appreciate hearing your thoughts on these bills.
Question on 7335. On the EBT card. I agree, the border towns, I mean, that's a logical use of them and that we need to protect that. Do you feel differently if someone is using a card for one or two months when it's clearly they've moved out of state? Is that a, do you feel differently about that? Than border towns is for me, it's a nonstarter. I mean --

KATHY FLAHERTY: [crosstalk] Right. Here's really the problem that I have with that. I think even just assuming this is going on is honestly making assumptions that people come here because our benefits are so incredibly generous, and with all due respect to the Department of Social Services who have very hard-working people there, I don't think people are doing that. I just don't -- I have a very hard time believing that there are people who, let me come up to Connecticut, jump through every hoop the Department of Social Services puts in my way, oh, and they, assuming they will promptly grant those benefits right away and keep you on those benefits for as long as you are eligible for them, yet, you've really relocated out of state. I just don't buy that that was happening. I mean, we heard the myths about welfare queens driving pink Cadillacs back in the 80s and that wasn't true either. And, I mean, really? I think this is the latest version of that. And it's just really, as someone who's been a legal aide lawyer for more than 20 years, it's just really, it's downright offensive. And I really think that people who keep telling these stories need to be called out on that. Because I just don't believe it's true. I don't know where they're getting their stories from, but that has not been my experience representing my
clients for the better part of two decades.

SENATOR MOORE (22ND): Understand, and I certainly can understand your point of view on that. But just isolating it to if there is somebody, if, just keep it to the very, is out of state for more than a month or more than two months, is it reasonable that their benefits, and their -- With this legislation, I understand that there is a examination period where the person would be able to say, well, my mother or my father-in-law are ill and I'm out of state because of that, so there would be a safety net aspect to it. Do you still see the merit, any merit in one to two months if they're living out of state?

KATHY FLAHERTY: No, and this is why. In order to do this, you would have to set up another level of bureaucracy at DSS to process all this and do the verifications of all of this, and deal with the additional paperwork that's coming in. And for better or for worse, this department does not have a great record of processing redetermination paperwork, eligibility verifications, as it is. So I don't know why you would give them more to do with assuming not more resources to do it because of the budget. And I think you would not only cause problems for that tiny group of people who may be doing this, you'll also cause problems for everybody else who's on their programs. So I just think there's no good reason to do this. So I would encourage you not to.

SENATOR MOORE (22ND): Sounds good. Thank you very much for your thoughts. Thank you, Madam Chair.
REP ABERCROMBIE (83RD): So I want to say I share your concerns. I was actually, I really felt bad at the comment that was made about people taking, having a vacation, or being able to go to Florida. Like people who are low-income aren't entitled to have a vacation. Do you know the circumstances of why someone is where they are? I thought it was a very broad judgement. But I appreciate your comments also.

KATHY FLAHERTY: Thanks.

REP ABERCROMBIE (83RD): Thank you.

KATHY FLAHERTY: Thank you.

REP ABERCROMBIE (83RD): Thank you. So I think this is Deiny Corado.

DEINY CORADO: (Through Translator) My name is Deiny. I'm an immigrant. And I'm here for SB 1053. I believe that all the immigrants, I know we don't, we are not from this country; however, when we come over here, we are with the thought of to have a better future and not to damage the country. It is because we are looking for a better life, because in our countries we don't have that opportunity. And I believe that it would be great if we had the same rights as everybody else, like for example, to go and see a doctor.

Just a few days ago, I had a very bad pain in one of my tooth. And when I, the pain was getting worse and worse, I attended the closest clinic and the first question was if I have medical insurance. Obviously, I don't. They didn't take care of me,
because the money that I had, it wasn't enough to pay the whole bill. So they gave me an appointment, and in the appointment when I attended, they only charged me $500 dollars. Praise God, I have my mom and thanks of God, we were able to pay.

But it's other kids who coming over here, and they're alone, and if it was difficult for me, you can imagine for them, because they are by themselves. At this moment, I also have problem with my sight. I asked a friend in my school. She told her to go to the community clinic and she told her that they can't take care of me. I don't have medical insurance. So her friend told her to go to another place that they can take care of her. And that's the reason why I am here, because for me and some other ones it would be great if they approved this bill. Thank you.

SENATOR MOORE (22ND): Don't leave. Thank you.

DEINY CORADO: De nada.

SENATOR MOORE (22ND): Gracias. I wanna make you aware that the Connecticut Mission of Mercy free dental clinic is taking place April 13 and 14 in Willimantic. I know it's a bit of a travel for you, but I wanted to make that aware for short-term, short-term, that there might be some help, and to check 211 to see if the dental clinic is any, gonna be anyplace else in Connecticut. It's the Mission of Mercy free dental care.

TRANSLATOR: (Explaining)

DEINY CORADO: Gracias.
SENATOR MOORE (22ND): So maybe someone could check 211 for her.

TRANSLATOR: (Explaining)

SENATOR MOORE (22ND): I hope you feel better. Thank you very much.

TRANSLATOR: (Explaining)

SENATOR MOORE (22ND): Julia Rosenberg.

PEARL HODELING: Hi there. My name's Pearl Hodeling. My colleague Julia Rosenberg wasn't able to come today.

SENATOR MOORE (22ND): What is your name?

PEARL HODELING: Pearl Hodeling.

SENATOR MOORE (22ND): Thank you.

PEARL HODELING: Would I be allowed to speak in her stead?

SENATOR MOORE (22ND): Yes.

PEARL HODELING: Thank you. Senator Moore, Representative Abercrombie isn't here, and the rest of the members of the Committee, I am here to substitute for Julia Rosenberg who had a conflict today at the hospital. I'm a chief resident in pediatrics and Yale New Haven Hospital and an attending doctor at the Yale Pediatric Primary Care Center. I'm here to testify in support of SB 1053, AN ACT EXPANDING MEDICAID AND HUSKY B COVERAGE FOR CHILDREN. HUSKY and Medicaid allow children to receive preventative care and screening. Let me
tell you two stories.

I tend to the clinic on Fridays. This past Friday, I saw a 13-year-old boy for his annual physical. He is doing well in school and he actually also wants to be a doctor when he grows up. At this visit, we noticed he's falling behind in his growth. Failing to put on weight and height like his peers. This is a sign he may have an insidious chronic disease. His access to preventative medicine and continuous care, which cannot be provided by an ER or an urgent care center, allowed us to identify this subtle finding in the child, who seems to be doing otherwise well. We are now pursuing testing for a treatable chronic condition so that he can grow and develop like his peers.

Two Fridays ago, I saw a four-year-old girl for her check-up. At this visit, her mother mentioned in passing that she has headaches. On her vision screen, her vision is 20/80 in one eye and 20/100 in the other eye. She needs glasses. Without prompt identification and treatment with getting her glasses, she could go blind.

These two examples are just a fraction of the preventative care we are able to provide when children have insurance. We have made sure that these two children are healthy, but there are thousands of children, some of whom we heard from today, who do not qualify to walk through the doors of our clinic, undocumented children. For these 17,000 children, what easily preventable illnesses are we missing that we'll only find when it's too late. We heard today from a patient who required dental extraction that could've been prevented with
routine care. We know that cavities and poor dentition, for example, are one of the most common chronic illnesses affecting children. We know that Medicaid access is associated with better health outcomes, improved school attendance, higher rates of graduation from high school and college, and fewer visits to the emergency room. I hope that these two cases that I've seen illustrate how Medicaid access for children with early identification and treatment of health problems, some of which have really simple treatments, can prevent downstream chronic disability and sequelae of disease. Thank you.


JAY SICKLICK: Good afternoon, Senator Moore and members of the Committee. My name is Jay Sicklick. I'm the Deputy Director of the Center for Children's Advocacy, which is the largest nonprofit children's legal rights organization in New England.

I want to thank you for providing the Center and me with an opportunity to testify in support of Raised Bill 1053, AN ACT EXPANDING MEDICAID AND HUSKY B COVERAGE FOR CHILDREN. I also want to thank the Committee for raising this extremely important bill. It speaks for the Committee's commitment and the state's commitment to help equity and health care access, two pillars which this committee has excelled in striving for over the past several years.

Let me start also by reinforcing what Sarah Eagan
said about the number of states that are presently providing coverage to undocumented children and youth under 19. Six states presently do so, and she named those states, in addition to the District of Columbia. In fact, New York began providing coverage for undocumented children as far back as the year 2000. So this is not a new and innovative idea, and despite the fact that the Department of Social Services has talked about federal reimbursement not being available, other states have taken the initiative to provide the coverage for reasons which you've heard today.

It's not hyperbole to state that we're at a watershed moment in our country. The vitriol that's displayed on the national stage and cable news and on Twitter feeds everyday is really beyond description. Immigrant children who come to this country without legal status are vilified to the point where we argue about the definition of a metal cage and whether that constitutes humane and justifiable treatment. The reality is whether we agree or not to engage in the national debate is that we are a state not unlike every other state in the country. We have in our midst thousands of undocumented immigrant children who are present in our communities, schools, and health care systems. What we have chosen to do as a state is protect these residents by providing them with a Constitutional guarantee for an education, allowing them to become valued members of our cities and towns, and to treat them with the respect and dignity to which they're entitled.

But what's missing from this equation is the ability for a parent to access health coverage and health
care for their child, as any other parent would in this state, with the same available resources as we would provide to any other child who is low-income.

We know that these low-income children have the poorest health outcomes due to the social determinants that plague all at-risk families. Poverty besets higher rates of childhood asthma, obesity, and emotional trauma, all of which are assiduously addressed by pediatricians such as Dr. Rosenberg, such as Dr. Hodeling, and other pediatric and family medicine practitioners. But the children who are most at risk, those who may have suffered physical or emotional trauma thousands of miles away from Connecticut are often unable to access critically important primary and specialty care because they cannot obtain Medicaid or HUSKY health insurance. That is what SB 1053 seeks to address.

You have our written testimony and a report which I provided to the Committee, which is very thorough in terms of documenting the exact data upon which our positions are based and how individuals like Eni Kassim, who is a Yale law student who couldn't be here today, grew up without health insurance because he's an undocumented youth and now is part of the team that's helping all of us try to provide this coverage. Our task today is to encourage this Committee to begin the process of expanding the coverage that will make a difference in the lives of almost 17,000 children and youth in Connecticut for a small cost that will impact a lifetime of health benefits. Thank you very much and thank you for allowing us to testify.

SENATOR MOORE (22ND): Thank you. Any questions?
Representative Wilson.

REP. WILSON PHEANIOUS (53RD): Yes. Yes, sir. I'm wondering whether you have any idea of whether most of these, well, maybe, I was gonna say most of these 17,000 children that you're talking about are likely to remain here in this state or in this country once they have arrived. Or do you have any feel for that at all?

JAY SICKLICK: I don't, I can't say with any certitude, but what we know is that most of, and we're talking about individuals who have come here not on temporary situations like who are students or who are tourists --

REP. WILSON PHEANIOUS (53RD): Right.

JAY SICKLICK: -- but we're talking about either visa overstays or what you see on television every night, which are individuals who come into this country like these individuals here seeking a better way.


JAY SICKLICK: My gut feeling tells me that most of them will stay. Whether they stay in Connecticut is difficult to ascertain. But the idea here is to try to provide the best possible preventative measures to avoid long-term costs in the future and hoping that the discussion on a larger level takes place to provide a pathway to some of these individuals and have a meaningful debate that's far from this room, but perhaps is somewhere down the line, about allowing adjustment of status so that folks can in fact become permanent residents and citizens down
the road.

REP. WILSON PHEANIOUS (53RD): Right. I think my point of what I was getting at is that I do believe that many of these people will stay here, on to either become Connecticut citizens or certainly to stay Connecticut residents to the extent that there are preventative measures to improve their health, dental health, mental health. We will have whole citizens contributing to the society, whole people contributing to the workforce in Connecticut rather than sick ones. If someone gets sick enough to go to the emergency room near death, the emergency room is gonna take care of them. I mean, they're not going to turn them away. But it's gonna cost thousands of dollars that would, could be avoided if something were caught early, if, particularly when you're dealing with a child, if something could be dealt with in childhood. So my, what I was trying to get at is if, whether you know, whether you're in agreement with that assumption which I'm making that [laughing] --

JAY SICKLICK: I am. I am very much, and one point to that, Representative, is -- I'm sure you know this as well as anyone. When the state took great pains to expand coverage to youth --

REP. WILSON PHEANIOUS (53RD): Mm-hmm.

JAY SICKLICK: -- children and youth, and delinked Medicaid from the other public benefit programs --

REP. WILSON PHEANIOUS (53RD): Right.

JAY SICKLICK: -- we saw an incredible decrease in costs that would have otherwise have been borne by
the state in uncompensated care plans --

REP. WILSON PHEANIOUS (53RD): Exactly.

JAY SICKLICK: -- and then payments to hospitals, and I think one of the most productive things the state has ever done was increase access to HUSKY --

REP. WILSON PHEANIOUS (53RD): Mm-hmm.

JAY SICKLICK: -- by delinking asset tests and just making an income test and then providing the next band of coverage --

REP. WILSON PHEANIOUS (53RD): Right.

JAY SICKLICK: -- so that low-income, working people could provide reasonable coverage to children. That's the same principle we're applying, and why would we leave out a cohort of individuals who can then provide just as much productivity --

REP. WILSON PHEANIOUS (53RD): Exactly.

JAY SICKLICK: -- and go to school and become a law student or a medical student or whatever else it might be.

