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Abercrombie and Senator
Marilyn Moore

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REP. ABERCROMBIE (83RD): I'm Representative Cathy Abercrombie and I want to welcome you to the Human Services Public Hearing for today, Tuesday, February 25. I want to thank you all for being here today and we will start right out of the chute with Commissioner Deidre Gifford. Good morning, Commissioner, and welcome. This is your first time before us so welcome. Sounds good whichever one works. I don't think there's a difference between them so whichever one you feel more comfortable with. Thank you.

DEIDRE GIFFORD: Well good morning Representative Abercrombie, Senator Moore, and distinguished members of the Human Services Committee. I'm delighted to be here before you this morning to testify on the proposed legislation. I am battling a head cold so I apologize in advance for the sniffles. So I, good morning. This being my first, my plan was to go through each piece of legislation with the department testimony and entertain your questions. Does that sound good? Very good.

My name for the record is Deidre Gifford and I'm the Commissioner of the Department of Social Services. Beginning with S.B. 191, AN ACT CONCERNING CHANGES TO

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THE HUSKY B PROGRAM. This proposal refers to section 8 of Public Act 10-3 that requires HUSKY B copayments to align with the state employee point-of enrollment health care plan. Since the time of enactment, state employee copayments have risen considerably. Notably, physician office visits rose from \$10 dollars to \$15 dollars. The \$15-dollar co-pay visit cost is high for children in low-income HUSKY B families who may need to see their outpatient providers frequently so this proposal repeals the requirement that copayments under HUSKY B align with copayment levels under the state employee point-of-enrollment plan and replaces it with language that provides that HUSKY B copayments may not exceed those levels. We have not raised the copayment levels and so this legislative language is requested to align with current practice.

The proposal also would eliminate a separate HUSKY Plus program that provides certain supplemental services, such as long-term therapies to members who have medical needs that go beyond the HUSKY B covered benefits. These services it's important to note would not be eliminated under this proposal. Rather, they would be made a part of the HUSKY B benefit package. We have already done the analogous change on the behavioral health side so this would align the physical health side of HUSKY Plus with the actions that the department has already taken on the behavioral health side.

As I mentioned, the scope of supplemental services that are currently offered under HUSKY Plus would be maintained. The Department also does not anticipate that there would be an increase in utilization as these children who have required the additional services offered by HUSKY Plus are already receiving those services. So the department supports this bill and urges its passage.

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Second, S.B. 192 - AN ACT CONCERNING A LIST OF THE ONE HUNDRED MOST DELINQUENT CHILD SUPPORT OBLIGORS. The Connecticut General Statute 17b-179(1) requires the Department to create, maintain, and publish on its website a list of the 100 most delinquent child support obligors based on information in the federally-mandated state case registry of all child support orders established or modified in the State. To date, the Department has not published such a list on its website for a number of reasons and this proposal would eliminate the requirement that we do so. The reasons are as follows: First of all, no funds have been appropriated for the programming changes that would be required in our system in order to develop and publish and keep the list updated. We have done a study and anticipate that system improvements would cost in the range of \$100,000 dollars.

Second, it became apparent to the Department that we would need to implement regulations in order to put this list into place. So for instance, an obligor whose name and address are to be published on the Internet would first be afforded due process, including the right to a hearing, and that custodial parents and children who are at risk of abuse or harm due to the publication of an obligor's personal information would also have a voice in the process. Such a regulation was publically noticed in 2016. However, noticing the regulations, the Department received significant feedback about legal and privacy issues related to the regulation and they were never promulgated.

Finally, and significantly, as many of you on this Committee know, we believe that this requirement is antithetical to the Department's more modern approach to operating the IVD program, and really does place

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Connecticut in the extreme of child support enforcement when compared to our peer states. As the agency leading the John S. Martinez Fatherhood Initiative of Connecticut, our Department is seeking to engage fathers to participate in their children's lives and upbringing rather than shaming or threatening fathers into the role of responsibility. We note that few states publish the names and identifying information of delinquent obligors. Among Connecticut's geographic neighbors, no state publishes the names of delinquent obligors and most states have moved away from this practice. While there are still six states that publish the names, they do so under much more restrictive parameters than in our current law. For example, one state has published fewer than ten names since 2014. For these practical, legal, financial and strategic reasons, the Department believes that the requirement to publish the list of child support obligors of the General Statutes should be repealed.

Next, I'd like to address two proposals pertaining to methadone maintenance and the payment for methadone maintenance services, S.B. 193 and H.B. 5232. With respect to 193, this proposal would modify existing language that passed in 2019 to provide more time to evaluate tests and implement performance measures that would impact rates for methadone maintenance. Community based providers that provide methadone maintenance have requested additional time to analyze outcome measures that would eventually impact their rates under the legislation passed last year. This proposed language passed in 193 provides DSS more time to evaluate the appropriate performance measures in partnership with providers, especially related to understanding any unintended consequences or perverse incentives of implementing new performance measures. DSS does not want to implement a performance program

that reduces the likelihood of providers serving at-risk members.

In light of the fact that we are still, as you know, experiencing an opioid epidemic, the proposed language allows DSS to be more deliberate about implementing a value-based payment model without disrupting the current service delivery model. Under this proposal, there would be 18 months of measured testing and implementation and as proposed, the new payment model would not be implemented until January 2022. We do believe, however, that during an opioid crisis is an appropriate time to begin having conversations with the provider community around process and quality measure improvement. We want to make sure that individuals who are seeking treatment for substance use disorder are getting the care and the outcomes that they deserve.

H.B. 5232 proposes to delete the language in the existing statute specifically related to provider rates decreasing if they do not meet the minimum performance level on established measure. As I stated, DSS does understand that methadone providers were concerned and therefore, in light of this concern, submitted the proposed language in 193 that would modify the existing statute to include a value-based payment model and the slow implementation slowing down to 2022. So for this reason, DSS does not support H.B. 5232.

Moving to S.B. 194, AN ACT CONCERNING OBSOLETE REFERENCES RELATING TO THE DEPARTMENT OF SOCIAL SERVICES IN THE GENERAL STATUTE. This proposal contains a number of what we consider to be administrative changes that make statutory language more consistent with practice. For example, the first provision would amend the Medicaid state plan, excuse me, the current statute 17a-485d requires DSS to

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"amend the Medicaid state plan to provide for coverage of optional adult rehabilitation services supplied by providers of mental health services." DSS already covers a comprehensive array of behavioral health services, many of which are equivalent to those contemplated by this statute. This is done through the Behavioral Health Partnership in collaboration with DMHAS and DCF. DSS has never amended the Medicaid state plan to add adult behavioral health services within the rehabilitation benefits services category because we believe it's not necessary given that those services are already covered. Because DSS may choose to add these services in the future, we are simply requesting that this statute be amended to make any amendment to the Medicaid state plan and the development of supporting regulations permissive rather than directed.

Also in this proposal, Connecticut General Statute 17b-59a requires DSS to work with the executive director of the Office of Health Strategy to, among other things, develop uniform regulations for the licensing of human services facilities. The Auditor of Public Accounts recently informed DSS that its interpretation of this language requires DSS to promulgate uniform regulations for the licensing of human services facilities which is not defined in the statute. DSS does not believe it was the intention of the General Assembly to charge DSS with promulgating regulations concerning the licensure of facilities since that is the purview of other departments so we are simply requesting that this unclear language be removed from the statute.

Finally, the third provision relates to 17b-349(a) that suggests that both federally qualified health centers and freestanding medical clinics are paid based on cost reporting. This is incorrect. The

current language is incorrect. Freestanding medical clinics always have been and continue to be paid rates based on a fee schedule. Therefore, DSS is requesting that the statute be amended to remove references to freestanding medical clinics.

Finally, we're suggesting that we remove reference to "a consortium of federally qualified health centers funded by the state" in Connecticut General Statute 38a-479aa because such a consortium no longer exists and this was a reference to Medicaid managed care. Since the department no longer uses Medicaid managed care and that consortium no longer exists, we are suggesting that the language referencing it be removed.

In S.B. 195, since the state-funded pilot program for the Connecticut Home Care Program for Persons with Disabilities was established in 2007, since the inception of that program in 2007 which again is state-funded, DSS has not allowed individuals who are eligible or active on Medicaid to participate in the program since they may obtain services through the Medicaid State Plan or a Medicaid waiver. General Statute 17b-617 does not specifically state currently that individuals who are eligible for or active on Medicaid shall not be eligible to participate in the pilot program so we propose amending the statute to clearly reflect our practice and clearly state that individuals who are eligible for Medicaid under Title XIX or a Medicaid waiver should not be eligible for the Connecticut Home Care Program for Persons with Disabilities.

S.B. 196, AN ACT CONCERNING THE STATE-WIDE HEALTH INFORMATION EXCHANGE BOARD OF DIRECTORS. This proposal would add the Commissioner of the Department of Social Services or her designee to be an ex-officio voting member of the Board of Directors for the Health

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Information Exchange. This change would acknowledge DSS's role as the single state Medicaid agency for Connecticut through which enhanced federal Medicaid matching funds are being leveraged to support Medicaid providers in accessing and utilizing the Health Information Exchange. This proposal is supported by both the Office of Health Strategy and DSS urges passage of this bill.

H.B. 5233, AN ACT CONCERNING PAYMENTS TO PROVIDERS OF SOCIAL SERVICES. While DSS strongly supports and has begun to implement the concept and practice of including peer support specialists within care teams, we respectfully oppose Section 2 of this bill as drafted. The Governor's budget does not provide funding for new peer support services under the Medicaid State Plan as proposed. Please note that peer support specialists are longstanding members of the Intensive Care Management teams that are affiliated with our behavioral health administrative services organization, Beacon Health Options. As you know, these individuals bring lived experience with behavioral health conditions and substance use disorder to inform their work with members who are grappling with those conditions. Furthermore, both community health centers and advanced networks who are part of DSS's PCMH Plus initiative have incorporated community health workers, some of whom provide peer support, into their care teams. This has helped further their goals around meaningful integration of behavioral health and physical health in HUSKY. DSS has held the view that it is most suitable to use value-based payment arrangements as opposed to fee-for-service payment as a means of enabling providers to support the costs of community health workers, including peer support specialists, in their work. As such, the Department must oppose House Bill 5233.

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H.B. 5234, AN ACT CONCERNING THE AUTISM SPECTRUM DISORDER ADVISORY COUNCIL. This proposal would simply add a third chair-person to the council, making it a tri-chair structure. DSS believes the ideal leadership of this council includes a DSS representative, an individual who has self-identified as having autism and a family member of an individual with autism. The council believes that a family member should be part of the leadership of the council and this revised language accomplishes this goal. The Department of Social Services agrees and supports passage of this bill.

And finally, two proposals relating to nursing fluid collection reimbursement, H.B. 5235 and 5236. You have our written testimony on both of these which is extensive and I wanted to preface my remarks on these two by stating again the department's commitment to a couple of things as we transition from our current payment system to a new acuity-based system.

First of all, the goal behind these transitions is to improve the quality of care and quality of life for our members living in nursing facilities. That is our interest and it's foremost in our minds as we make this transition. We want to make sure, however, that payments to nursing facilities reflect the differences in acuity of the individuals who reside in their facilities and that is the main goal of transition from the current fee for service process to an acuity based system and we also want to modernize a payment system that is not a best practice. Approximately two-thirds of states have already made this transition from a fee for service process to an acuity based system and we believe it's time for Connecticut to also move in this direction. However, we understand and appreciate the uncertainty involved when making such a significant change in a payment system for the

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industry and for all of the stakeholders involved and that is why we have been aligned with you on this Committee in a couple of important ways.

First of all, we want to make that this transition reflects careful planning and preparation. We want to make sure that we use validated data and are transparent in sharing that data with the involved stakeholders. We also are aligned with you in our interest in making sure that the new payment system reflects meaningful stakeholder feedback, including, but not limited to, advice and comment from the Nursing Home Financial Advisory Committee. We want to make sure that the new system examines and addresses any negative impacts and involves a high level of transparency, and we also agree that it should be implemented on a staged basis as opposed to implementing in full on July 1, 2020.

As such, S.B. 5235 does a few things. It does build on last year's legislation by establishing that case-mix is the required means of Medicaid reimbursement for nursing homes. It confirms that consistent with the enacted budget, case-mix will be implemented on a cost neutral basis. Importantly, I want to emphasize that the language suggests starting the implementation on July 1, 2020, but does not require full implementation by that date and in fact, allows for a period of time for the changes to be phased in and significantly, to be updated quarterly such that as the case-mix in nursing facilities changes, the payment would be adjusted to reflect that. The 5235 includes geographic groupings of nursing facilities which has been an expressed concern. It continues to recognize the allowable cost in the five cost components that are already recognized in the current payment method, but importantly, and this is something that we'd like to emphasize, it retains the flexibility

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for DSS to negotiate with the industry on a very complex payment system with multiple interrelated elements.

We have already begun to work with the industry on this transition. We have demonstrated, I believe, our adherence to the values I described earlier. We've been actively meeting with the nursing home industry and continue to do so. We have, as you know, engaged with you all with presentations to MAPOC and the committees of cognizance. We have posted all of our model design and related materials on a public website and we continue to partner with the national expert in this process, Mercer Government to work with us and with our industry partners as we make the transition. Furthermore, we are committed and in fact required to fulfilling all of our obligations in amending the Connecticut Medicaid State Plan, including a full public comment period.

So with respect to 5236, DSS respectfully opposes subsections (b), (c) and (d) of this bill. We believe that this language would significantly disrupt DSS's role in managing the Connecticut Medicaid Program and we oppose the following provisions: Subsection (b), which prevents DSS from implementing the case-mix system until regulations detailing the system have been fully adopted. Subsection (c), which seeks to require that the Medicaid State Plan Amendment associated with case-mix be reviewed and voted upon by the committees of cognizance prior to submission to CMS, and subsection (d), which directs in detail the content of the SPA. We believe that subsection (b) would significantly delay the implementation of case-mix, could delay it until beyond 2022, and it also imposes requirements on DSS that are not typical of its implementation of new initiatives that have been

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acknowledged to be of benefit to both the industry and to our members.

In subsection (c), it requires that the Medicaid State Plan Amendment associated with case-mix be voted on by the committees of cognizance prior to submission. DSS has not historically been required to present SPAs to the committees of cognizance, with the narrow exception of certain waivers. Given that implementation of case-mix involves a rate methodology, we believe this resides squarely under the authority of the State Plan and DSS will fully comply as required with full notice and comment period, and we don't believe it's necessary to require that the SPA be reviewed in advance by the committees of cognizance.

And finally in subsection (d), in details in great detail the content of the State Plan Amendment. Almost none of the elements proposed in the bill are typical of the elements of a State Plan Amendment and the requirements are quite prescriptive. A couple of particularly concerning notes, Federal law already requires that Medicaid payments be consistent with quality and access to care which is reiterated in this language, and the proposed legislation does not contain a definition of a funding shortfall, which DSS would be required to address in the State Plan. We are confident that through the payment methodology development process, all of the elements necessary to evaluate the impact of the new methodology will be available both to the industry and to the Nursing Home Finance Advisory Committee.

Finally, the financing language in subsection (d) is too prescriptive and would be damaging to DSS's ability to negotiate a payment strategy in the best interest of our members and for the foregoing reasons,

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the Department opposes House Bill 5236. That concludes my testimony, Madam Chairperson.

REP. ABERCROMBIE (83RD): Thank you, Commissioner. Good job for the first time being before us, even with your cold. [laughs] Thank you for being here. Questions from Committee members? Really? Okay. Just gotta raise your hand, Representative. No, we like to close out so I'll, go right ahead, Representative.

REP. MASTROFRANCESCO (80TH): Thank you, Commissioner, for your testimony. A lot of information here which is really good. Just a couple quick questions. On Senate Bill 191, the changes to the HUSKY Program, can you just give me a little background on what the HUSKY Plus Program provides as far as services go and long-term therapies? Can you give me an example of what that covers?

DEIDRE GIFFORD: Yes and then I have my valued team members behind me so if you have additional questions they can provide that. HUSKY Plus provides certain supplemental services such as long-term therapies, and I believe long-term physical therapy, speech therapy, occupational therapy, and certain types of specialized medical supplies and equipment.