REP. WILSON PHEANIOUS (53RD): In effect, it's humane cost avoidance.

JAY SICKLICK: Correct.

REP. WILSON PHEANIOUS (53RD): Is what it is. Right. Thank you. I have nothing to comment.

SENATOR MOORE (22ND): So I'm -- Thank you for your testimony. I'm looking at the testimony from the
deputy commissioner. Her estimate is $64 million. I'm trying to figure out how can we have such disparate amount between the two. You're saying $15.5 million for a year, for year two --

JAY SICKLICK: Right.

SENATOR MOORE (22ND): -- 3.4 in the first year. Where's -- The number's different.

JAY SICKLICK: Well, I think that the deputy commissioner's assessment is based on every one in the HUSKY A band for Medicaid, as opposed to splitting some of those individuals off into the HUSKY B band, number one, which wouldn't reduce the amount greatly. But the data that we've provided in terms of cost estimate is based on a graduated increase in enrollment. You can imagine how difficult it is for states to actually enroll individuals who are without documentation --

SENATOR MOORE (22ND): Mm-hmm.

JAY SICKLICK: -- because of obvious reasons. So what we've done is we've extrapolated some data, for example, from Oregon and Washington state and others that are somewhat analogous, knowing that in year one and in year two, we will not have a full enrollment capacity because it's going to take an Homeric effort just to get people to enroll in this type of program. So the data is based on what we've perceived to be the number of individuals who might enroll in year one and then enroll in year two. It's extrapolated from other states where we know that this is a graduated climb. And I think the report that we provided to the Committee does have a chart that indicates the assumptions based on the
numbers as to where this will go based on prior data from other states.

SENATOR MOORE (22ND): So let's live in Florida right now and Disney, and let's say we had the money to do this. How do you see this being implemented?

JAY SICKLICK: Well, I think that there is a good model and that model is -- The statute, for example, in Oregon, which is the most recent state to expand Medicaid to undocumented children, has a entire kind of model or template for the state agency and its partners to work on ramping up the type of outreach in the community that would be necessary to not only encourage but to assure individuals that reporting personal data to the state would not put them in jeopardy as is very much the case, I suppose, with individuals who have children who are born here, but they may not be documented. So that's also a difficult pattern. But I believe that the department and the state has within its infrastructure the same outreach that they've done in HUSKY for years; it would just be expanding that to the next level of individuals who would be eligible because of their documentation or lack thereof. But it's not an easy ask. I understand that and it might take -- I think the deputy commissioner was correct in asserting that there would be some additional expenditures necessary to do community outreach in terms of understanding the language issues and other barriers that might prevent people from just understanding the concept of health insurance and then moving toward assuring and then providing assistance in enrolling and then providing all the, the type of assistance that HUSKY already has in its infrastructure.
SENATOR MOORE (22ND): So that would require more staffing?

JAY SICKLICK: It might, but again, given the first two years and the numbers, it probably would require minimal additional staffing, but I don't, I don't have the inner workings of what the department's infrastructure is in terms of HUSKY outreach these days. I mean, I don't think they do as much as they used to because there's such a high percentage of individuals who are enrolled. But I think given the opportunities that exist within the networks of community action agencies and different partners that are utilized in the enrollment of HUSKY and recertification, I think the infrastructure is already in place and I think that that could be utilized in a way that then could provide outreach to this particular community.

SENATOR MOORE (22ND): So that's utilizing staffing that's already being done for low-income people coming in applying for different services? They could be a part of that?

JAY SICKLICK: If you think about the fact that these are agencies that are already committed to the enrollment for programs for low-income individuals, whether it be for any kind of SNAP, for example, or other public benefits or fuel assistance that we were just hearing about, I think that the ability to provide that additional outreach to those communities could be, at least it could be a foundation. I can't say for absolute certainty that there wouldn't need to be additional staff to provide other types of assistance, such as language access, but I think that the foundation is in place.
But I'd be remiss if I said that there would not be a need for additional staffing.

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

JAY SICKLICK: You're quite welcome.

SENATOR MOORE (22ND): Is Sarah still here or did she give all her testimony? Sarah Eagan.

UNKNOWN: [Off Mic]

SENATOR MOORE (22ND): Okay. Thank you. So then Maria Lima.

UNKNOWN: [Off Mic]


UNKNOWN: [Off Mic]

SENATOR MOORE (22ND): Okay. Thank you. What about Maria? Maria did also?

UNKNOWN: [Off Mic] Yes.

SENATOR MOORE (22ND): Thank you very much.

JONATHON GONZALES: Good evening, members of the Human Services Committee. My name is Jonathon Gonzales Cruz. I am a graduate student at University of Connecticut pursing a master of science in quantitative economics as well as the policy coordinator at Connecticut Students for a Dream. Connecticut Students for a Dream is a statewide youth-led organization that fights for the immigrant, for immigrant rights and their families.
And today, we stand in support of AN ACT EXPANDING MEDICAID TO UNDOCUMENTED CHILDREN.

Just to address the issue, right now in the state of Connecticut, there are only two feasible ways that an undocumented individual could obtain health insurance. The first is if you are a full-time student on university, but with that you are paying on top of out-of-pocket tuition for your cost, and then insurance through there is $3,000 dollars alone. And then the second way is through your employer. But unless you are one of the 8,500 DACA recipients, obtaining it through your employer legally is unfeasible as well. Given that there are an estimated 130,000 undocumented individuals in this state and given the limited options of obtaining health insurance, as a parent or as someone who wants to get insurance for your children, it is very unfeasible at the moment. Given that, it is a very big public health concern. The fact that there are an estimated 17,000 undocumented children without access to health insurance, because then their health issues will continue to develop if left untreated.

And secondly, it is an economic equality issue. As we all know, uncompensated care costs are distributed across both the public and private sector, so one way or the other, the state of Connecticut is paying for it. But we see that it's better to insure the children, so that way they are able to get the preventative services that they need, so then that their health issues don't develop and then cost more and then are harder to treat. And it is also an economic equality because in the state of Connecticut, undocumented taxpayers
Contribute approximately $145 million dollars in state and local taxes alone, $252 million in federal taxes, and out of that, I believe it's $57 million that goes into Medicare and $127 million that goes into Social Security. And that's according to a study conducted by the New American Economy report. And so in turn, us undocumented taxpayers, we are contributing into the state health care programs and all we are asking is that our children are eligible to access the very same insurance that other children throughout this state are able to access. Because we should not be discriminating on helping children based off the fact that one child has a piece of paper that says "citizen" and then the other one doesn't.

So in summary, we do hope that this Committee does vote favorably and then sends it to the floor and then the Senate so that it can become a reality and that the children are able to get the proper care that they deserve. Thank you.

Senator Moore (22ND): Jonathon, did you submit written testimony?

Jonathon Gonzales: Yes. It's online.

Senator Moore (22ND): Okay. I just want to, first of all, congratulate you on your education and your ability to articulate your case. Were you on the debate team?

Jonathon Gonzales: No. [laughing]

Senator Moore (22ND): Very thoughtful.

Jonathon Gonzales: No, just -- Thank you.
SENATOR MOORE (22ND): Very well thought out. I'm gonna, I wanna see your testimony so I could use some of those phrases that you used. It was very good. Thank you. I appreciate you coming here today. Questions? Representative Wood.

REP. WOOD (141ST): Thank you, Madam Chair. I thought the same thing. Very articulate. And thank you for your testimony.

JONATHON GONZALES: Thank you.

SENATOR MOORE (22ND): Make sure you, I see that testimony so I can pull some things out.

JONATHON GONZALES: [inaudible 03:46:37]

SENATOR MOORE (22ND): I wanna say how well thought out it was. I'm not surprised that you could articulate it. I'm just impressed with the level of thinking that went into that testimony.

JONATHON GONZALES: Thank you. I appreciate it.

SENATOR MOORE (22ND): We’re now on Senate Bill 1051. Julianne Roth.

JULIANNE ROTH: Good afternoon.

SENATOR MOORE (22ND): Good afternoon.

JULIANNE ROTH: I commend you for your ability to sit through all of these hearings.

SENATOR MOORE (22ND): I stopped to get a little something to eat. I cheated today.

JULIANNE ROTH: [laughing] Thank you so much for
allowing me to be here today and for all of the work that you all do. My name is Julianne Roth and I'm here today as the board chair of the Association of Connecticut Home Care Agencies and also as the secretary of the board for the Home Care Association of America. I am also the founder and owner of Companions for Living in West Hartford.

As I’m sure you are aware, the home care industry is essential in the services that it provides to our seniors in the state of Connecticut. We have over 600 companies in Connecticut who provide both private pay care as well as care for folks who are on waiver programs. And home care allows individuals to remain in their own homes by providing an extra pair of hands to assist with activities of daily living. Services are offered to clients with needs ranging anywhere from companionship all the way through end of life care, and the folks who we employee at our agencies are essential in the continuum of care. Without the services that we provide, a lot of these folks would be forced to move to a nursing home or family members would have to take care of them and thereby leave the workforce potentially.

There are four components to SB 1051 and I'm gonna outline each of those four and then a response to each of them if that would be okay.

The first is to report personal information for every employee including their full name, job title, date of hire, gender, home address, mailing address, telephone number, email address, employer name, and all training offered by employer. This list would then be compiled into a directory, including
specific information which would be made available to the general public. Our response to this is that this is an overreaching requirement that conflicts with employee privacy requirements. Connecticut personnel and privacy laws prevent employers from disclosing any individually-identifiable employee information with any outside entity. Further, this provision does nothing to achieve the objective of this bill, which is to strengthen home care services.

The second provision is the training requirement for all employees. We do not disagree with having a specific training requirement, or specific training standards for home care workers, although those in this provision are overly aggressive. If we're to create training standards, we should take the time to determine what is reasonable and really sit down as a group and think about this, instead of just throwing numbers against the wall. Additionally, if home care agencies are held to these standards, the requirements must be ubiquitous for all home care workers. That would include those who provide services under all state waiver programs and those who are privately hired by the consumer. It's unreasonable to expect one segment of workers to maintain standards that others doing the exact same work are not required also to uphold.

The third provision is background checks. This is a redundant provision as we're already required as agencies to do background checks on all of our employees. And that's a DCP requirement.

And then the fourth requirement or the fourth provision is annual cost reports and audited
financial statements. This again is overreaching. What other industry would be required to provide financial records for privately held companies? I don't know of any industry that's required to do that at the state level, nor at the federal level. Further, the provision does nothing to, again, to achieve the objective of this bill which is to strengthen home care services.

So while we feel that this bill is overreaching, it exclusively and unfairly targets one industry. SB 1051 would require HCA, home care agencies, to standards that no other industry is, nor ever has been required to comply with. Should any of these provisions become required of agencies, they must be ubiquitous for all workers, including those who are employed by self-directed individuals, whether that be privately or under a Medicaid waiver program. We urge you to reject this bill, and all the provisions that it contains.

Thank you for your time and I'm happy to answer any questions.

SENATOR MOORE (22ND): Any questions? Can I just ask, can I ask you about turnover? What does it look like in your business?

JULIANNE ROTH: Industry strat -- in -- try that again! Industry standards is well over 50 percent in our business. And that largely is because our business is probably most similar to a temp agency, where we have clients who all the time either need to go to a higher level of care, go to the hospital, or pass away. And in those cases, if the worker doesn’t, if the agency doesn’t have another case
immediately to send that worker to, that they would fit for that case, then they would go to another agency. And in fact, many of our employees, and we encourage this, are employed by more than one agency at a time.

SENATOR MOORE (22ND): So that you know what I was thinking about, there's a bill that would now allow an aide to leave and go to another agency. I was just wondering if there's --

UNKNOWN: [Off Mic]

SENATOR MOORE (22ND): -- yeah, the noncompete. If there's such a high turnover, why would that be? But, thank you. I'm, I've never met you before. I appreciate you coming here to give that testimony and I'm gonna read through it a little deeper.

JULIANNE ROTH: My pleasure, and I'd be happy to comment about the bill as well.

SENATOR MOORE (22ND): That's not being heard here. But you just triggered something that I had not heard before.

JULIANNE ROTH: Sure.

SENATOR MOORE (22ND): Thank you. Anyone else? Thank you.

JULIANNE ROTH: Thank you.

SENATOR MOORE (22ND): Leikesha Nails.

LEIKESHA NAILS: Do I just speak?

UNKNOWN: [Off Mic]
LEIKESHA NAILS: Oh, hi. This is my first time here, so --

SENATOR MOORE (22ND): Well, welcome. That's okay.

LEIKESHA NAILS: -- I'm a little nervous. Thank you. I'm a little nervous.

SENATOR MOORE (22ND): I'm such a nice lady, it's gonna so easy.

[general laughing]

SENATOR MOORE (22ND): I am the nicest person. That Kathy Abercrombie is the one you gotta watch. Not me. Not me. [laughing]

[general laughing]

SENATOR MOORE (22ND): It's okay. I'm, you're gonna be fine. I'm looking forward to hearing what you have to say.

LEIKESHA NAILS: Okay. Good afternoon, everybody. Well, I think it's evening time now, but. My name's actually Leikesh Nails and I live in Willimantic. I've been doing home care for about 15 years. I'm also a CNA.

And first I wanna say that I love what I do. I like what I do. And, you know, God gave me the ability to have healing hands. And so with that being said, sorry -- I just wanna start by saying that, that this bill that is being put forward needs to happen. That the bill will start by establishing training standards that will help elevate the voice that the workers would have in home care. Because right now, you know, we don't have much of a voice. And we get
hired for these home care agencies, and they don't want to honor their agreement. They want us to show up for work, but sometimes they don't have work for us. Or sometimes in the middle of us being on an assignment, they'll tell us, well, today you're not going over there. I need you over here. So, you know, "over there" might be further away from where I live. And, you know, right now I live in Willimantic. Further away could be, oh, I need you to do a home, you know, a case in New Haven. Well, for me, that's far away, you know. And they don't want to pay you mileage or gas or any of those things.

You know, and then they wanna hire you at $10.25 or $10.75. That doesn't work! Especially when you're a mom, single mom with kids, and you have bills you have to pay, you know. And so -- I was supposed to read this, but I'm all over the place. Sorry. With that being said, you know, we just wanna be able to take care of our families and take care of the patients that we love taking care of, you know.

Like the person before me spoke on that, you know, it's very, it's encouraged that, you know, home care workers get other jobs through other agencies. That's too much sometimes. If I have to be hired at four different agencies, and let's say they all want me one specific day, well, which master do I serve? I can't be in four different places at one time! And then that agency might get upset because you can't be where they need you to be or they want to call you short notice at 10:45 at night that, oh, I have a case. Somebody just called out. No! That doesn't work! You know? Give us the tools that we need! You know, you want me to show up to work, you
I want me to be professional. You will absolutely get all of that, and then some! You know. Just be able to pay me what I need to make that happen, you know.

Not only that, but also health insurance. They don't wanna pay health insurance. They wanna just pay you, they wanna put you on the books for less than 24 hours, and they're smart like that. Because if I only give you 24 hours or 16 hours on the book, I don't have to pay you health insurance. You know, you gotta get it elsewhere. That's another thing, you know. And I am currently a mother of a special-needs child. I have a autistic child. I also have a son who is 14 who when he was born, he had cancer. And those bills are expensive. So all I'm asking is you to put this bill into play and hold these agencies accountable. And thank you for your time. [laughing]

SENATOR MOORE (22ND): Well, I think you did real well!

LEIKESHA NAILS: Thank you. [laughing]

SENATOR MOORE (22ND): I just wanna say, sometimes, you're better off just speaking from your heart.

LEIKESHA NAILS: Thank you.

SENATOR MOORE (22ND): You know, 'cuz that is the real you, and it came across very positive. And I feel your pain. I've supported home health care workers from the day I've walked in here. I understand the scheduling piece. I took a job at Target. I know this bouncing back from the front of the store to the back of the store, to over here, working till 11 at night and calling me back at 7
for the next day. I feel your pain. I know what you're talking -- My strength was that I didn't have to do it on a regular basis. I just got a little taste of what you go through every single day. So I appreciate you. I also appreciate so many health care workers who really are the backbone for many of our parents and our children who need someone to take care of them so we can go to work, so people can go to school and do their jobs. I appreciate you. I want you to know that.

LEIKESHA NAILS: Thank you.

SENATOR MOORE (22ND): And I thank you for your testimony.

LEIKESHA NAILS: Thank you.

SENATOR MOORE (22ND): Representative Wood. Now that I've had my say. [laughing]

REP. WOOD (141ST): [laughing] Well, that is your privilege. I'm just glad we didn't go under the bus wheels like your colleague. [laughing] Thank you, Madam Chair. And thank you so much for your testimony. I echo again Senator Moore's comments. You spoke from the heart. And that resonates very strongly.

LEIKESHA NAILS: Thank you.

REP. WOOD (141ST): Very much appreciate your coming up here and telling us how you feel and what it's like. Thank you.

LEIKESHA NAILS: Thank you.

UNKNOWN: [Off Mic]
REP. WILSON PHEANIOUS (53RD): Yes, thank you for your testimony. I just wondered whether or not the provisions in the bill, which would have the employer set out certain information like your name and address and training and where you lived, are those troubling provisions to you?

LEIKESHA NAILS: No, because I also am, I also work for a nursing home company.

REP. WILSON PHEANIOUS (53RD): Mm-hmm.

LEIKESHA NAILS: And they have to provide those things, you know, I'm out there already in the system. So I'm out there for everybody to see. That, I have no problem with that.

REP. WILSON PHEANIOUS (53RD): Okay.

LEIKESHA NAILS: You know. In our field, we already have to be background checked --

REP. WILSON PHEANIOUS (53RD): Mm-hmm.

LEIKESHA NAILS: -- and when you run my background, you have to run where I live or all the places I lived at already. So I already know going in what I'm getting in to. So that's not a problem for me.

REP. WILSON PHEANIOUS (53RD): Okay.

LEIKESHA NAILS: That's, that's the least of the worries.

REP. WILSON PHEANIOUS (53RD): Okay. Thank you very much.

LEIKESHA NAILS: You're welcome.
REP. WILSON PHEANIOUS (53RD): Appreciate your testimony.

LEIKESHA NAILS: Thank you.

SENATOR MOORE (22ND): So do you work more than one agency?

LEIKESHA NAILS: I work, currently work in a nursing home as well. And the nursing home provides me with the health insurance I need to be able to take care of my kids and myself. Because if I just did straight agency, I wouldn't have health insurance. That would be another thing. I would have to come to the state for health insurance. And with that being said, a lot of times and some of the times, my kids are covered, but I am not. Because when you look at my paystub, my gross pay will tell you I make too much money. Well, in fact, I'm not bringing home that gross pay. That would be nice if I was, 'cuz, you know, I would be okay. But I'm not. After taxes, I take home maybe a fraction of that or half of that, you know, and with, you know, the daily living, house, car, car insurance, car taxes, house taxes, food. And by the way, I have five boys, young men in my home. So they eat me out of house and home. So I'm always at the grocery store. You see what I'm saying? And I also have an older daughter. She's 17. But she's not as --

Well, I take that back, 'cuz she eats a lot too. So, you know, I'm a busy mom, you know. And I work. I work very hard. I wanna put that out there. Us in the health care field, we work very hard. I work with behavioral and psych patients. Even though, I love what I do, you know. But I need to be able to take care of my family as well. When I leave those
doors, I have to be able to provide for my family. And that's all we want. So.

SENATOR MOORE (22ND): So I understand that. And I bet you if Representative Abercrombie was here, so I can clean up my act a little bit, she would've been good to you also. [laughing] She would have been good for you also. But thank you so much.
LEIKESHA NAILS: Thank you.

SENATOR MOORE (22ND): I appreciate your testimony.
LEIKESHA NAILS: Thank you.

SENATOR MOORE (22ND): Thank you. So, Lynette Dockery.

LYNETTE DOCKERY: Good afternoon, Senator Moore, Representative Aber --

UNKNOWN: [Off Mic]

LYNETTE DOCKERY: Okay. -- and members of the Committee. Okay, if I pronounced it wrong, I've very sorry. My name is Lynnette Dockery and I'm proud to be home care giver from Meriden. I've been doing home care for over 20-something years. I started in 1980. I was taking care of my grandmother. What happened with that is in the 80s, you didn't have home care coming in like you do today. You weren't able to take care of a family member. They pay you today for that, and I think it's a blessing. So what happened was we started getting in a caregiver. The caregiver would come two or three days a week only for a couple of hours. Eventually, my grandmother was diagnosed with Alzheimer’s, so she needed around-the-clock care. At that time, I was a manager at a clothing store.
So I decided to let that go. For two years, I stayed home and I took care of my grandmother around the clock. We were very happy with the small care that she did receive. So myself and my mom, we decided to give back and we both became home care workers.

Today, I'm here to speak in support of the bill 1051. This bill would create training and opportunities for, to personalize and professionalize the work place. In addition to that, it would also give the state an understanding in, a much-needed understanding of the oversight of this industry that we work in. Okay, it would also help to elevate the voices of home care workers in Connecticut.

I have two clients. I work for an agency. I've been working for agencies, again, over 20 years. I had a opportunity to work for a consumer. This is my third one, that has a direct consumer waiver. Joining my union, we won our raise. So we get $15 dollars. With my consumer, I am making $15.25. With my agency, I'm only making $11 dollars. I've learned through the agency, the agency is making twice what I'm making. But I'm the one doing all the work. My client that I'm with, with, through the agency, I'm only getting $11 dollars, I've been with her now, this August would be three years. I've watched her decline. I've watched her go from a person that was able to feed herself when I started with her to do small things. She loved to sew. She loved to garden. Now, we have hospice in the home. The agency is not going to give you a dollar more. You're still gonna do the job, but the job has now become total care.
So as a PCA, in one job I'm getting paid $15.25; in another job, I'm getting paid $11 dollars and I'm doing a lot more now in this job. But I care for her. I lost my mom a couple of years ago, and I received my client shortly after. And I wanna be there with her into the final days. That's because I feel, you're not only there for the client. After two or three years, you're there for the family as well. So I wanna be there for the family through this time that we are all going through.

I think also to establish a home care directory would be a very first important start for us. Creating a pathway for a better training, and understanding the workforce. The gaps in training and moving forward into recruiting people and understanding that we need critical training in this workforce that we do. We need for the state to understand the things that we do. We don't just go into a home and -- Yes, we are companions. Yes, we are friends. But we have to take care of this person.

I have a bedridden client now. So there's a lot more to stress on the body. I've been doing this for over 20 years. Yes, you do. You come home, you're hurting. You know, you get up in the mornings and you're barely making it, but you just left one client. I leave one client, and I gotta go to the next one. So I'm asking that we pass this bill to help all of the workers just as myself, you know, that we do get training and that it can help us to be better caregivers. And that we can be here for those that need us. The agencies are fine. We don't receive any sick pay. You don't get vacation pay. You don't get time off. You don't get any of
that. I'm the type of person, I've been doing this for over 20 years. I would never or barely ever call out. Because I feel that when I get up in the morning, that person is waiting for me. That person needs me today. So I'm gonna get up and I'm gonna do my job. At this time, yes, I would love to make $15.25 on both jobs, but the $11-dollar job, I care, regardless. The money doesn't matter now. It's about the care of my client and her dignity to see her leave here. And her quality of care that I feel that I give. I hope that one day when it's time for me to be cared for, I get that same quality of care and dignity that I show my client. And I think people that work in this field, they need to be paid for the work that they do. I'm a single parent --

SENATOR MOORE (22ND): I just need to -- I'm sorry.

LYNETTE DOCKERY: I got a kid in college.

SENATOR MOORE (22ND): I just need you to wrap up your testimony here.

LYNETTE DOCKERY: Yes, okay. And I have a son in college as well. And I'm a single parent, so I know what it's like to work very hard. So again, I'm just asking the Committee to pass this bill.

SENATOR MOORE (22ND): Thank you for your love of your patients and the people you take care of. I appreciate that. I know how hard it is. It's also an emotional drain --

LYNETTE DOCKERY: Oh, yes, it is.

SENATOR MOORE (22ND): -- when you, if you have someone in hospice. But also to watch someone
decline and you know what they could do at one time. And to stay with a client that long is commendable. So I thank you for your commitment to that job --

LYNETTE DOCKERY: Thank you.

SENATOR MOORE (22ND): -- and to that person, and to the industry. I think you all do, really do give a lot to it. So I appreciate that. Any comments? Thank you so much.

LYNETTE DOCKERY: Okay. Thank you.

SENATOR MOORE (22ND): Oh, I'm sorry. Representative Butler.

LYNETTE DOCKERY: That's okay.

REP. BUTLER (72ND): Thank you, Madam Chair. And thank you for your commitment and your compassion. I could tell you that what you described is very much what my sister and I had to deal with both of our parents that were sick, and we, over six months, were able to take care of them because I worked first shift, she worked second shift. When I got out of work, I went to stay with my parents, worked until my sister got out of work, she came. So we were able to have three 24-hour coverage of taking care of our parents with people coming in during the day. So, and that was so, that meant so much, not only just to my mother and father, but to our whole family to be able to do that. So the value of what you provide is, is just, it's priceless, really. But seeing that it all comes down to the almighty dollar, I just wanted to know, basically, what's the difference, what do you think the difference is, or can you, you know, identify the difference between
making the different salaries and working for the different agencies, and yourself?

LYNETTE DOCKER: Well, okay. Well, when I won, when we won the $15 dollars for the consumer, and we got that raise, it made a lot of difference for me financially. I was able to actually see a little money left over in the bank account at the end of the month. You know, I mean, the $11 dollars, you know, it's fine. It provides a living. And I've been doing it for years, but to understand that I can get paid my work, at the $15.25 that we're getting now, I feel like I'm going to work and I'm getting paid what I'm worth. You know, they're not just looking at, oh, well, just call her in today and, I mean, I was getting $9 dollars, $10 dollars, you know, for just companionship, you know, just to come in and you have to do so much in a lot of ways. I travel with my clients. I take them to appointments sometimes. I take them to the grocery store. So you have a lot more to do besides just be there as a companion for someone. You know, so the quality of care and the quality of my life and the financial, I found that getting that raise really helped me and it made a difference in my life. Having a son out there in college, I have to help him. I have to.

REP. BUTLER (72ND): Okay, and let me ask you so I could zero in specifically. I'm trying to understand what the difference is in responsibility in training in each of these jobs and then tell me how this bill will help.

LYNETTE DOCKER: Well, at this time, we can always use extra training, you know, and far as the
difference in care, there is not much of a difference. I'm a PCA at both jobs. I do quality of care at both jobs. I'm on-hand care, and again, I have a client that I'll also take out and doctors' appointments, this client here is bedridden. So I'm doing more for her than I was doing at one point. You know, so the quality of care is not much of a difference in either one of my cases. It's just that I'm making more at one than I am at the other.