REP. MASTROFRANCESCO (80TH): Okay. Thank you for that, I just needed clarification. On Senate Bill 193, the methadone maintenance, can you explain to me the performance measures? Right now there's performance measures in place that will just determine the reimbursement rate; is that a correct analogy? Is that right?

DEIDRE GIFFORD: They are not yet in place, Representative, so the legislation that was passed last year directed the Department to put such measures into place in fairly short order. They have not been implemented yet. We heard concerns and frankly shared

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those concerns about the repetitiveness with which that new system would need to be implemented so what this bill does is prolong the time to develop and test those measures in partnership with the provider community so that we can learn together about the feasibility of gathering, measuring, reporting, collecting all of those measures so nothing has been in place to date. This bill would allow 18 months to develop that process and then would delay the implementation of the new payment system until 2022.

REP. MASTROFRANCESCO (80TH): Once the performance measures are created, does it come back to the legislature? No? To this Committee? Cathy's saying no, Representative Abercrombie, no?

REP. ABERCROMBIE (83RD): No.

REP. MASTROFRANCESCO (80TH): Okay.

DEIDRE GIFFORD: They would be available in an aggregate generally depending on the program, sometimes providers' specific measures might not be available but in aggregate in reporting on the program, the department could certainly share the performance on those measures.

REP. MASTROFRANCESCO (80TH): I don't know if you know the answer to this question. Do you have any idea how many people on the program right now?

DEIDRE GIFFORD: Methadone maintenance? We will find out for you.

REP. MASTROFRANCESCO (80TH): Okay. Thank you. Let me just find the bill number. The bill regarding the, hold on one second, oh the delinquent child support, that was Senate Bill 192. I'm not familiar with it. Can you tell me what the purpose is of publicizing the names, publishing the names of fathers or people who

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are delinquent with child support? Is it a federal program or is it just a state program?

DEIDRE GIFFORD: The publishing of the names is not a federal program. The 4D program, the Child Support Enforcement Program is a federal program but the publishing of the most delinquent obligors was something specific to Connecticut.

REP. MASTROFRANCESCO (80TH): And would you know what the purpose of that program was, why that was implemented, what, for the reason of?

DEIDRE GIFFORD: I believe and I'm joined by John Dillon who directs our program so he may wish to elaborate but I believe the intent behind the original legislation was to by publicly making those names available, prompt individuals who were behind to pay. If you guys want to introduce yourselves?

GRAHAM SHAFFER: I'm Graham Shaffer. I'm an attorney with the Department that works with John.

REP. MASTROFRANCESCO (80TH): Thank you.

JOHN DILLON: And I'm John Dillon. I'm the 4D director, the Child Support Director for the State of Connecticut.

REP. MASTROFRANCESCO (80TH): Thank you. How many people are on this list currently?

DEIDRE GIFFORD: We don't currently publish the list.

REP. MASTROFRANCESCO (80TH): Oh we do not.

DEIDRE GIFFORD: We have not for the reasons that I articulated in terms of the challenges of promulgating the regulations, the Department has not yet published the list.

REP. MASTROFRANCESCO (80TH): So I guess I just misunderstood the bill. I was under the assumption

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that the list is published and this bill would reverse it. Am I wrong with that? Okay. I am wrong with it.

REP. ABERCROMBIE (83RD): So just for clarification, there is statute that says it should be listed, but DSS has never done it so what they're saying is they want to reverse so that it's not listed because there'd be a price tag of about, I think you said, Commissioner, about \$100,000 dollars or something like that to start listing that so they just want, they want to remove the statute that says we have to list it.

REP. MASTROFRANCESCO (80TH): Okay. So it was never implemented?

REP. ABERCROMBIE (83RD): Exactly.

REP. MASTROFRANCESCO (80TH): Okay. That clarifies that. It just seemed, I don't know, just personal opinion, I wonder what business is it of anybody's when they, what their financial situation is just kind of struck me. I thought it was the names listed there, it's not like a pedophile name listed. It's more of a personal situation between them and their former spouse. It just struck me on that one. Okay. Thank you. And the reimbursement for the nursing homes?

DEIDRE GIFFORD: Yes.

REP. MASTROFRANCESCO (80TH): Currently it's based on the reimbursement. What is the current reimbursement rate now? I know we talked about this last session. Percentage wise, would you know?

DEIDRE GIFFORD: So the rates vary by facility, Representative, based on a complicated cost base calculation and multiple different factors.

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REP. MASTROFRANCESCO (80TH): Occupancy is part of it as well or no?

DEIDRE GIFFORD: Well to a certain extent there is an element of occupancy but it's not always, there's sort of a lesser than choice in the current calculation so the actual occupancy is not always reflected in the facility, in the payment.

REP. MASTROFRANCESCO (80TH): So if an average nursing home stay was cost, I don't know let's say \$10,000 to \$12,000 dollars a month, about an average, what would be reimbursed?

DEIDRE GIFFORD: Are you asking me about the ratio between nursing homes' calculated cost and Medicaid payment?

REP. MASTROFRANCESCO (80TH): Yes.

DEIDRE GIFFORD: Okay. I would not be able to tell you that off the top of my head.

REP. ABERCROMBIE (83RD): I think if I may it's a little more complicated than saying X, Y, and Z gets this amount. Just for clarification about what this legislation is about so currently the payment system that we have in place, everybody is kind of treated equal. What this does is looks at nursing homes and nursing homes that have higher needs. So say they have dementia units or they have, they do dialysis, they'll get a higher reimbursement because of that, so that kind of mix that this legislation is going towards. Where I think it gets a little complicated and we heard this at the forum that we had a couple of weeks ago around nursing homes is, if you keep it cost neutral, somebody loses, right? Cause there's not enough dollars in the system, right? So if somebody is doing just for lack of a better word straight nursing homes with a low-case, a low-needs case,

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right? They're gonna get a lower reimbursement, right? Whereas someone that has a higher mix of cases will get a higher one and that's where I think, and I'm just going to speak for myself, that I think it's become a little bit complicated and I think nursing homes have been involved with this process and thank you to DSS, there have been numerous meetings. I think their just anxious and there's other things going on. Like for example, what do you consider an add-on? How do you do that? What do you consider between a nursing home that someone's there long-term or short-term so there's a lot within the system that has not been vetted out in my opinion and I think that's why you hear from nursing homes, that they're concerned about this. And the other point is that, and I'm just gonna say it, nursing homes have taken a hit over the last few years. We've done a lot of changes within that industry and so with some of the legislation that we've done, I think they're like really anxious at this point. I hope that helps.

REP. MASTROFRANCESCO (80TH): Yeah, it does. Thank you. It makes sense. So if reimbursement was based on acuity, would there be certain levels of acuity and a different rate based on a level 1, 2, 3 and 4 based on the needs of the resident there?

DEIDRE GIFFORD: So it's actually even more nuanced than that. So nursing homes are required by CMS, by the federal agency that oversees Medicare and Medicaid, they are required to collect on a period basis very detailed information about the clinical condition of the individuals who reside in their facilities. That's referenced in the bill. It's called the minimum data set and there are periodic MDS assessments on every resident. The acuity adjustment would use those MDS assessments which the facilities themselves complete, the caregivers actually complete

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on a periodic basis. The acuity-based system uses those MDS assessments as a component of the rate so it doesn't rely only on that assessment of acuity but it becomes a component of the rate which as the Representative pointed out, in our current system, although we do have a differential rate for some highly complex individuals like ventilator or dialysis, we currently pay differently for those because they're so much more intensive, but other than, beyond those very intense cases, the day rate is the same and so as the Representative rightly pointed out, it does not provide an incentive for facilities to take some of the more complex individuals nor does it reward those who do and it can, like a lot in healthcare payment, can provide a perverse incentive for facilities to want to accept individuals with lower care needs because they're going to be getting the same rate for that individual or for somebody with end-stage dementia and complex medical needs. So that's the reason why, Representative, the majority of the rest of the country has already transitioned to this type of acuity-based rate and why we feel so strongly that it's in the best interest of our members as well as the industry and the industry has, although as I stated, we certainly understand the anxiety associated with this type of a significant transition, they have in general around the country been supportive also of this type of transition. And just one other thing I'd like to emphasize because it's very important to us at DSS and to the Governor, this transition will allow us for the first time to take the quality of care provided in the facilities into account in the payment structure. It won't do that right out of the starting gate so just to be clear, if you heard the Meyer's presentation at the forum, that's a later phase of the implementation. The first part involves the acuity, but later on we will be able

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to look at quality differentials in facilities and reward those facilities that are providing a higher quality of care and we think that's a critical need for the residents that are residing in nursing facilities and are very much looking forward to partnering with the industry to develop that strategy.

REP. MASTROFRANCESCO (80TH): Thank you. So I guess I can assume to say right now there's no different pay structure for somebody that may need a Hoyer or a two-person assist?

DEIDRE GIFFORD: That's correct.

REP. MASTROFRANCESCO (80TH): But this particular program will allow for that and somewhat of a tier for that.

DEIDRE GIFFORD: Correct.

REP. MASTROFRANCESCO (80TH): Okay. Thank you. I think that's it. Thank you for the clarification and your testimony. Much appreciated. Thank you.

REP. ABERCROMBIE (83RD): So I would just for clarification about the methadone clinics, so last year in the budget, all of them get paid different rates. So the lower ones were brought up to a different rate so that they were more equal. Along with that language, we put in that we wanted performance measures so that's what this is, is that DSS has not had the time really to put into that because it was a really short timeline for them to come up with those measures so what this does is it asks for longer time. The reason why you see another bill is because the providers are not happy with that portion of it, because it wasn't something that was negotiated ahead of time. It kind of was put and it wasn't from them so for clarification, it was kind of put in the budget at the last minute, the performance

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measures being linked to it so that's why you see two different bills here right now, okay? Representative Wood? Did I, yeah?

REP. T. WOOD (141ST): Thank you, Madam Chair, and thank you, Commissioner, for being here. A couple of questions on HUSKY B. I've read through this and it appears if I'm correct that it's simply putting everything into the HUSKY Plan and eliminating these side, yes, okay, I see it.

DEIDRE GIFFORD: That's right.

REP. T. WOOD (141ST): I see heads shaking behind you indicating yes. It was a lot of language to say that but I'm always keep it simple.

DEIDRE GIFFORD: I think we wanted to be clear that the understanding that we weren't eliminating benefits, that this was a vestige of sort of an administrative process and so that's the reason for the extra language.

REP. T. WOOD (141ST): So you're simplifying the billing on both sides, both the patient's side and the administrative side.

DEIDRE GIFFORD: That's correct.

REP. T. WOOD (141ST): Thank you.

DEIDRE GIFFORD: You're welcome.

REP. T. WOOD (141ST): Smart idea. And then on Senate Bill 196, the act concerning the statewide health insurance information exchange board of directors. I just, I have more of a holistic question on this. What year was this created? I'm sure it's been in the last couple of years but I just, we do a lot here and sometimes you fog on all that we do.

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DEIDRE GIFFORD: So the health information exchange resides, the authority to implement resides with the Office of Healthcare Strategies, not with DSS so I don't have the history. OPM is telling me 2011, the first one. There was an initial foray into health information exchange in 2011 which ran into some roadblocks. This is a reboot of the health information exchange which again, resides at the Office of Health Care Strategies and this is a more recent iteration.

REP. T. WOOD (141ST): Simply adding you as ex-officio on the board?

DEIDRE GIFFORD: That's correct.

REP. T. WOOD (141ST): Because just in looking up on the web, you can't find any information on it so I'm a little baffled on what this group is and what they're, I mean, I understand what they're trying to do. The purpose is to create statewide health information sharing.

DEIDRE GIFFORD: Yes, so the entity --

REP. T. WOOD (141ST): But there's no information.

DEIDRE GIFFORD: The entity that -- I wonder if you can link, I'm sorry, I don't know exactly how to find it. I wonder if you can link through the Office of Healthcare Strategies. The entity that was, that will oversee the health information exchange was only recently, since my arrival which was June of last year, was only recently put into place so is a rather new structure and you know it has a formal, obviously a formal board to which DSS was not originally a member.

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

DEIDRE GIFFORD: Sure.

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REP. T. WOOD (141ST): Thank you, Madam Chair.

REP. ABERCROMBIE (83RD): So, Representative, we would be more than happy to get you some information about this board. They did come before Appropriations so they are in the budget so we can get you some more information on that. They are newly formed so you're right, I think it was about 2018 when they really started to become up and running.

REP. T. WOOD (141ST): Thank you.

REP. ABERCROMBIE (83RD): You're welcome.
Representative Hughes.

REP. HUGHES (135TH): Thank you, Madam Chair, and thank you, Commissioner for walking us through all of these different proposals before us. I do want to acknowledge that going off of what Representative Mastrofrancesco said, that this is an attempt, the acuity-based reimbursement to reflect that the needs of most of our long-term-care residents change. So it's not static and so we have to adopt a model that really reflects that changing need you know in a more real-time reflection. I work in a nursing home setting and it's very, very difficult for, they are under-reimbursed basically for their services under Medicaid. I think ours is about 70 percent of the cost so they're eating the rest of the cost so how to make that more reflective of the actual needs of the population, it changes. You know it changes sometimes week to week but certainly month to month so I think that those benchmarks are really, really important and also, I think that what is really important is that peer group alignment because, and I'm not clear, are you saying that's also geographic group alignment? So lower Fairfield County has a significant higher cost of --

DEIDRE GIFFORD: Yes, that's correct.

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REP. HUGHES (135TH): Right. Okay.

DEIDRE GIFFORD: The methodology as we're proposing it in 5235 includes geographic groupings of facilities.

REP. HUGHES (135TH): Right, right. So that'd be really important because what we don't want is a race to the bottom of facilities competing for those residents, right?

DEIDRE GIFFORD: The lower acuity residents?

REP. HUGHES (135TH): Yes.

DEIDRE GIFFORD: Exactly.

REP. HUGHES (135TH): Yeah, so, and also is this, and maybe you covered it but in terms of the acuity-based, does it look like it captures more of the Medicaid funding reimbursement from the federal dollars?

DEIDRE GIFFORD: It would not change our federal financial participation for nursing homes residents. To the extent that, well only a very subtle way within a facility, if a facility had more highly complex residents and therefore was getting a higher rate, then our federal match would be concomitant to that higher rate.

REP. HUGHES (135TH): But it doesn't cover it aggregate over the state?

DEIDRE GIFFORD: Because the proposal as it stands is cost neutral, it doesn't overall increase the amount of federal revenue.

REP. HUGHES (135TH): Darn. Okay. [laughs] And I guess I really applaud the use of data section about Medicaid funded home and community-based services in Connecticut's long-term-care system. This is part of a pilot that we started in 2007, the rebalancing taskforce and it's amazing when we look at the

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utilization of homecare from 2017 levels of 67 to 82 percent by 2040, that's really an extraordinary care. Do you know what it was from 2007 when we started the project? 45 percent?

DEIDRE GIFFORD: 45 percent I'm hearing.

REP. HUGHES (135TH): Yeah, I was on that advisory taskforce as an intern so I remember that.

DEIDRE GIFFORD: And I think, I'm glad you pointed that out because I do think although the transition to acuity-based rates is not strictly related to our efforts to enhance home and community-based services, the transition to HCBS does impact the acuity of the individuals who remain in nursing facilities.

REP. HUGHES (135TH): Right. That's right.

DEIDRE GIFFORD: So I think there is a correlation and as we continue with the rebalancing and we're seeing more people receive home-based services, those that are remaining in nursing facilities are by definition going to be the individuals with higher needs and so we want to, that's another reason why we think it's important to recognize that within the payment system.

REP. HUGHES (135TH): That's all. Thanks.

REP. ABERCROMBIE (83RD): Thank you, Representative. Representative Wilson-Pheanious.

REP. WILSON-PHEANIOUS (53RD): Good morning, Commissioner. Thank you. [coughs] Excuse me, I guess I'm fighting a bit of a cold myself. Regarding Raised Bill No. 192, I just wanted to applaud the Department for finally moving in the direction of this, what used to be a list of shame often for men who, for a variety of reasons, could not afford to keep up with child support payments and it was one more thing keeping men away from their children. Now,

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I know that there are, will always be some people who do not pay, can pay and don't pay and we do need to go after those people but shaming is not the way and I'm so glad to see after these many years the department moving in that direction and in support of the fatherhood initiative to the extent that we can get men to work with their families and back into the lives of their families, children are so much better off so I'm very, you know particularly happy to see that after all of these years.