SENATOR MOORE (22ND): So can I just interject? Are both your jobs union jobs?

LYNETTE DOCKERY: No.

SENATOR MOORE (22ND): Are any of them union?

LYNETTE DOCKERY: No. I don't work for the union. No, I work for a consumer that has a directed, consumer direct waiver totally.

SENATOR MOORE (22ND): But under, I'm trying to understand. Under the $15-dollar job, is that not a union bargaining job that you have positions?

LYNETTE DOCKERY: Okay. Yes, because we won our, our vote for that.

SENATOR MOORE (22ND): Right.

LYNETTE DOCKERY: Yes, our [crosstalk]

SENATOR MOORE (22ND): So that's the difference between the $11-dollar job, that had a union bargain. They just got a raise I think it was last year to get them the $15 dollars.

LYNETTE DOCKERY: Yes.
SENATOR MOORE (22ND): The union worked to get them that raise, and that's why there's a difference in pay between the two of them.

LYNETTE DOCKERY: Yeah. No, I thought you were asking me, do I work for the union. No. [laughing] No, I haven't --

SENATOR MOORE (22ND): You work under a union. You're a union member, correct?

LYNETTE DOCKERY: Yes, yes, I am a union member. Yes. I misunderstood you.

SENATOR MOORE (22ND): The workload is the same regardless; it's just that they work under the union who negotiated a contract to get them $15 dollars over a period of time.

LYNETTE DOCKERY: [Crosstalk]

REP. BUTLER (72ND): Okay. Thank you. And thank you for your answers. So basically, the, what accounts for the difference is that one group is under a bargaining unit that negotiates their salary and one group doesn't have -- Okay. Thank you.

SENATOR MOORE (22ND): Yeah, and they say we don't need unions. [laughing]

REP. BUTLER (72ND): [laughing] Hey, thank you, Madam Chair.

UNKNOWN: [Off Mic]

LYNETTE DOCKERY: And thank you.

UNKNOWN: Sherry Falsetti.
SHERRY FALSETTI: Good afternoon, members of the Committee. My name is Sherry Falsetti. I work for a private agency that places me into a nursing home in Meriden. Today, I'm here to speak in support of Senate Bill 1051.

The bill would make, help make changes to the private agency home care industry that's very much needed as you've already heard from the last two people. I actually fully agree on what they've said back and forth in "I need to be here, but they want me here." And to create training standards and opportunities that would ensure workers like me and the two ladies that spoke before me to be compensated fairly for the work we do, it could help us live with our own respect and dignity in our own home, not to mention our clients' or the people we take care of.

I enjoy working with others. I spent ten years going to college and then went into home health care. Not what I went to school for. But I have psychology background, so I work with dementia patients. And I don't only help my two individuals, I help the whole entire floor when I'm there. And I love being there. They tell me I'm beautiful. They tell me they love me.

But as spoken before, it doesn't pay enough. I have four college degrees and I make $10.25 an hour. I can't find a job in my field. I moved down here from another state. Can't find a job. But I love my clients. I take them out for walks. I take them to get their hair cut. Take them to the park. I take one to the movies and he sits there and watches the movie the whole entire time. And they love
that. 'Cuz I'm showing them that I'm not just there
to take care of them; I'm their friend. I don't
like calling them my clients. I don't like calling
them patients. They're my friends. And with these
individuals, I have a problem where I can get hit
when I go to work. I've had a client push me. I've
had clients tell me if she had a gun, she'd shoot
me. And I've even had clients hit me and then look
at me and say, "Sorry, I love you." I mean, other
days, I've been proposed to twice. Like today,
someone was saying that he wanted to marry me all
morning. But that's just what I deal with.

My company doesn't take care of that. I could go to
work, get hit, walk, come home with a black eye. Or
if I fall because someone hit me, my company's not
gonna cover the medical bill, medical part of that.
And making $10.25 an hour, I'm not going to be able
to pay to go to the hospital. And I love taking
them out to go do stuff. It actually honestly gives
me a break from being in the facility itself, and it
shows them -- They can be independent; they're still
people. Just because they have dementia, they have
issues, they may see people walking down the hallway
that aren't there. They're still people. I still
learn from their past. My two clients are veterans.
And I've dealt with PTSD episodes. I've dealt with,
like I said, people hitting me or running me over
with their wheelchair. But I still go back the next
day, because that person's not gonna remember they
hit me the day before.

And I work for two different companies. My main job
is Companions and Homemakers. It's not unionized
and I make $10.25 an hour. Those are my main
clients. I recently picked up a private client
through, that gets paid through Allied, it's consumer union, and I make $15. I do a lot less with him than I do with my dementia clients. And I don't see how that's fair for me. I don't take my union client out. He's blind; he doesn't go anywhere. I just sit there and listen him. My dementia clients, I take them everywhere. Whether it's for a walk, to the park, to a movie, anywhere, just to get them outside. They're in a locked facility. I take them out, give them quality of life, and show them that they're still alive. And even though I've lost seven people on that floor since I started working there, it hurts. It does. It's a downfall to the job. But at least I know I was there giving them good days at the end of their lives.

And on top of all that, work is stressful, no matter what you do, where you work. And if I'm going to work, taking care of someone who has paranoia up and down walking down the hallway, I'm gonna get a little stressed out, because he's not gonna listen to me and sit down. And like they say, we don't get paid vacations. We don't get enough money to be able to go and destress ourselves. When you're stressed out, you're gonna stress out other people. And even with illnesses or just elderly in general, they sense it. They still know what's going on. And, honestly, dementia clients are probably smarter than me. And that says a lot! [laughing] But I honestly think the bill would help us, not only the training among everyone to deal with my dementia people or just normal client, not normal. Sorry to use that word, but regular clients like the guy I had that's blind. The training should be across the board.
SENATOR MOORE (22ND): Thank you, but I just need you to wrap up your testimony.

SHERRY FALSETTI: Yeah. That was basically about it anyways. [laughing] And thank you, and just a better work environment would help us and our clients.

SENATOR MOORE (22ND): So thank you again for the work that you do. I don't know what we would do without these workers. I just don't know what we would do. So I appreciate you and I appreciate the work you do. Representative Case.

REP. CASE (63RD): Thank you, Madam Chair. I just wanna thank you for what you do and I think it's so important. I worked across the board to try to help with, you know, just intellectually and developmentally disabled people to get education for caregivers and things like that. And you know, our most vulnerable, people who take care of our most vulnerable are the ones who get slashed the most. You know? You need our help, we need your help. We need to work to make this an equitable system. You know, I can sit in another committee. We did $1.5 million dollars of raises yesterday. Nine weeks paid vacation. The equitability needs to come together. So I appreciate you coming up today.

SHERRY FALSETTI: Thank you.

SENATOR MOORE (22ND): John Shulansky.

JOHN SHULANSKY: Madam Chair and distinguished members of the Committee, my name is John Shulansky and I'm managing director of EldersChoice of Connecticut, which is a homemaker companion agency that's classified as a registry, and that means I'm
also an employer fee paid employment agency registered with the Department of Labor. I'm also acting president of the Connecticut Association of Home Care Registries.

My testimony has been filed with the Committee and I'm not gonna read it word for word. I'd like to say a couple of things. First of all, I feel like the Committee is listening to comments that I've made over the last probably six years before the General Assembly. Right now in this state, anybody can be a caregiver for your frail mother. No training, no experience, no health exam, ladies and gentlemen. This bill doesn't include a health exam. Anybody can come into your home and they could be, they could have a chronic illness, they could have an illness that would make them unable or unqualified to be in a private home. We are not addressing that here.

We need to do training. We need to have some requirements for training. Unfortunately, this bill doesn't do it. We need, as Julianne Roth said, we need to decide what that training is, what the training parameters are. We have a lot of good training programs in this state already. I think ideally to put the burden on HCAs to mandate that anyone that we refer or place in a home has met certain minimum training requirements. And I would also put in there health exam within the last couple of years, but that's just me. But require that HCAs are mandated, they must place someone who has training is in my opinion appropriate point.

I will say that when it comes to continuing education, we as a state have a bigger issue. We
have no continuing education requirements for registered nurses in this state. We have no continuing education requirements for licensed practical nurses. We have no continuing education requirements for CNAs. So we're gonna put continuing education requirements on people that are hypothetically at a lower level of care, because, remember folks, this is not a business that's health care.

This is classified as nonmedical care and is regulated by the Department of Consumer Protection, which is a real anomaly in this state. Because we have people who are taking people who are frail and old, who are on certain medications that may render their skin frail, that may have an illness that makes them hard to transfer from their bed to their wheelchair, from their wheelchair to the commode. You need to be trained to know how to do that. You need to know when you're going into a house that this particular client has a particular disorder, and you should be equipped to do that. Caregivers are amazing. They shouldn't go into a home where they're not equipped to take care of somebody, but they've been assigned to go there. They need to have some basic skills. And some caregivers are better at some things than others. So we need to recognize that. But if I have a caregiver who is not experienced in dementia care, I am not going to refer them to a family with a loved one who has dementia. I'm doing them a disservice.

So I guess we're on the right track here. We need to look at this differently. I think we need to find a way to incorporate training standards and training regimens and requirements, but not put such
of a burden on the Department of Consumer Protection right now. I don't think they can do it. There are over 100 registries in this state of the 650 registered ACAs. If this bill comes into effect as is, registries will have, it will affect over 100 businesses because a registry cannot train caregivers that it refers. It violates federal regulation. So all these businesses will disappear.

But I encourage the adoption of some training standards. I encourage the adoption of a health care standard. I'm not sure what those standards should actually be. I have some ideas, but this is gonna take some thought and some collaboration, and we need to do it right, and we need to protect the health care workers and we need to protect our domestic workers. And while this bill does not address compensation, hopefully, we will have a workable living wage for every caregiver. I'll be glad to answer any questions.

SENATOR MOORE (22ND): Thank you for your testimony. Anyone? Okay. So I have some. So it's almost like, if not now, when.

JOHN SHULANSKY: Mm-hmm.

SENATOR MOORE (22ND): If not them, who? I have not seen the industry move toward any of the things that you've talked to. This bill actually came from workers trying to protect themselves. So you mention that this is a lower level of care. Just before you stepped up there, there was a young woman in here who said she handles dementia patients.

JOHN SHULANSKY: Mm-hmm.
SENATOR MOORE (22ND): Do you know what level of education she has or training that she's allowed to do that?

JOHN SHULANSKY: Well, she's talked about her training. Okay? But I don't know specifically what her training is.

SENATOR MOORE (22ND): Is there a standard when you assign these jobs to the CNAs, is there a standard on what you expect them to be able to do in their level of education before you assign them?

JOHN SHULANSKY: When I -- It's not a -- Well, I have particular standards in my particular business. And my business requires them to be an L, a RN, LPN, CNA, HHA, or PCA. And then I must probe further in an interview to determine what experiences they have. If they have no experience with dementia care, they're not going into a dementia care case. It's that simple.

SENATOR MOORE (22ND): So I'm just quest, I'm wondering about adding health exams to employees. Do you do that now for the people you employ?

JOHN SHULANSKY: I don't employ anybody. I'm a registry.

SENATOR MOORE (22ND): Okay.

JOHN SHULANSKY: But anyone who's on my roster must have had a health exam in the last two years and must have had a clean PPD or a chest x-ray, a clean chest x-ray in accordance with CDC standards before I will refer them to a family.
SENATOR MOORE (22ND): You know, 'cuz I'm thinking we could add this to this bill that you would. If you think that's the answer that, you know, adding health exams, perhaps grandfathering people in and people in the future would need health exams. It's something that we could look at. You also said that the Department of Consumer Protection would not be able to handle this. Did they say that? Or is that your assumption?

JOHN SHULANSKY: I don't know if they've made any testimony. I have spoken privately with representatives of the commissioner's office, and I'm aware that there's a real problem here. We had a hard, we tried five years to get them to put a question on the renewal for HCAs, which HCAs are agencies and which are registries. We got that this year for the first time. It took them a long time to get there. I will say New Jersey has a registration program for CNAs and HHAs. It was that kind of registration program was included in a bill that passed Aging Committee, House Bill 5322, last year. It was ultimately opposed by the Department of Consumer Protection, never made it to the floor. But again, there are other approaches here that we can take that will make sense, and we can implement without creating a huge administrative burden both on organizations and on the state, both on HCAs and on DCP. My biggest concern is that if you were to require a registry, one of the 100 registries, or 121, that are identified in Connecticut, if they are required to provide training, they are no longer registries and that can't exist. So their purpose is gone.

SENATOR MOORE (22ND): So I would love to see your
recommendations in writing.

JOHN SHULANSKY: Absolutely.

SENATOR MOORE (22ND): That would be really great to help us along to figure this out on how we do this.

JOHN SHULANSKY: I'd be glad to.

SENATOR MOORE (22ND): And we'll just look further into this to see how we can strengthen this that it works for both parties. Now what do you pay your workers?

JOHN SHULANSKY: I don't pay them. I don't pay them. I can't pay them. [crosstalk]

SENATOR MOORE (22ND): So the people in your registry go out to -- How -- Just tell me a little bit about your industry.