DEIDRE GIFFORD: Thank you, Representative, and thank you for your support of the fatherhood initiative and your engagement and I just want to acknowledge our staff in the Child Support Enforcement Program who have been advocating for this approach and supporting the fatherhood initiative so [crosstalk].

REP. WILSON-PHEANIOUS (53RD): Well I know for sure Mr. Dillon has been around in the days when there was a very different attitude and we had to fight against it as a department to make the change that you've now made and it is delightful to see in action. Regarding Raised Bill No. 193 --

REP. ABERCROMBIE (83RD): Can you just say the meaning for the public [crosstalk].

REP. WILSON-PHEANIOUS (53RD): Oh, certainly. AN ACT CONCERNING METHADONE MAINTENANCE AND THE PERFORMANCE MEASURES. My question here or my concern here is that recovery is a very individualized effort and I'm concerned that performance measures that might be created might not fully recognize that and I'm, as these performance measures are developed, I'm wondering how are you adjusting or how are you going to adjust that particular issue?

DEIDRE GIFFORD: Thank you and we agree, Representative, which is among the reasons why we are

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suggesting slowing down the implementation and eventual starting up of this payment system. And by the way, thanks to Kate and the team in response to an earlier question, we have 16,000 individuals receiving methadone maintenance currently in our system.

REP. WILSON-PHEANIOUS (53RD): Thank you.

DEIDRE GIFFORD: So the measures would need to be carefully crafted and let me give you a couple of examples of the types of things that we might be looking at. For example, are individuals who are receiving methadone maintenance also receiving a visit to a primary care provider? Are individuals who are starting on methadone maintenance, are they retained in some way in treatment or do some facilities have higher rates of engagement than others. Are people receiving dental care which is often an issue. So it would be, the measures would be things that are universally applicable and less so things that have to do with the individual outcome of treatment for a particular individual. This is, I want to acknowledge, we have providers in the room, I want to acknowledge that this is a new area of measurement in the Medicaid program and these things do take time to implement but I think we are firm believe at DSS that because it hasn't been done before doesn't mean we shouldn't dip our toe in the water and begin down that path particularly in such a critical part of our substance use disorder treatment system.

REP. WILSON-PHEANIOUS (53RD): Absolutely.

DEIDRE GIFFORD: And so I will emphasize again that we and DMHAS and all of the behavioral health partnerships want to partner with the industry as we set up this program, but we do think it's an important way to move forward.

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REP. WILSON-PHEANIOUS (53RD): I would also comment and ask for your, I don't know, as you develop these performance measures you take into account the fact that in various parts of the state, the service array is very different and the supportive services that might be available in a big city area are not available in a rural area like the one I represent and so it's harder for people to maintain their treatment and to show success when they don't have the ancillary services to support them.

DEIDRE GIFFORD: I appreciate you bringing that up and I think that measurement is the way that you, one, root to solving those problems. If we shine a light on some of those issues and a provide is actually looking at the performance of their program with respect to those elements, then you can say well why aren't my clients getting dental care? Why aren't they seeing a primary care provider compared to providers in other areas and that's how we can actually get to improvements in the system.

REP. WILSON-PHEANIOUS (53RD): Transportation is a big element in that but what I wouldn't want to see happen is the methadone providers be hurt because they cannot keep up with people who have an array of services that they don't have so that's a concern. Thank you for that. In Raised Bill No. 194, AN ACT CONCERNING OBSOLETE REFERENCES RELATING TO DSS, I note that you are proposing or that it is proposed that notice no longer be given in the Connecticut Law Journal, but rather posted on the eRegulations System and that it would become effective, I don't, I'm sorry, I don't think this was in your comments but rather in the underlying law or the underlying bill and I'm wondering. I see somebody approaching that might have the answer. I was wondering what impact that will have if any on the legal community's ability to

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advocate? I know that there was a 40, you know when you publish in the Law Journal you do it within 45 day of the time the regulation takes effect. Here, the regulation would take effect immediately and I wonder who all, whether everyone has equal access to the eRegulations system, whether the advocates who customarily find things out in the Law Journal would be apprised of the change and maybe you can comment on that?

GRAHAM SHAFFER: Sure. Again, I'm Graham Shaffer. I'm an attorney with the Department of Social Services and I deal with our regulations at the agency to some extent. This is sort of a cleanup of a change that was made four or five years ago now I believe which was the creation of the eRegulations System through the Secretary of the State's office and the primary statutes out there that talk about posting public notice of regulatory changes were at that time amended to reflect that that posting should now occur on the eRegulations System. There are some of these lingering statutes we come across every now and then where that change had not been made, but I think broadly speaking that the practice in Connecticut since the eRegulations System became effective, and I believe it was about 2016, has been for people to sign up through the eRegulations System that are interested in a particular agency's rule-making processes and they can even get automatic alerts from the eRegulations System if there's rule making that's proposed so my general perception and topic talking with advocates is that that has actually worked quite well.

REP. WILSON-PHEANIOUS (53RD): Okay. All right. Good. Thank you for that. I'm an old girl and I miss some of these newer changes so thank you very much. Regarding Raised Bill 5235, AN ACT CONCERNING NURSING

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FACILITY REIMBURSEMENT, again, I want to raise the issue that as you're shifting towards the acuity-based methodology, that you take into account the dearth of services that may be available, ancillary services that may be available within a given region. Even though I know this is about what happens within the home, so many things are impacted by poor transportation, by services in the area that may not be available to assist in one or another and I didn't see, I remember the presentation, the wonderful presentation you all gave regarding the change to the new system and the new system, but I didn't see much in there that would make me feel easier about an area like the one I represent where you just don't have the transportation services and other services that might be available, and I fear that homes in those more rural areas will be negatively affected because of that.

DEIDRE GIFFORD: I appreciate the concern, Representative. With respect strictly to the acuity of the residence, that's more of a characteristic inherently of the individual and their particular medical condition.

REP. WILSON-PHEANIOUS (53RD): Except that they may not have received the kind of services that could have assisted them earlier because those services weren't there so you may get them sicker or sooner.

DEIDRE GIFFORD: That's right, but that wouldn't necessarily impact the facility with respect to the prior treatment. So if they're sicker when they arrive at the facility, the case-mix adjustment should take that acuity into account. I think where we may have need to talk about the issues that you're talking about is when you get to the quality measurement system and we're talking about hospital readmissions and those kind of things. I know [crosstalk] levels

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are challenging in rural areas in some states so those are places where I appreciate you bringing up the issues of more isolated communities and how we need to make considerations for them.

REP. WILSON-PHEANIOUS (53RD): Yeah, I didn't see anything in the formula that would allow for that.

DEIDRE GIFFORD: Right. I don't, we're certainly interested in discussion it further with the facilities impacted. I'm not seeing how the acuity-based piece per se, absence of quality measure aside, would be impacted by a facility in a rural area.

REP. WILSON-PHEANIOUS (53RD): It may not be. It's just that these things tend to work together and if you are disadvantaged in very basic ways, then you're gonna be, I mean I'm talking about the facilities and how would you be equally disadvantaged when you start looking at quality measures and how things are measured in general so that was just my concern that you have that sensitivity as these are developed and recognize that services are not the same all over the state and some of us are really on the short end of the necessary services to help people you know thrive so thank you, but I appreciate the work you all are doing and thank you very much.

DEIDRE GIFFORD: Thank you.

REP. ABERCROMBIE (83RD): Senator Moore.

SENATOR MOORE (22ND): Good morning.

DEIDRE GIFFORD: Good morning.

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

DEIDRE GIFFORD: You're welcome.

SENATOR MOORE (22ND): You're doing a great job.

DEIDRE GIFFORD: Thank you.

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SENATOR MOORE (22ND): Thank you. So I just have a question first on Senate Bill 191, it's Connecticut Health Network. Are they the only administrator of HUSKY?

DEIDRE GIFFORD: They administer the physical health benefit. The behavioral health benefit is through Beacon Health Options.

SENATOR MOORE (22ND): Does this impact Beacon Health at all?

DEIDRE GIFFORD: I believe that the HUSKY Plus services have already been combined into Beacon. If you recall in my comments, I mentioned that this is sort of phase II which would take the HUSKY Plus physical health benefit and combine it with CHN. We had already effectuated combining the behavioral health benefit into Beacon Health options under HUSKY Plus.

SENATOR MOORE (22ND): Thank you. And then on Senate Bill 192, I do want to compliment you on taking this out of legislation. I know about the fatherhood initiatives and I've talked to many young men who have been delinquent for all positive reasons, just being out of work and trying to work and I don't think shaming is the way to get any of this done and I'm glad that we're moving to the other side of being supportive and really putting fathers as a part of the family and not as a separate unit so I thank you for that. And then on Senate Bill 193, so I think we rushed on moving that bill along to not give you the time. So how many months will you need to develop it? I heard you say 18 but when would you want the start date to be?

DEIDRE GIFFORD: SB 193 currently proposes a start date no earlier than January 1, 2022. So that would give us all of the remaining 2020 and all of 2021.

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SENATOR MOORE (22ND): And then I want to, disparity in the services as the Representative mentioned, when you think about rural versus urban centers and what's not available, those disparities really create more problems when there's not a transportation and when there's not those services available. Many urban centers have everything that you need in one place, but as I learn more about the outlier cities and towns, just to make sure that there's a fair and equitable process in the performance measure would be important and I think that's it for me. Thank you so much.

DEIDRE GIFFORD: You're welcome.

REP. ABERCROMBIE (83RD): Senator Logan.

SENATOR LOGAN (17TH): Thank you, Representative Abercrombie. I appreciate that. Commissioner Gifford, again, thank you for being here. Thank you for clarifying your take on these proposed bills and again your director, Director McEvoy is always doing I think a wonderful job throughout the state. I think with your leadership, particularly you're thorough and thoughtful in every aspect and program that you're involved with. When it comes to the Medicaid nursing home facilities, you know when we're talking about hospitals, 5235 and also 5236, my concern has to do with as I had mentioned in the forum we had previously, the cost neutral basis of the entire program and I'm just very concerned about that. I mean even when we look at the transition plan in terms of careful planning and preparation, looking for feedback from the stakeholders, I just hope when this goes through which it most likely will that we will just keep an eye out in terms of just you know year over year what the actual you know meat and potatoes is. You know, what the actual reimbursement dollars are to the nursing home facilities because they're

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gonna claim arguably that their reimbursement rates are low where they are right now and with this you know switch over from a you know free fee for service reimbursement model to acuity based, this case-mix payment system starting from you know a budget neutral standpoint, again this is what I kind of mentioned at the forum, just concerned that it looks like even if they're perfect in the new system, they will, nursing homes will only be able to achieve you know what their current reimbursement rates are now which would be somewhat problematic. Now I also understand and this is you know not necessarily your, you know your bailiwick. You know you're not in charge of the budget that these folks are forced to deal with so I do agree that we need to follow the national trend and make this transition. I just think we just all need to just pay very good attention to what this actually means in terms of the actual reimbursement rates year over year because if the Medicaid nursing homes, these long-term care facilities, if this ends up being more just of a budget cut, a reduction in their reimbursement rates across the board, the folks that they're serving are the ones that are actually gonna suffer in the end if they are challenged with being able to properly staff the facilities, if there's a challenge with being able to properly provide you know the services that they're trying to and it could have a downward effect. So again, I think the switch to acuity based payment model is certainly I think the way to go. I just think that we, we're missing something here where there isn't that sort of bump up if you will in terms of budget to allow us to make that transition in a smooth fashion. Thank you.

DEIDRE GIFFORD: Thank you, Senator. If I might respond to a couple of things. First of all, just to be clear, there are no savings in the budget attributed to this transition so in terms of your

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concern about this being an implicit budget cut, there are not savings attached to the transition to an acuity-based rate so that's an important thing to note. Secondly, I would say that the facilities that are currently caring for members that are higher acuity and are not being recognized for that may in fact see higher rates under this system. As we've said, as many of you have brought up, there are individual with severe cognitive impairment, severe physical impairments requiring high levels of care and our current rate strategy does not recognize that so to the extent that you know facilities in your district have many individuals with higher acuity, that will be recognized and some facilities may see an increase in their overall payments. Now, the converse of that is of course also true and that is that there are facilities who care for many, many low-acuity individuals. We've been working with them through Money Follows the Person to try to see how many we can appropriately transition to home and community-based services or who need a lower level of care, but we think it's appropriate and I think the industry overall agrees that the payment for those lower-acuity individuals should also be reflected so it will not be a uniform change in payment on a facility by facility basis. And I also just want to emphasize again, we agree similar to the conversations we were having about the methadone payment, we agree that a phase-in process is important. That allows the industry to adjust. It's not in anyone's interest to have a big shock to the system with an abrupt in payment so we agree that a phased-in process is important, and we also agree that transparency at the facility level is important. That's why our consultant, Meyers, has already begun working with each individual facility to look at their MDS scores, to look at how they will

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fare under this new process so it won't be a surprise to the facilities when this changes.

SENATOR LOGAN (17TH): Thank you, Commissioner, and I do agree that a phase-in approach certainly will help that situation and hopefully it will give us time to keep our eye on it and see. I do agree, I think theoretically it should work out, just hopefully in a practical sense. We're not the first state to implement this but hopefully in the practical state it will improve overall service for everyone and allow us to utilize our limited you know state budget dollars more efficiently and effective so thank you.

DEIDRE GIFFORD: You're welcome. Thank you.

REP. ABERCROMBIE (83RD): Anything further second round? Yes, Representative? Sure.

REP. MASTROFRANCESCO (80TH): Thank you. I appreciate it. Just two quick followup questions. We were given a number earlier but I had asked and I think somebody had answered it how many people are currently on the methadone maintenance program right now and it was 16,000 people. Are those, is that the total number that are using services through Medicaid or HUSKY or that are being paid, it's not everybody, it's not the total number because obviously if somebody's using private insurance, we would not have that information; is that correct?

DEIDRE GIFFORD: I'm seeing nods. The 16,000 refers to individuals with HUSKY coverage who are receiving methadone maintenance.

REP. MASTROFRANCESCO (80TH): Okay. And then just one more followup question. I agree with Senator Logan on the reimbursement right for the nursing homes. I don't know if you can give me the answer but do you know what the total reimbursement dollar amount is

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right now that we provide to the nursing homes? Do you have that total dollar?

REP. ABERCROMBIE (83RD): Are you talking the total Medicaid reimbursement for nursing homes?

REP. MASTROFRANCESCO (80TH): Yes. Knowing Cate, she probably knows it off the top of her head [laughs].

DEIDRE GIFFORD: \$1.2 billion dollars.

REP. MASTROFRANCESCO (80TH): I'm sorry, \$1.2?

DEIDRE GIFFORD: Billion dollars per year.

REP. MASTROFRANCESCO (80TH): That's the reimbursement rate to the nursing homes.

DEIDRE GIFFORD: That's the total nursing home payment.

REP. MASTROFRANCESCO (80TH): And do we have any, has there been any analysis done as to what the new system based on acuity would increase to? I would assume it's gonna increase, the dollars, it's higher care. I can't imagine it being budget neutral. I could be totally wrong but I would think that that would increase any estimate.

DEIDRE GIFFORD: It is designed to be budget neutral, Representative.

REP. MASTROFRANCESCO (80TH): Oh, it is designed to be budget neutral. Okay.

DEIDRE GIFFORD: So we're in the process of implementing the increases related to wage increases. We issued the first I believe over the summer and a second one is coming soon. We're releasing those increases based on the wage increases by the payment system is designed to be budget neutral.

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REP. MASTROFRANCESCO (80TH): Okay. Good. Thank you. And then the \$1.2 billion dollars nursing home reimbursement Medicaid, is that, what part of that do we get back from the government and is part of the state, comes out of --

DEIDRE GIFFORD: Approximately 50 percent is federal and --

REP. MASTROFRANCESCO (80TH): 50/50? Okay. Perfect. Thank you. I appreciate your testimony.

DEIDRE GIFFORD: You're welcome.