JOHN SHULANSKY: So I'm like an employment agency. Someone's gonna call me and my business is only full-time care. I don't do hourly work whatsoever. So I'm gonna place somewhat who is highly trained and skilled and refer them to a family in Connecticut and that person's gonna stay there full-time. I am obligated to give the family what I'll call a range of reasonable compensation. I'm not paying them. The family is paying the caregiver directly. I try to explain to the family that based upon what I'll call federal guidelines and minimum wage in Connecticut, the minimum amount of hours that I would expect a caregiver's gonna work at a private home is probably between 13.5 and 14 hours during the day. And that means that the family is gonna have to pay them a minimum of $145 dollars a
day. I've gotta tell you that I say to the families, "If you want an untrained person to work at minimum wage at $145 dollars a day, you're gonna get what you pay for. You need to -- You know, these people that I'm referring are highly trained, highly skilled. They are experienced. So I give the family a range. I recently started a case with an individual who is very frail and bedbound and I suggested to the family that this caregiver should probably be paid not less than $185 dollars a day and should be at least $200 to $210 and what -- My goal is to put the two fam, two individuals together and have them negotiate the compensation, the terms of their work, the work agreements, and get that all laid out between the two of them. I cannot interject myself in there. Otherwise, I'm the employer. So I don’t tell them what to do. I don’t tell them how to pay. These people are highly trained. They know what to do when they go into a home, how to take care of someone, and what they need. So they're not being directed.

SENATOR MOORE (22ND): So I don’t believe this bill would impact you as a registry.

JOHN SHULANSKY: It would make me, it would make me not a registry if I had to train somebody. If I had to provide ongoing training, if I had to register those people with the state, it would mean I'd become an employer under federal law. So that makes it, means that I can't be a registry. So if I am, if I have to assert and attest to a governmental body and to a consumer that everybody that I refer is, has got training and experience -- And in Pennsylvania, you've got to be at minimum CNA, HHA, PCA, or two years of relevant experience that you
can document. And every caregiver must have in his or her file two written pieces of paper from the agency that demonstrates that they have validated those references, they have validated their experience, and that has to be in the file. And in Pennsylvania, the Department of Aging audits every HC, the equivalent of an HCA every three years. We don't have that here. We don't have -- We have basically no requirements.

Anybody can start an HCA today with no experience, no knowledge of taking care of the elderly or someone who's chronically ill, no knowledge, no experience. It's $375 dollars for the Department of Consumer Protection and a surety bond. And that's it. And then anybody can be a caregiver. So we've got to look at this whole business and change it. I was with Representative Wilson at the Labor Committee earlier and they've got some other very interesting approaches that -- We really have to look at this whole industry.

SENATOR MOORE (22ND): Thank you for your testimony. I think this is the beginning of that dialogue.

JOHN SHULANSKY: Yeah. Thank you. We really need it.

SENATOR MOORE (22ND): And I appreciate your testimony though.

JOHN SHULANSKY: Thank you.

SENATOR MOORE (22ND): Thank you. Sheila Greenhouse.

UNKNOWN: [Off Mic]
SENATOR MOORE (22ND): She's gonna pass? Is it Mork McGoldrick? Mark. You know, Mark, I thought it was that but I wasn't sure.

MARK MCGOLDRICK: That's all right.

SENATOR MOORE (22ND): How are you?

MARK MCGOLDRICK: I've been called worse.

SENATOR MOORE (22ND): Not Mindy, though. [laughing]

MARK MCGOLDRICK: Thank you. Thank you, Madam Chairman and other distinguished members of the Human Services Committee. This has been all very confusing for someone who even works in the industry.

[general laughing]

MARK MCGOLDRICK: Hearing from registries and union employees and PCAs and I can understand how you can get overwhelmed by listening to this. My name is Mark McGoldrick. I own five Comfort Keepers offices serving three counties in the state of Connecticut. And all of our clients are private pay. So they don't receive any state aide or funds for services. And we're an employer-based agency, which would be different from the last gentleman who spoke as a registry. This means that all of the people we hire are our employees and they are our most important asset. We distinguish ourselves and compete in the market based on the quality of people that we put in elders' homes. And our clients have a choice. We don't have contracts with our clients. We have agreements, and they can leave us at any time if we do not provide them with the services that they
demand and require.

So our standards have to be very high because, as you can imagine, when you're dealing with the care for an older person and you have a lot of interested parties, like family members and spouses and siblings, you've got a lot of opinions about how you're doing. And so we live every day to care for the seniors and the people who are do that for us are our caregivers. So we have to treat them well.

I heard a lot of testimony about, you know, not getting vacation pay, not getting sick pay. Those are all things we provide. When they get hurt on the job, not being covered. That's not true. We provide workers' comp insurance. As an employer-based agency, you have to provide workers' comp insurance, so there's a lot of things that are confusing, but we take care of our employees and we provide them with adequate benefits, pay, and insurance coverages.

In addressing this bill, I want to talk about specifically two pieces. Section one, which proposes making personal private information publicly available and specifically available to labor unions. This bill would be a violation of Constitutionally protected privacy rights for health care workers. There exists no public interest for the state or consumers in publicly disclosing personal information such as home addresses, email addresses, and telephone numbers for this registration. The Federal Privacy Act of 1974 says that government agencies must not give personal information out without explicit personal consent. The bill treats home care workers in a manner
fundamentally different than the treatment afforded other workers in the state.

Under SB 1051, a home care worker's personal information would be subject to disclosure to labor unions for purposes of employee organizing. This bill represents an unconstitutional intrusion by the state of Connecticut into an area of law exclusively reserved for federal law, the area of labor management relations. Federal law dictates that the area of labor management relations is exclusively governed by the National Labor Relations Act. Under the National Labor Relations Act, employees working for other private entities, covered by the NLRA may not have their names and phone numbers disclosed to a labor union until there has been a direction of a union election by the National Labor Relations Board. I would also like to comment on Section 4 --

SENATOR MOORE (22ND): I'll need you to summarize. Did you give written testimony?
MARK MCGOLDRICK: I did, yes.
SENATOR MOORE (22ND): Do we have it?
UNKNOWN: [Off Mic]

MARK MCGOLDRICK: Section 4 is the requirement of audited financial statements and other information. Most home care agencies in Connecticut are small privately-owned small businesses and providing audited financial statement would provide an unnecessary financial burden on these companies, and there is not compelling interest of the state in requiring audited financial statements. That section also makes reference to annual reports submitted by the agency for the Centers for Medicare and Medicaid Services. As I alluded to at the
beginning of my testimony, we are private pay and do not provide any reports to DSS or the state because we take no funds from them. So we have no idea what this involves and wouldn't be able to comply with it. Thank you.

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

MARK MCGOLDRICK: Thank you.

SENATOR MOORE (22ND): Brunilda Ferraj.

UNKNOWN: [Off Mic]

BRUNILDA FERRAJ: Okay, hi. Good afternoon, Senator Moore, Representative Case, and members of the Human Services Committee. My name is Brunilda Ferraj and I am with the Connecticut Community Nonprofit Alliance. We're the statewide advocacy association for nonprofits.

The Alliance supports Senate Bill 1052, AN ACT EXPANDING MEDICAID COVERAGE OF TELEHEALTH SERVICES, which would require DSS to expand Medicaid coverage of telebehavioral health services statewide.

Telehealth is an innovative form of service delivery rather than a new type of service. The Centers for Medicare and Medicaid Services considers telehealth a cost-effective and alternative to the more traditional face-to-face way of providing medical care. It's a technology that improves patients' access to care, including behavioral healthcare, by allowing providers to conduct counseling and other behavioral health services through a simple, confidential videoconferencing platform.
If telehealth is implemented in Connecticut, providers must have the ability to bill to Medicaid for services at a rate that covers the true cost of care.

According to a 2016 nationwide study, Connecticut is now the only state in the nation that does not allow for any Medicaid billing of telebehavioral health services. Most commercial insurance plans now include telehealth services, including, or leaving Medicaid recipients with less access to care. And to provide some background, in 2016, the legislature passed Public Act 16-198, which directed DSS to implement telehealth services in the Medicaid program and submit a report to this Committee and the Public Health Committee, but that hasn't happened yet. And then, in September 2018, all five of Connecticut’s members of Congress wrote to DSS urging them to implement telehealth in the Medicaid program because they recognized the benefits of telehealth, which include -- So telehealth would mitigate the impact of the widespread shortages of mental health professionals in Connecticut, especially in rural areas of our state. Telehealth reduces the impact of stigma as a barrier to access to care. It allows patients to receive treatment from the privacy of their own home. And it also improves access to addiction treatment amidst the opioid crisis that we're currently experiencing.

In Connecticut, there is two sectors specifically in which telehealth would improve access. One is in the kids' sector. So there's a current shortage of child psychiatrists in the area and telehealth would allow for access for those professionals.
In the adult world, the adult-serving sector right now, the need for behavioral health services continues to grow. The surging opioid epidemic has drastically increased the need for more efficient and accessible addiction services.

Those two issues are compounded by the fact that there's a shortage of mental health professionals in Connecticut overall. Over 2.7 million Connecticut residents, about three-fourths of the total population, live in areas without a sufficient number of providers.

And then further, studies have shown that consumers want access to telehealth. Surveys of consumers aged 18 to 44 found that 72 percent would be willing to receive services remotely through videoconferencing in lieu of a face-to-face visit.

And I understand that right now DSS is working on a proposal to allow for this. We are not sure how that will materialize, but I know there have been discussions at the Behavioral Health Partnership Oversight Council and its subcommittee and the Alliance supports that work and asks that this Committee pass Senate Bill 1052 to complement the work that's already going on at DSS. Thank you.

SENATOR MOORE (22ND): Representative Case. Thank you.

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

BRUNILDA FERRAJ: Hi.

REP. CASE (63RD): Your testimony says it all and
gives us a lot of background information. I just want to say, I appreciate you doing the history and doing the background for us. I sure us, as leadership, we will be working on this and just a question for you. When is Ben gonna testify?

BRUNILDA FERRAJ: [laughing] We don't let him come up here. Kidding.

REP. CASE (63RD): [laughing] But, thank you. Thanks to both of you for the work you do and it helps us out a lot.

BRUNILDA FERRAJ: Thank you.

UNKNOWN: [Off Mic]

BRUNILDA FERRAJ: Thank you.

SENATOR MOORE (22ND): Sheldon Toubman. Not here?

UNKNOWN: [Off Mic]

SENATOR MOORE (22ND): John Hischauer [sic]?

JOHN HIRSCHAUER: Good afternoon, Madam Chair and members of the Human Services Committee. My name is John Hirschauer and I've had the privilege of spending countless hours of my life as a volunteer with the residents at the Southbury Training School, a residential campus for adults with profound disabilities located in Southwestern Connecticut.

Thank you for the opportunity to testify on Raised Bill number 1065, AN ACT CONCERNING LONGTERM CARE SERVICES. I’d like to share points of both concern and optimism in this bill on behalf of a group of people who are unable to do so themselves.
The act seeks to commission a wide-ranging study on the long-term care needs of both the aging and disability populations in Connecticut.

For persons with profound disabilities, the need for long-term residential supports has reached crisis levels. In most other states around the country, legacy facilities like the Southbury have functioned as natural safety nets for those in the disability community whose medical or behavioral complexity leaves them in need of specialized long-term supports when other placements fail to meet their profound needs in the private sector. Because of the arbitrary prohibition on admissions to Southbury, which started all the way back in 1986, it has been artificially prevented from functioning in that capacity, and the results have been catastrophic, and I think damning. A 2016 report, for instance, found that over 350 people in the state of Connecticut with intellectual and developmental disabilities were forced to reside in nursing homes, a tragically inappropriate placement, all because specialized facilities like STS were prevented from serving them.

I’d like to briefly comment on a few of the provisions in this bill.

First, the bill instructs the proctors of the study to find “the number of residents removed from institutionalized settings to home and community-based settings under the Money Follows the Person demonstration project.”

On behalf of one Southbury resident who was recently diagnosed with a brain tumor on top of his co-
occurring schizophrenia, schizo-affective disorder, autism, Parkinson’s disease, hydrocephalus, and kidney condition, I would like to offer my sincere hope that his potential displacement from his so-called “institutionalized setting,” which, as it happens, is his community, and his one and only certainty in a world of increasing uncertainty, is not, as this bill’s language would seem to suggest, counted as a positive policy outcome. A resident with complex needs who is inappropriately “removed from” a “institutionalized setting” in pursuit of what this bill calls "savings" in state expenditures, savings which, as it happens, don't exist, according to DDS studies done in 1994, 2002, and 2010, each of which had every intent to define the opposite of what they did. It seems to me to be a decidedly barbaric metric of success.

Residents with disabilities who live in close proximity to their peers -- And make no mistake, that's the only criterium that's used to render someone “institutionalized” is if they happen to live in close proximity to others with disabilities. They live in communities all their own, with friends and neighbors that enrich their lives. The unspoken suggestion made by the institution community dichotomy is that the movement of an individual with profound, co-occurring disability, like the individual I referenced above, who resides by medical necessity, and I'll finish up in a moment, at a place like Southbury with his staff and friends of many years, is not a member of a legitimate community in his current place of residence, but would magically become one upon his move to a medically inappropriate placement at the bottom of a cul-de-sac in a residential neighborhood with two
strangers and underpaid service staff. Who is more isolated, exactly? And who decides?

I would be willing to cede this as an insignificant matter of semantics if it weren’t for the plain fact that for some individuals who have complicated medical and behavioral conditions, uprooting them from their stable home in Southbury with intensive on-campus support to a less intensive setting staffed by minimum-wage employees with high turnover rates could be a literally fatal mistake. The relocation of an individual with profound disabilities from what this bill arbitrarily deems an “institution” to what it deems a “community-based setting” is not a self-evidently desirable policy end for every single member of the disability population, which has a tremendous diversity of needs that aren’t acknowledged by such reductive language about the places that they call home.