REP. MASTROFRANCESCO (80TH): Thank you.

REP. ABERCROMBIE (83RD): Any other questions or comments? Thank you very much, Commissioner. We appreciate your testimony.

DEIDRE GIFFORD: You're welcome, Representative, and -
-

REP. ABERCROMBIE (83RD): I know you're looking at me like where's yours? I'm good. [laughter] I know shocker, right?

DEIDRE GIFFORD: I did not have my poker face on there. [laughter]

REP. ABERCROMBIE (83RD): So we have moved past the first hour which is normally what we set aside for elected officials so we will be moving back and forth on the agenda. We will be moving into the public portion which is three minutes. You will hear a buzzer and we appreciate you wrapping up. If you don't, we'll kind of pull out the hook and wrap you up ourselves so we would really appreciate you adhering to the three minutes so with that, the first person up is Michelle Bissell. Ma'am, if you could just state your name for the record and then just push your

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button so that you see the red around the microphone.
There you go.

MICHELLE BISSELL: Hi, I'm Michelle Bissell from APT Foundation. Good afternoon Senator Moore, Representative Abercrombie, Senator Logan, Representative Case and members of the Human Services Committee. My name is Michele Bissell and I am the Director of Administrative Services at APT Foundation.

APT's Foundation is celebrating 50 years of service this year. We provide services for persons with substance use and behavioral health disorders. These services include diagnostic evaluations, counseling, vocational, psychiatric and primary care. Last year APT provided 342,326 unduplicated services to over 7000 persons, 5600 persons receiving medication assisted treatment or (MAT) for opioid use disorders, 4600 with methadone and 1000 with buprenorphine and 75 to 80 percent of those folks are covered by Medicaid. APT admits all persons despite their ability to pay. We provide walk in evaluations and most patients seeking MAT who are clinically indicated for treatment are given medication on the same day of their evaluation.

Currently we employ 340 staff members. These are comprised of prescribers, licensed clinical staff, counselors, patient care associates and support team members. Some of APT's recent fiscal challenges, so 2018 and 2019 include a change in methadone billing methodology, a reduction in DMHAS grant funding, a targeted primary care grant reduction and a targeted reduction in HIV/AIDs funding. The two-year total for these reductions is over \$1.6 million dollars.

I'd like to thank you today for the opportunity to provide testimony in support of H.B. 5232, AN ACT CONCERNING A MINIMUM BASE RATE FOR METHADONE

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MAINTENANCE TREATMENT, and to raise some concerns regarding S.B. 193, AN ACT CONCERNING METHADONE MAINTENANCE. Last year, the budget implementer included language directing DSS to create performance measures for methadone providers which included setting aggressive deadlines for those measures to be developed and to go into effect. As providers would ultimately be penalized with rate cuts if these measures were not met, methadone providers responded immediately by working with DSS around the performance measures they proposed.

Although there was significant effort on the part of DSS to enact these measures, they were ultimately unable to meet the deadlines imposed by the budget implementer. It became quickly clear that hastily implementing performance measures on providers and treatment for opioid use disorders during an opioid crisis seemed counterintuitive. Supporting H.B. 5232, which would repeal the problematic language in its entirety, is the cleanest solution to the problem the bill has created. As such, I respectfully ask you to consider supporting this bill, bearing in mind that methadone providers are already subject to overlapping and sometimes conflicting compliance guidance and regulations from DSS, DMHAS, DISTAL PHALANX, the federal government, and most are also CARF accredited, which means they are already meeting very stringent performance standards.

Although we appreciate the value-based payment proposal in S.B. 193, we feel it's preferable instead for DSS to continue to work with providers to establish a value-based reimbursement system without the legislative authorization proposed in S.B. 193. We continue to express our willingness to participate in designing such a system, so long as it is fair to

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providers and allows them to better serve people suffering from opioid use disorders.

REP. ABERCROMBIE (83RD): Thank you, ma'am. Thank you for your testimony. So just a quick question. I don't understand the concerns with having performance measures put into place. From your testimony, you've already been working with DSS around this. Two years out is a pretty lengthy time to try and get it right. I don't understand the concerns.

MICHELLE BISSELL: Well the preference would be for establishing some value-based reimbursement where there could possibly be incentive for meeting measures as opposed to running the risk of missing a measure that would reduce reimbursement. I think some of the Representatives said it very eloquently, in different parts of the state, there's just different access or lessened access to treatment. I don't feel providers want to be worried that if a particular patient can't get to the dentist because there's no transportation to bring him or her there, that they need to be concerned about a rate reduction. So we feel that the value-based measures would be preferable to that. No one thinks it's a bad idea for a person to see the dentist or the primary care physician, but we always have to be concerned about creating perverse incentives, right? You don't want only the most able of patients to be admitted to programs for fear of providers losing reimbursement and the reimbursement has, for methadone anyway, has been about the same for over a decade so the fear of losing reimbursement on an already flat rate would be very difficult.

REP. ABERCROMBIE (83RD): Thank you. Questions? Seeing none, thank you for your testimony. We're going to flip back to agencies and Mairead Painter from the long-term ombudsman and then we'll go to Tia Reid. Good morning.

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MAIREAD PAINTER: Good morning Senator Moore, Representative Abercrombie, Senator Logan, Representative Case and distinguished members of the Human Services Committee. I want to thank you and offer this testimony today on behalf of the residents of Connecticut's skilled nursing homes and the bill I'd like to testify on is Bill 5235, AN ACT CONCERNING NURSING FACILITY REIMBURSEMENT.

The Long-Term Care Ombudsman Program is in full support of the Department of Social Services moving to implement an acuity-based methodology for Medicaid reimbursement for nursing home services. A case-mix reimbursement system will allow DSS the ability to reimburse the nursing home not only for the fixed costs, but also for the assessed level of care the resident requires. Having the ability to reimburse providers for the care residents are receiving is crucial. There are residents that require substantially higher levels of care than others and this is captured in the MDS, the minimum data set. This is a tool that's been used for over 20 years in the nursing homes and is the primary tool used to create the residents' individualized care plan. That's why we feel that's important that it is based off of that tool.

This new methodology also has the ability to include value-based criteria and can tie enhancements to those value-based outcomes. The LTCOP would advocate to have staffing ratios, resident satisfaction, and quality as components of such value-based rate enhancements. Then, once in place, we will be able to ensure that the residents in the need of the highest level of care are able to receive that care, and that nursing homes who put funding back into providing high levels of quality care will be appropriately compensated for the care that they're giving.

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I'm sure that with any system, there are some quirks when it first rolls out. There needs to be adjustments that will happen; however, I've been very pleased with the department's transparency, open discussions, and willingness to address questions as they've come up about this process and our ability to move it forward. Thank you for your time and I'm available if you have any questions.

REP. ABERCROMBIE (83RD): Thank you and thank you for what you do. You're definitely a resource that I'm personally very appreciative of, to be able to pick up the phone and ask questions about things cause in my opinion, you're the boots on the ground so thank you for what you do. We're lucky to have you. Questions from Committee members? Wow! You did such a great job! No questions. Thank you. [laughter] Have a good day. Tia Reid followed by Asher Delerme.

TIA REID: Good afternoon, Senator Moore, Representative Abercrombie, Senator Logan, Representative Case, and members of the Human Services Committee. My name is Tia Reid. I am the Director of Operations and Implementation with Liberation Programs located in Norwalk, Connecticut.

Our organization services methadone administrative services, substance abuse services, and mental health services. Thank you for the opportunity to provide testimony and support of H.B. 5232, AN ACT CONCERNING MINIMUM BASED RATE FOR METHADONE MAINTENANCE TREATMENT, and with concerns regarding S.B. 193, AN ACT CONCERNING METHADONE MAINTENANCE.

Liberation Program will be celebrating 50 years of service as of next year. We have serviced over 2267 individuals in the year 2019. We have programs located in Stamford, Norwalk, Bridgeport. We also service Greenwich and Wilton areas. We employ 110 to

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130 employees including clinicians, APRN's, medical doctors, and psychiatrists. Some of our barriers are in the change in the billing with department administrative services as well as the ability to hire and sustain qualified staff to provide treatment. Last year, the budget implemented including language directing DSS to create performance measures for methadone providers, setting unrealistic deadlines that those measures be developed, go into effect, and untimely penalize providers with rate cuts if the measures were not met. After months of work, DSS was not able to meet any of these deadlines. In July, methadone providers immediately working with DSS would raise concern if implemented. In the midst of the opioid crisis, lifesaving methadone treatment would be the only service in the entire Medicaid program in which providers' rates would be cut for not meeting performance metrics with no benefit for improving PISHA outcomes.