The residents at Southbury Training School with whom I've had the unparalleled privilege to volunteer unfortunately cannot come up today and articulate to you that their home, their friends, and the dedicated staff who care for them form a community in their own right. I thought it important that such a fact be offered into the record, even in spite of their inability to offer it themselves. Thank you. I'll take any questions you have.

SENATOR MOORE (22ND): Thank you. Thank you for your volunteer and your willingness to be a voice for someone who doesn’t have a voice and for people. I appreciate that. Representative Case.

REP. CASE (63RD): Thank you, Madam Chair. Thank
you for coming forward. I know Ben and I are anxious. We saw you earlier this year at a training session for testifying.

JOHN HIRSCHAUER: Yes.

REP. CASE (63RD): So, you talk about -- The bill is long-term care and --

JOHN HIRSCHAUER: Yes.

REP. CASE (63RD): -- we talked about Southbury Training in it in a few emails that we had, but the total number left at Southbury is what, 183?

JOHN HIRSCHAUER: One hundred and eighty-four I think was the last count.

REP. CASE (63RD): Yeah. As of yesterday, it's 183.

JOHN HIRSCHAUER: Yeah, I think there was another death recently.

REP. CASE (63RD): So your average age is about 69, max age is 92.

JOHN HIRSCHAUER: Thereabouts, yeah.

REP. CASE (63RD): And I, you know, there comes a time when institutionalizing is, needs to change. But I agree with you that there are family out there. They've been out there for a long time. That is their family. That is the people that they associate with.

JOHN HIRSCHAUER: Mm-hmm.

REP. CASE (63RD): The staff is very accustomed and
used to caring for them, so they know it. It's a very difficult decision, but what in this bill concerns you the most that would have impact? Because we just got the statistics for a budget hearing that I'm supposed to be in next door --

JOHN HIRSCHAUER: Yes.

REP. CASE (63RD): -- for DDS regarding Southbury.

JOHN HIRSCHAUER: Yes. What concerns me is that I feel like this is going to be used -- The wording inside the bill is sort of a prima facie acceptance of the premise that institutions by themselves, whatever that means by the way. I mean, an institution could have 17 people who live within, you know, it's been, so it's a very, you know, it's a huge term. But it's of course rendered as, you know, where would you rather live, in an institution or a home and community-based setting. I mean, the terms themselves are biased. And this is my position on the matter. I mean, you say that institutions by some sort of grand dictate of capital H history are forced to close for unspoken reasons.

I think, to me, if I offered you today a choice for free between a 2018 Cadillac and a 1968 Gremlin, you wouldn't have to be artificially prevented by the state legislature from not choosing the 1968 Gremlin. If Southbury's as bad and as arcane and as archaic as its opponents make it out to be, nobody will choose it. But I have a feeling, and I think other folks do too, that there's a diversity of needs in this populations and living at the bottom of a residential neighborhood in a cul-de-sac
within, you know, a white-fenced area, while it might be great for many or most people with disabilities, there might be individuals who need a more intensive placement either in the short run or the long run.

So this sort of bizarre manikin desire to have a one-size-fits-all solution at the expense of the real lives of families who know that, you know, life is complicated and behavioral and medical conditions are more complicated than "community living for everyone," which is a noble goal, but that might not be the reality. And I think other states around the country -- I mean, there's again this canard that, you know, every state is getting rid of their institutions, which is by the way, not true. The stasis that other states are reaching that I think Connecticut would be smart to reach is to use a legacy facility like Southbury as a respite center or sort of a safety net, okay, for folks who are having medical or behavioral challenges who end up in a nursing home or the 36 individuals with IED who are currently incarcerated. I mean, there are just -- Southbury is a super, is a flat-out superior placement for those folks than a nursing home or incarceration. And I think we can all, whether, whatever our position on, you know, congregate facilities, could agree on that at least.

REP. CASE (63RD): Well, you know, and I thank you for coming out and I just want to comment on a few things. I agree with you; a nursing home is not a facility --

JOHN HIRSCHAUER: Yeah.
REP. CASE (63RD): -- for this population. It is --
You know, my brother was in a nursing home for
probably a month and a half before he went to an ICF
facility.

JOHN HIRSCHAUER: Mm-hmm. Yes.

REP. CASE (63RD): But, you know, we have Southbury,
we have different regional centers, we have public
community living agreements, CLAs, intermediate care
facilities, we have private CLAs.

JOHN HIRSCHAUER: Uh-huh.

REP. CASE (63RD): We have many places for people to
go, but it's the type of care and their LON, their
level of need is that we need to look at and their
quality of life.

JOHN HIRSCHAUER: Yes.

REP. CASE (63RD): So your passion and your ability
to come forward and speak will go far with us, and I
think that that is something that we need to look at
seriously when we look at these bills. We're all
gonna need long-term care, but this population, it's
imperative that they have it in the proper facility.
Somebody in a nursing home is not gonna get the care
or the need that somebody with IDD --

JOHN HIRSCHAUER: Yeah.

REP. CASE (63RD): -- or, really needs, because they
are a special population and once again, I thank you
for coming and I will get out there to meet with you
and --

JOHN HIRSCHAUER: Thank you. That'd be great.
REP. CASE (63RD): I have worked out there --

JOHN HIRSCHAUER: I know. Yes.

REP. CASE (63RD): -- as I said, so I know the facility and anybody who hasn't gone out there, it's a beautiful facility. We are shuttering quite a bit of the buildings.

JOHN HIRSCHAUER: There's enough of it left [crosstalk]

REP. CASE (63RD): There's enough of it left, and thank you for coming out.

JOHN HIRSCHAUER: Thank you, all.

REP. WILSON PHEANIOUS (53RD): Yes, I also [clears throat], excuse me, I also want to thank you for your passionate articulation of the need to individualize everybody.

JOHN HIRSCHAUER: Mm-hmm.

REP. WILSON PHEANIOUS (53RD): There may have been a time when there were people trapped in institutions that couldn't get into the community, but I think that time may have passed and many of those that are there are there by choice and by love and by all of the things that you articulate. And I think I'm really very happy that you did that, because that's a perspective that I don't think is often shared. Once size doesn't fit all. And if you're really dealing with the individual, which is what you're doing, I'm glad that they have you there for that purpose.

JOHN HIRSCHAUER: Thank you.
REP. WILSON PHEANIOUS (53RD): And the points that you've raised are very well taken and very much appreciated.

JOHN HIRSCHAUER: Thank you and if I could just offer briefly in response.

REP. WILSON PHEANIOUS (53RD): Please.

JOHN HIRSCHAUER: [hits mic] Oh, I'm sorry. I mean, I think there was a totally legitimate desire at one time, like you're saying, in the past to swing the pendulum. Because it was too far in the direction of institutions, congregate facilities, whatever you want to call them. The fact is, nationally now, 93 percent of all folks with IDD receive services in the "community." So what really bothers me is that the opposition to our facility seems to want it to be 100 percent or nothing. It has to be 100 percent. And for me, it's like, you know, the parents are smarter than any of us on this issue. The people and the siblings and guardians who have loved ones there, they know more than any of us do about what their loved one needs. And I think we ought to respect that. That's all I'm, that' all I'm saying. So, thank you.

SENATOR MOORE (22ND): Thank you.

JOHN HIRSCHAUER: Thanks.

SENATOR MOORE (22ND): All right, now, Jocelyn Gates.

JOELEN GATES: Good afternoon, Senator Moore, members of the Human Services Committee. My name is Joelen Gates. I'm an attorney with Connecticut
Legal Services in Willimantic. Connecticut Legal Services provides free legal services for low-income people, and I personally mostly work with the elderly, and I'm here on behalf of our nursing home residents in support of Senate Bill 1079. It's a staffing bill that would raise their staffing levels to 2.3 hours, nursing staff hours per day per resident.

As you know, life in a nursing home is not easy for most residents. They are completely dependent on nursing home staff to provide their basic care, everything from assistance with eating, bathing, going to the bathroom, being turned over in bed to avoid bedsores, or assisted with range of motion exercises to maintain muscle tone.

The most common complaint we hear from residents and their families is that there are not enough staff to do all of the work. Residents often have to wait over 30 minutes, maybe more, just to get help to go to the bathroom, which may lead to accidents, urinary tract infections, and incontinence.

Between 2015 and 2018, the state Department of Public Health cited Connecticut nursing homes for 247 incidents involving lapses of care according to an article in the Hartford Courant from December 12, 2018. Moreover, not every incident that's reported, is not reported to the Department of Public Health.

Higher staffing levels lead to higher quality of care. Staffing is measured as the ratio of direct health care workers to residents. And Connecticut’s Public Health Code mandates only 1.9 hours of nursing home care, nursing staff care per resident.
per day. This is one of the lowest staffing standards in the country, and it has not changed in 30 years, despite consensus that the acuity needs of nursing home residents have increased over this time. A comprehensive federal study done in 2001 and reanalyzed in 2011 found that a typical resident needs at least 4.1 hours of care per day for adequate care.

Senate Bill 1079 would require nursing facilities to provide a minimum of 2.3 hours. While this standard does not meet the 4.1 hours recommended by the federal study, this modest increase would raise the bar for the lowest staffed nursing homes and bring Connecticut regulations closer to the national average. Since most nursing homes in Connecticut already staff above 2.3 hours, this change would only affect those few homes that do not meet this minimum threshold. However, the hundreds of residents in those homes would certainly benefit by having more staff to meet their daily needs.

And so, in conclusion, I would urge you to support Senate Bill 1079. I want to kind of add that I've been testifying on staffing for over 20 years to raise the minimum standard. And we're hopeful that just, we really don't support, we would really like to have a higher staffed floor here, but we understand the realities of the state budget and we're hopeful that by just raising it a little bit, we won't affect the state budget too much. And so we're hopeful that you'll support this bill.

SENATOR MOORE (22ND): Representative Case.

REP. CASE (63RD): Thank you, Madam Chair, and maybe
Matthew behind you will hear the same questions --

JOELEN GATES: Yeah, Matthew and I are in agreement on this. But, yeah.

REP. CASE (63RD): -- I'm asking. Because I know he's gonna talk about the same thing.

JOELEN GATES: Yeah.

REP. CASE (63RD): And I know I've communicated with him regarding this. Whether we get 1.9 or 2.3, wouldn't we rather have and push towards some type of a system that can account for that 1.9? We are not -- People who -- Family needs to know that they're getting the 1.9 hours of care towards their loved one within the facility. How do we account for that in the state of Connecticut?

JOELEN GATES: I think you probably heard the ombudsman testify earlier about they are looking at the payroll records of staff in homes to make sure that those people are actually working that day [crosstalk]

REP. CASE (63RD): But, but you're looking at the payroll of the staff and you're looking that they have enough staff to cover 1.9. How do we know that Patient A got 1.9 and Patient B got 1.9? What if Patient A got .9 and Patient B got 4?

JOELEN GATES: I think it's the only way you can account for the number of staff in the facility to account for the number of people that are there. It's possible that maybe one resident wouldn't get 1.9, but it's the only way we have to measure the number of people in the nursing home.
REP. CASE (63RD): Well, I know. So we measure it by the number of staff and we times that out so that we can cover the 1.9. I mean, it was useless, but when my brother was in a nursing home and staff would come to us and say, "Well, you're here all the time, so why do we need to keep coming in?" And we've heard that in a meeting when we were in Torrington not too long ago with somebody who had a problem who, the family was having a problem with staffing. And they're being by CNAs and nurses, well, you know, you're always here so we don't need to get in here right away. But, I mean, we have to use these key cards. Can't we figure out some type of a system that can document or can they document within their patient file that, geez, I just did 20 at 20 minutes of care with Patient A? I did -- They have to go in and put when they give the medication. Can't they record so that we can see those records that that patient is getting the 1.9 hours of care, so that we can start there and make sure that everybody is getting the pro -- We can say 1.9, but all's the state of Connecticut is looking at is that there's staffing at 1.9.

JOELEN GATES: I understand.

REP. CASE (63RD): Is that, do you agree with that?

JOELEN GATES: Yeah, yeah, I agree with that. I, I've seen it a little bit in the home care field where the people who, what's that universal verification system or UVV, something like that, they have to, when they check into the home, they have to call in to say they've arrived, and they have to document that they've done their half an hour or one hour or two hours of care, and then when
they leave, they check out with their [crosstalk]

REP. CASE (63RD): There's too many peop, or there's a few people in this room that know about EVV and, yes, it is a system that has an app on your phone and --

JOELEN GATES: Yes.

REP. CASE (63RD): -- when you check into the person's house, you hit the app and you go. And it has helped us bring that under control that the patient or the home care person is getting, we're knowing that the caregiver is there at a certain time and leaves at a certain time. How do we do that in a nursing home facility?

JOELEN GATES: I don't know how to do it in terms of time. But what I have seen in nursing home records are in nurses' notes, I've seen documentation of medications given, there'd be documentation I would think of that, bathing, and I'm not sure about the toileting part, but I have seen just in the medical records some documentation of care given. But I, I don't -- Maybe Matt can answer that better than I about how to document 1.9 hours of, of personal hands-on care. I just see it in notes.

REP. CASE (63RD): I think we'll talk about it more and maybe I'll have some more questions for Matt --

JOELEN GATES: Yeah.

REP. CASE (63RD): -- but I think it's wrong that the state of Connecticut is looking at 1.9 hours of care just by staffing levels that come through the front doors. And not seeing that each patient is
getting that one, or that each resident is getting that 1.9 hours of care. I think that will alleviate a lot of the questions that are going on now. And it's not only 1.9 hours of care; it's 1.9 hours of the physical person in with them. Because it's not only care, it's visiting the person, it's being with the person, it's letting them know that somebody cares. So there's a lot more to it. And I agree with you. Maybe 1.9 isn't enough. But we don't even know if they're getting 1.9.

JOELEN GATES: Yeah.

REP. CASE (63RD): So with that, thank you, Madam Chair.

SENATOR MOORE (22ND): Thank you for your testimony.

JOELEN GATES: Thank you.

SENATOR MOORE (22ND): Matt Barrett. We have a lot of questions for you too.

MATT BARRETT: Good afternoon, Senator Moore and to the distinguished members of the Human Services Committee. For the record, my name is Matt Barrett. I'm the president and CEO of the Connecticut Association of Health Care Facilities in the Connecticut Center for Assisted Living. We're a 160-member trade association of skilled nursing facilities and assisted living communities, and I appreciate the opportunity to offer testimony concerning Senate Bill 1079, AN ACT CONCERNING NURSING HOME FACILITY MINIMUM STAFFING LEVELS.

Our association is in agreement that legislation can and should be adopted this session to increase the
existing minimum staffing requirements. We agree that the Public Health Code is outdated and overdue for an update in this regard. For example, the Public Health Code now only requires a minimum of one and nine-tenths hours per patient for a skilled nursing facility. Senate Bill 1079 would increase the minimum staffing ratio to not less than two and three-tenths nursing hours per resident. We favor of maintaining the nursing home staff definitions now included in the Public Health Code, which are altered in the underlying bill.

Importantly, the bill includes a provision that if any nursing home facility experiences increased costs or expenditures to comply with a higher standard, the Department of Social Services must provide Medicaid reimbursement associated with these new costs.

And finally, we recommend that the new reporting requirements be consistent with the existing federal CMS Payroll Based Journal requirements in the interest of efficiency and to assure that scarce nursing home resources remain focused on patient care, rather than on additional administrative reporting. It should be noted that nursing homes now provide a daily manual report on staffing ratios on site at the facility. Adhering to these existing requirements and existing definitions would be the best approach to monitor a true comparison to the existing ratios with the higher ratio recommended in the bill.

And again, I thank you for this opportunity to testify and I would be happy to answer any questions you may have.
SENATOR MOORE (22ND): So I believe Representative Case is going to ask you some questions.

REP. CASE (63RD): I hope! Oh, boy! Now we got more questions. [laughing] So, can you -- You heard some questions earlier. Do we, can we account for the 1.9? I mean, either way it is going to be an increase of cost. But how do we account and start -- I mean, I just don't agree with the way we calculate the 1.9 for enough staff coming through the front door. We gotta make sure that the residents are getting the 1.9.

MATT BARRETT: I appreciate your question very much, Case, Representative Case. And putting aside the question of costs, aside just for a moment, although I do believe we can increase the minimum staffing requirements and make a very remarkable difference in terms of the floor on a minimum staff and without increasing costs.

But I think there's at least three bodies of information in the current system that should be very reassuring to you that Connecticut nursing facilities are at the very least meeting the 1.9 hours per, a minimum, per day, per resident across the system. And the first body of information is the one that's been discussed pretty openly in this bill, and there are several staffing bills, as you know, in other committees, and that's the electronically reported payroll-based journal requirements that nursing homes started to utilize under federal rules since November 2018. These are based on payroll, verifiable payroll records that are reported electronically directly to CMS. They are auditable, and while no system is perfect, they
very clearly capture the staffing ratios in all Connecticut nursing facilities, including weekend staffing ratios that have been called out recently for being at lower levels.

Secondly, under current Public Health Code requirements, every nursing facility, and I would, not even going out on a limb on that saying that I'm virtually certain that there is wide-scale compliance with this requirement across the system. I've discussed this with my 116 members at various occasions, and every shift must indicate their staffing ratios for registered nurses providing direct care, licensed practical nurses providing direct care, and really the lifeline of the whole system, the CNAs providing direct care. This is reported every shift and it is required under the Public Health Code to be made available for viewing in a common area in the nursing facility and in most places, they're at the nurse's station or at the, out in the lobby to be reviewed.

But secondly, and I think this is the most, out of our, the third sort of body, and this is the most important one. And intuitively, I don't think it's, it's intuitively more difficult concept to grab because it doesn't have a numerical figure to it. But, you know, since I've taken this job, the Department of Public Health has educated me that the strongest staffing ratio requirement is the one that is a federal requirement, it is mirrored to state requirement that requires every nursing facility to staff to meet the resident needs. It's the big teeth Public Health Code requirement that pale, that makes the minimum fairly pale in comparison, because when a nursing home admits a resident, it creates a
duty to meet, you know, a duty on the facility to meet whatever care needs that resident has that are appropriate for a skilled nursing facility setting. And that's where nursing homes can get in big trouble with the Department of Public Health, and sometimes do.

It's never for not meeting the minimums. Because Connecticut nursing home facilities are largely, strike that, not largely, across the system, are staffing over the 1.9 level. I have no question about that whatsoever. And it's what, and I think, and this is not just public relations, I think it's important to raise this floor. But I think the danger with raising the floor is you don't want to raise the floor so much that it invites a fiscal note, and here we go again without another staffing bill. It's important in terms of the quality of performance to raise the floor itself, even if it doesn't require a nursing home to hire an additional staff person. So I think that's the answer to your question. I'm sorry for the long answer, but I have been watching the testimony saying we can't figure this out. I think we can, and I think we can reasonably raise the standard to 2.3 this session, which would be a pretty good jump in the minimum requirement.

REP. CASE (63RD): I thank you and I know you need to, you're going to be going to a meeting tonight. But personally, going to the 2.3 doesn't answer the question that I have to answer to residents' families. They want to know that 1.9 hours of service is going to their loved one. And there's no way that the nursing homes are accountable for that because they're accountable for the staffing ratios
as their employees enter the door, sign in to work; that's what they're reporting out. They're reporting out, I have enough today to serve this 1.9 hours per everybody that's in this building. But we don't know that Resident A got 1.9 and Resident B got 1.9, Resident Z got 1.9. We don't know that. How do we -- How do -- You, you, we don't put that into their medical records, it's not in to their, when they give their prescriptions, you know. How do we account for the time that they're actually in the room at the bed?

MATT BARRETT: Representative Case, I respectfully disagree. I think we do know that. I just don't think we know that in advance. What we know in advance is what are the minimum staffing ratios at the beginning of that shift and we know with certainty the electronic reporting that is based on the actual payment that the facility is making to its employees and that is being reported to the facilities. I think the previous speaker, Joelen Gates from Legal Services really got to how do we figure it out after the fact. We can't know it in advance. We can know after the fact through all of the charting, all of the medical records that are taking place every single day, and sometimes electronically reported, but in many cases, still hand-written reports, we can know. And when Connecticut nursing facilities are not meeting that standard of care, and the Connecticut Department of Public Health is in there at least once a year and sometimes more -- Sometimes complaints are made when staffing is a concern of residents to the Connecticut Department of Public Health or to the State Ombudsman's Office. I do think we can know whether or not nursing homes are meeting that
standard. What I'm saying to you is I think they are meeting that standard. I think we can know it. I think we could raise it.

REP. CASE (63RD): Well, I, I agree with your, well, that the nursing homes might be doing 1.9. But we could've alleviated some of the meetings that are going on at the facility that you're heading to because we've asked the facility to give us direction on how they can prove that the residents are getting 1.9. I walked into that meeting and there had to be 12 families there. And they're like there's no way somebody's gonna get 1.9 hours a day. And the staff and the executive couldn't answer that. They said, well, we have enough most of the time without people calling in sick. We think we have 1.9 coming through the door. But I asked the question, and I'll leave it at this because I think we can work on this bill, we've gotta find a way that we can assure these families that, per state statute, 1.9 hours of care is going to each resident. It could be within a few here or there. But it's, to go from 2.3, we can go from 2.3, but we're still not accounting for it. So with that, I know you have to get to a meeting, but if anybody else has --

MATT BARRETT: No, but I, if I could, Senator Moore, just briefly respond. I agree with your concern very much. I do think we can provide that assurance.

SENATOR MOORE (22ND): So, I was just asking Representative Abercrombie what she thought about a work group with DSS, DPH, and perhaps some representatives from your organization to sit down
and try and figure this out, that we could come up with a way of addressing this. But I, you, this -- We're talking about 24 hours of care, right? I mean -- It's about 10 minutes? How many minutes is that an hour? That you would give to someone at 1.9? And I think about the level of care. It depends on -- 'Cuz I heard what you said is how do you know that they get 1.9 hours.

UNKNOWN: [Off Mic]

MATT BARRETT: No, no, per 24-hour period.

SENATOR MOORE (22ND): Per 24 hours. Right? So my mom's 103, gonna be 104 in July. She takes no medication, she eats regular food, she lives in her own house. I spend eight hours a day with her on Sunday. During that eight-hour period, I might have to give her 15 minutes of actual time while I'm there to make sure she's drinking water, getting fluids. But the rest of the time, she's pretty much either just sitting, not doing anything. So I'm thinking about how much time we give her, other than feeding her her meal. Right. We have to stay with her the whole time while she's eating and she eats three meals a day. We have to, I mean, just doing that, that is at least four hours of dedicated time that we have to give her every single day. And she's not sick. So I don't know what 1.9 looks like to dedicate to a person.

MATT BARRETT: For the record, I, I'll use a word that may be -- I think it's a ridiculously low standard. And I think that we, and that raising it is long overdue in Connecticut. But I think the challenge has been that we have, there have been
attempts to raise it. But you invite a fiscal impact analysis on, if you raise it too much. I think that's been my experience. And so, what I'm suggesting is raising it in and of itself has great value. Just raising the floor in and of itself has great value, even if it's raised in a way that doesn't require a nursing facility to hire an additional person or increase staffing. Because as I've said, for the record, I believe everyone is staffing over, in fact, I'm certain they're staffing over 1.9, and I believe, based on, you know, an informal sort of survey in my group that they're staffing in, at 2.3. But just raising it itself is important. It's important for this reason alone. We continue to live in very difficult and challenging budget times. And some 70 percent of a skilled nursing facility's cost is staffing. And we've been fortunate. We've had the support of Governor Malloy and the support of this legislature, that we have not been cut. We have not been, our rates have not been increased.

Although we've had a couple of nursing, you know, wage enhancement and benefit programs that were very important and I certainly wouldn't say they weren't significant and very, and certainly very badly needed. But in the event that we were cut, it would be important to have a higher floor in the event that it would prevent anybody from going below that. And this would be the opportunity to raise the floor at a time when we can do it that wouldn't invite -- I think we if can do it in a way, and the work group that you suggest, Senator Moore, is where I think we could come to an agreement. I think we could come to agreement -- I don't want to overpromise and underdeliver, but I think we could come to an
agreement in a meeting or two on what would be a number that we could feel good about raising the standard, but not in a way that would invite an analysis that would cause, you know, the Office of Fiscal Analysis based on their, you know, interactions with the Department of Social Services and the Department of Public Health to say this will cost several million dollars.

SENATOR MOORE (22ND): You know, and I did hear the Undersecretary say that she was willing to work with DPH to address this, DSS and DPH working. I think that may be a directing that we might be able to go to get started, because I'd don't think 1.9 is very much and I really don't think 2.3. But I see the fiscal impact of raising it more than that. But I think it's a place to start to start moving it. Representative Case.

REP. CASE (63RD): Just to follow up on that and the impetus, the way this bill started, Representative Cook and I met out at a facility, and the people just wanted an accountability that their loved ones were getting the 1.9, and nobody could give that. So if we can go up to the 2.3, but we still don't have the accountability. So I, we can go to 4, but we need to have the accountability and the checks and balances that they're getting to each and every patient for that amount of statutory time that's required. I'll leave it at that. We can do it in the working group, but that was the impetus of the start of the bill, because of that meeting with the 12 families, they really don't feel as though they're getting the 1.9. And they're families who are there every day with their loved ones. And they see who comes in and out of the room.
And, you know, and I agree with you; we can see the reports that show 1.9 is coming through the employee door. But that doesn't mean what rooms they're going to. I mean, it's, we just need to see that there's an accountability of the employees that, they, the loved ones are getting what the statute says, the 1.9 hours of care for the 24-hour period.

MATT BARRETT: I'm sorry I haven't reassured you of that. But I'm delighted to have the opportunity to keep working with you on it.

SENATOR MOORE (22ND): Representative, did you have something?

UNKNOWN: No.

SENATOR MOORE (22ND): So, you know, I think there is something that we could work on and do, and it, you know, it'd be great if they could create some simple app to be able to track that, even if you did a study of just an average of a couple of different locations to figure out what people are getting. We'll be in touch. We thank you for your staying to the end.

MATT BARRETT: Thank you so much.

SENATOR MOORE (22ND): And I appreciate your testimony. Thank you. Is there anybody else who didn't get an opportunity?

UNKNOWN: [Off Mic]

SENATOR MOORE (22ND): Yes. And just let us know what bill you're speaking on.

DAVID DENVIR: Thank you very much, Chairman Moore,
I appreciate you calling upon me, and Chairman Abercrombie, and Ranking Member Representative Case, Senator Logan, Representative Green, Representative Wilson-Pheanious, and members of the Human Services Committee. My name is David Denvir. I'm an employee of Companions and Homemakers, and I thank you very much for this time since I wasn't signed up to comment on House Bill 1051, which is, I'm very happy to see entitled AN ACT STRENGTHENING HOME CARE SERVICES.

But before I get there, I'm wondering if I might assist this Committee with the courtesy of a number of other prior issues that were raised, having spent the last five years of my life heavily invested in home care. I'm hoping that I can address some of the questions that were asked earlier. For example, Senator Moore, you were very interested in the turnover of home care employees, and it's a great question, and I'm glad it was asked. And the answer from two people was that many home care workers are employed by multiple agencies, and the president of the Home Care Association of America and the Connecticut, excuse me, the Association of Connecticut Home Care Companies said that home care employers encourage that. And, yes, we do. And we encourage that because that's how home care workers develop the schedule of care that they want, by maximizing their employment opportunities from employers. So it is in that regard, Madam Chairman, that I don't think the non-solicitation agreements interfere with people moving from agency to agency. It's a good thing that they move from agency to agency. And to my knowledge, providers don't block that.
Also a question was put forward by, excuse me, a point was put forward by Mr. Shulansky about physicals for home care workers. And I just would like to point out that it's well-known that most of the home care workforce is of a senior population. So I certainly -- In fact, they make some of the best caregivers, because they've raised a family and they've acquired the skill and compassion to be a good home care worker, and I would have a concern that if we started with physical compli, physical requirements, that a large segment of the home care workforce would have difficulty finding employment, not to mention the number of potential ADA claims that could arise. We don't want to stop anyone from providing home care if they have the spirit and compassion to do that.

Representative Butler raised a question about the difference in the pay rates. And what I don’t think was addressed was that one of the significant reasons there's a difference in pay rates is that so many home care companies operate in the state's Medicaid program where their reimbursement rate is $16.36 per hour. They would love to pay their workforce more, but working with $16.36, they can't, because the labor cost, when you figure in taxes and health care and everything they have to pay is $13.34 an hour. So they only have $3.02 to work with to meet all of their other business expenses, excuse me.

And, lastly, on that point, I note that Commissioner Seagull's testimony with regard to this bill acknowledged that the Department of Consumer Protection, this again goes to your question, Senator Moore, they've acknowledged that they do not
have the funds or the resources to implement this bill. And going on that premise that is in her testimony, I make the following observations without any further preamble.

UNKNOWN: [Off Mic]

DAVID DENVIR: It is. It's on her testimony that is posted, Senator Moore. The title of the bill is tremendous and every home care provider I know would like to strengthen home care as much as they can, but as others have voiced, I have concern that the portions of this bill that would propose to do that would in fact not do it and would be expensive and duplicative. For example, Section 4 of the bill proposes that home care providers, private providers and Medicaid providers, submit financial statements and other financial documents to the Department of Consumer Protection. Senator Moore, I'm pleased to tell you that that already happens. Providers that are working in the state's Medicaid program, in order to be what's called "credentialed" or permitted to work in the Medicaid program, they are required to submit their tax returns, their internal policies, their dispute resolution policies, many of the other internal documents that they have, they're required to submit those to an entity called Allied Community Resources.

Allied works under a state contract. So the state of Connecticut is already paying money to an entity to gather that information and credential the providers. And that information eventually makes it's way to the Department of Social Services before any entity is in fact credentialed to participate in the Medicaid program as a provider of home care.
services. So aside from the question of whether that improves home care or not, or strengthens home care, it's already being done. So I don't see how having the commissioner of Consumer Protection do it would in any way add an additional strengthen to home care.

Similarly, on the issue of redundancy, Section 2 of the bill proposes training requirements, and we've heard a great deal of testimony on that point. Effective July 1st of 2018, the Department of Social Services enacted a training program that requires home care companies that are training their employees to meet the highest level of care, which is personal care assistance. Those employees have to, within 90 days of being employed, complete a training program and pass a seven-part, written test, so that they can be established as a home, as a provider to personal care services. Allied Community Resources, also again being paid by the state, monitors that program by conducting spot audits to determine whether or not those training requirements are being met on a provider by provider basis. So, again, irrespective of whether you would find that it strengthens home care, it's already being done. Questioning whether it's necessary for another providing regulator to do that.

And lastly, on the question of whether or not it strengthens home care, on the assumption that the only way that this bill would work would be if the Department of Consumer Protection were to receive additional funding, I would like to suggest ways that that funding would most definitely strengthen home care. I don't think a list strengthens home care. I don't think collecting personal data
strengthens home care. But what would strengthen home care, I believe, is if the DCP had more money to conduct more field audits to actually go out and check on the care that's being provided, since it's all about care. It would also help if DCP had funding to do more site visits to the actual business headquarters of these companies to check their records to make certain that they're meeting all of the compliance standards. Often, the best way for government to improve the quality of the program that it's administering is simply to spend more time enforcing the laws that are already on the books, as opposed to passing new ones. On that same line, the Department of Consumer Protection should be funded to expedite the speed of its investigations and its prosecution and suspension, or perhaps elimination of the program from providers who are not complying with the existing regulations that are already on the books.

On that point, one thing that would definitely strengthen home care has to do with the elimination or restriction of caregivers who shouldn't be providing home care. Now, for example, in one of the care models in the state of Connecticut, individual elderly persons select their caregiver from a list of potential caregivers. That list is maintained by an entity that is not the employer of that person. To my knowledge, that list is never updated if the caregiver on it was fired from a private home owner or has been arrested and charged with a criminal offense or has been accused of theft. And so what happens is that person stays on the list and bounces from agency to agency, excuse me, employer to employer to employer, 'cuz there's no one to tell that new employer that that person
shouldn't be hired.

One thing that my employer, Companions and Homemakers, has advocated for for some time would be for the allowance of providers with immunity to give a negative reference when they have let a caregiver go because they have endangered a home care client. Or they have been accused of a crime or they have committed theft or they've failed to follow an important policy or they've been accused of time care fraud, or timesheet fraud. If those were allowed, if employers could do that, and give negative references without fear that there was gonna be a civil prosecution after that, then caregivers who were abusing the process and not following the rules might not be providing care. And that would strengthen home care.

So those are some of the thoughts given the financial constraints of matters that we think would make a big difference if we focused on care. Certainly, providers who were in the business of providing care have every interest in providing care, because that's what helps their business grow, sustain itself, create jobs, develop revenues, pay taxes. I do thank you for your attention. If I can answer any questions to assist your Committee, I'd be happy to do so.

SENATOR MOORE (22ND): Thank you for your testimony. I do wanna say that there's some points that you've made, and I definitely agree on oversight and monitoring. That's a major overhaul of the systems, I think you're talking about, that needs to take place. And I don't think that's going to happen in this session. I don't think there's going to be a
bill to do that. But it is something to think about in the future, because I agree that there should be better oversight and monitoring. But I also believe that is true for evaluating the grants that we give to people that nobody monitors to make sure the work is being done, other than a piece of paper that someone turns in at the end of the year when the grant is over. But nobody's monitoring that, or evaluating the outcomes of other things. So I agree with you there. I, I'm thinking that the testimony that you're talking about from the Department of Consumer Protection must have come in online because I still don't see it. So where did you see it?

DAVID DENVIR: I saw it online this morning, Senator.

SENATOR MOORE (22ND): Okay.

DAVID DENVIR: Probably as early as 10am.

SENATOR MOORE (22ND): Okay.

DAVID DENVIR: And I might be able to [crosstalk] --

SENATOR MOORE (22ND): Okay. So it came in after we started.

DAVID DENVIR: I'm sorry.

SENATOR MOORE (22ND): That -- Okay. 'Cuz I'm looking for it, 'cuz I wanna read that because I did ask that of the other gentleman. Where did he get that information from regarding the Department of Consumer Protection? So does anybody else have a question or a comment? Representative.

REP ABERCROMBIE (83RD): So just two quick
questions. So my understanding, Allied does not do recruitment, they just keep a list of people that can be employed as home, under Companions and Homemakers. So there isn't any background check done by Allied. That's not their role is my understanding.

DAVID DENVIR: Thank you for the question, Representative Abercrombie. And far be it from me to differ with your understanding; however, I can only tell you my understanding. My understanding is that based on the written contract that Allied has with the state of Connecticut, Allied is specifically charged with not only recruiting home care recipients and visiting with them and training them for two hours to be an employer and obtaining for them an employer identification number so that they can actually be a taxpaying employer, but it is also their obligation to the contract to recruit caregivers and perform background checks on them and then place them on a list.

So, for example, if are someone who lives in the town of Enfield and you're interested in receiving services under the self-directed program and you are approved for those waiver services, you would obtain from Allied a list of probably a number of a few hundred caregivers that are willing to serve the Enfield area, and you would then, individually, on your own select a name from that list of someone you would like to interview. You would then interview them and you would then hire them, and Allied then serves as the fiscal intermediary, the payroll agent that processes the payroll.

REP ABERCROMBIE (83RD): That part is right, but I
wasn't aware of the other piece, so I'm gonna do some checking on that. And then you talk about the fraud of employees, you know, submitting for hours that they actually did not work. That shouldn't be an issue now either because under the EVV, right, someone goes into the home, and I assume Companions and Homemakers is using this because it was mandated under DSS last year. You know, you go in and you have to sign in, so I don't understand how there's a fraud issue with the individuals. That's what the EVV was supposed to be all about. Are you saying that people have found a way around that?

DAVID DENVIR: My point, Representative Abercrombie, had to do with caregivers who were being dismissed for reasons that suggest they shouldn't be in the program. You can certainly have a caregiver that provides care to Medicaid clients and also is providing care to private clients, and you can find that that caregiver in the private purview is in fact, you know, not completing her timesheet correctly or was fudging hours and, yes, I hate to say it, but there is still fraud in the EVV system. We don't see a lot of it. It's not my area of technical expertise, but I can certainly provide you with examples of how it is still being done, Representative, because it's a very important matter. I certainly think that EVV has diminished it because of its technical capabilities, but it is still there. But my point more to that is there are caregivers who abuse the system. That's gonna happen in any industry in any circumstance.

One way to strengthen home care would be to make certain that employers have the ability to make a negative reference without fear of a civil lawsuit
for any reason. Fraud could be one, but you could have a caregiver that endangered a client through their own reckless activity, that's not someone who should be -- When an employer calls for a reference because that person's applying for work, that employer ought to be able to say, "No, don't ever hire them. They can hurt someone." But employers won't say that. A regulation that would permit employers to do that without fear of a civil suit would make certain that we only have safe caregivers and responsible caregivers.

REP ABERCROMBIE (83RD): But isn't that common practice around all businesses? So if someone works for a manufacturer, right, unless there was legal action taken and you call for a reference, they can't give you a negative reference.

DAVID DENVIR: Respectfully, as an attorney with 30 plus years of experience, not to diminish the experience of anyone assembled here, as a matter of law, the truth is always a defense; however, that doesn't stop employers from being afraid that in this litigious society, they're gonna be sued even for telling the truth. A mechanism that would let employers because of a state regulation or a state statute says they can give a negative reference, for the benefit of keeping people who are receiving home care services safe, would be a very positive thing and certainly strengthen home care.

SENATOR MOORE (22ND): Thank you. I just have one more question. You mentioned PCA training. So the CNAs don't get that. Are you saying the CNAs are different than the PCAs and they don't get that
level of training?

DAVID DENVIR: That's an excellent question. Someone receiving CNA training receives training that exceeds what the Department of Social Services requires. My point, Senator Moore, was that the training the Department of Social Services now requires is training for the most demanding level of home care there is. So if the caregivers are already being trained to meet the standard of the most demanding home care there is, there's really no need for a redundant training program that would train them on a much lower standard of care. They're already receiving the highest standard that they can get.

SENATOR MOORE (22ND): Thank you.

DAVID DENVIR: You're welcome.


REP. WILSON PHEANIOUS (53RD): Yes, that's good. Yeah, I wanna go back to the health issue you mentioned. I, you seem to be suggesting that to keep records might disadvantage some of the older workers and some of the people who populate the field of caregiving. And I was just wondering about, is there nothing to -- I'm concerned about communicable diseases or something that someone might have, regardless of whether they're older or not, I wouldn't necessarily want them serving, you know, weak and vulnerable clients. And so I was surprised to hear that there aren't regularly kept health records. Is that, am I correct in understanding? Is that my, that a good
understanding?

DAVID DENVIR: Well, I thank you for the question and my point, Representative Wilson-Pheanious, was not about the records as much as it was a requirement that someone pass a physical exam in order to administer home care --

REP. WILSON PHEANIOUS (53RD): Okay.

DAVID DENVIR: -- endangers the ability of older workers or those that may themselves have some type of infirmity from engaging in home care. And they very often make the very best caregivers.

REP. WILSON PHEANIOUS (53RD): Right. Well having, getting a, passing a physical, some kind of physical requirement and having a clarity about the fact that the person is safe in terms of their not having any diseases they can pass on seem like two different things to me. I understand your point about a physical requirement or something like that, but I am concerned about the other. So --

DAVID DENVIR: If I've answered your question, thank you, yes.

REP. WILSON PHEANIOUS (53RD): You have, indeed. Thank you.

DAVID DENVIR: Thank you. I'd just like to thank you, Madam Chairman, and you Madam Chairman, for your kind attention to my testimony and again, your remarkable stamina in these hearings. It's quite impressive. Thank you.

[laughing]
DAVID DENVIR: [laughing] Thank you very much.

UNKNOWN: [Off Mic]

DAVID DENVIR: Thank you.