The language never received a public hearing. If it had, we would have expressed concerned and hopefully the legislature would not have passed the language in statute. That's why we support H.B. 5232, which would repeal the problematic language in its entirety, repealing the language which is not being implemented and the cleanest solution to the problems it has created. We appreciate the proposal in S.B. 193, which would establish a value-based payment system that includes financial incentives as well as a downside of risk for providers and pushes deadlines out to the future. However, we still believe that this language is too restrictive and worry that the deadlines it sets may not be correct as work begins on a value-based reimbursement system.

DSS could work with providers to establish a value-based reimbursement system without the legislation

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authorizing proposed in S.B. 193. Since July, we have expressed our willingness to participate in designing such a system, so long as it is fair to providers and allows them to better serve people recovering from opioid addiction. Given our willingness to work together, we ask that you support H.B. 5323 repealing the language. Thank you for your consideration.

SENATOR MOORE (22ND): Thank you, Tia, and thank you for the work that your organization does. I've been involved and known your leader for quite a long time and I wanted to ask you, did you provide written testimony to us?

TIA REED: No, I did not.

SENATOR MOORE (22ND): Could you send that to us, please?

TIA REED: Sure. Absolutely.

SENATOR MOORE (22ND): All right. Any questions? Thank you, Tia. Take care. Next is Asher Delerme.

ASHER DELERME: Good morning, Senator Moore, and the other members of this Committee. It's nice to see you, Representative Santiago. My name is Asher Delerme and I am the Executive Director of the Chemical Abuse Services Agency, otherwise known as CASA. Thank you for the opportunity to offer my testimony in strong support of H.B. 5232, AN ACT CONCERNING A MINIMUM BASE RATE FOR METHADONE MAINTENANCE TREATMENT.

I first want to tell you that CASA, the Chemical Abuse Services Agency has been around for over 30 years. We operate out of two cities. We operate in New Haven and we also operate out of Bridgeport. Our mission is to provide holistic and culturally competent behavioral health services to individuals, families, and communities that are seeking recovery from

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addictions, co-occurring disorders. We were established as the response to the need for available and accessible behavioral health services to populations, which are traditionally under-served. We operate, as I said, programs in New Haven and in Bridgeport and we service over a 1000 people every year.

First, I would like to thank the Human Services Committee and the General Assembly for supporting legislation last year which resulted in raising the minimum rate for methadone providers. I know that you express it as an equalization, an equity bill but the reality is that some providers are still being paid, there's a bearing of some providers, but that's another bill for another time.

However, my understanding was that a penalty provision was added to the final bill which never had a public hearing. As I understand it, no other Medicaid provider is subject to reductions for not meeting performance metrics. It is not fair to single out methadone treatment providers for a performance penalty. We are also aware that after working with providers, the Department of Social Services could not establish the metrics to be able to penalize providers. A little more than 90 percent of CASA's Methadone Maintained clients are on Medicaid. Currently the Medicaid rate for methadone maintenance is below what it costs us to provide treatment. Given the current opioid crisis, the high demand for services and the steady reduction in grant dollars, it is fundamentally unfair to impose a penalty on providers like CASA who work with some of the most vulnerable populations in the state. Any imposition of penalties will seriously impact our ability to maintain staffing levels and maintain quality of services.

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We support H.B. 5232 because it would repeal the problematic language in last year's bill in its entirety. Furthermore, the reality is that this language is not being implemented and repealing it is really the best solution for the problem it has created. We have a proven track and we use evidence-based treatment which is methadone treatment, which works well for the population we serve. Given the magnitude of the opioid crisis in Connecticut and the number of deaths that are attributed to this epidemic, CASA would continue its resolve and capabilities to provide high quality methadone and addiction services to populations in Bridgeport and New Haven.

Finally, Connecticut methadone providers should be incentivized, not penalized for the lifesaving work that they provide for the communities that we're talking about, highly vulnerable individuals in the state of Connecticut. Thank you for your consideration. I appreciate your time.

REP. ABERCROMBIE (83RD): Thank you, sir. Thank you for your testimony. Questions? Comments? Yes, Representative.

REP. MASTROFRANCESCO (80TH): Thank you. Can you tell me the name, thank you for your testimony, can you tell me the name of your organization again and what does it stand for?

ASHER DELERME: Well the acronym is CASA but it stands for the Chemical Abuse Services Agency. We operate out of Bridgeport and New Haven.

REP. MASTROFRANCESCO (80TH): And how many locations do you have?

ASHER DELERME: Specifically, there's six total locations that we operate out of.

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REP. MASTROFRANCESCO (80TH): And how many people do you serve? I'm just curious.

ASHER DELERME: Total a year is 1000.

REP. MASTROFRANCESCO (80TH): I'm just curious, are there programs in place within your locations that you, I mean is there a plan at some point to try to get people off of methadone? Obviously it's a big task right and it's not for everybody and there's many people out there who stay on methadone forever but there are some of those people that want to wean off of it. Do you have programs in place to do that and if so, how many people are currently in that phase of weaning down?

ASHER DELERME: Methadone programs are really designed to meet individuals where they are at and that is really an individualistic process whether you want to get off methadone or not, whether you can, and that's a discussion that has had with your provider, with your doctor. We don't design a program to wean you off of methadone. Most methadone programs are not designed that way. They're designed to help people litigate the issues, the clinical issues and the behavioral health issues that come along with an addiction. So when you're on methadone you resolve those issues but ultimately, it's your decision as to whether or not you want to totally stop using it. For some people, it's almost, it's a lifetime medication. For others, it's not but again, it's a, programs are not specifically designed to wean people off although that is a possibility within programs.

REP. MASTROFRANCESCO (80TH): So would you know, I don't know, maybe within the last year, this many people came in at a level of this high on methadone and you know this many people are not, it's not as

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high because they're trying. Do you have a number, any --

ASHER DELERME: This many people are drug free you're saying [crosstalk].

REP. MASTROFRANCESCO (80TH): Not necessarily drug free because I believe it's a, it could, it's a lifetime problem for some people but some people may be weaned down so maybe they're not taking a high dosage and maybe they're trying to wean down to a lower dosage, little by little and they may never get there. It's possible, but is there an attempt to bring them down to a lower dosage and how many people within your facilities right there that you serve, the people that you serve have started at one level and maybe they decreased it a little bit to get, to try to get to that goal?

ASHER DELERME: Well if it is a goal, yeah, we try to get that goal but what I'm saying, for a lot of people, that's not even the goal. The goal is stability. It's just to feel normal and you're kind of, it's almost, you're asking me like a philosophical side of this, a philosophical question about weaning off methadone. Some of folks look at this in our society and say that you know some people, you're just substituting one drug for another and the truth is that that's not the way it works. Some individuals will require a daily dosage of methadone perhaps for the rest of their lives, others will not so it's a very individual process and something that again, programs are not designed just to wean people off. That's not necessarily the goal, but if that is your goal personally then yes, we will work with you to do that. But some folks have misconceptions about the use of that medication and how it applies to really resolving issues in your life.

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REP. MASTROFRANCESCO (80TH): Okay. I understand and let me just simplify the question. Do you have people in your facilities that you are treating that do have a goal?

ASHER DELERME: They all have a goal. [laughter]

REP. MASTROFRANCESCO (80TH): Okay. I understand. I'm not saying it's not working. I get it. Trust me. I think anybody in this room probably knows somebody or has a relative that is in need of those services. It's not --

ASHER DELERME: And maybe to clarify a little bit because of your question. There is a small percentage of folks that do eventually become drug free, methadone free, but that is the minority by far.

REP. MASTROFRANCESCO (80TH): Okay. Thank you so much for answering my questions and for your testimony. I appreciate it.

ASHER DELERME: You're very welcome.

REP. ABERCROMBIE (83RD): Any further questions? Yes, Representative Stallworth.

REP. STALLWORTH (126TH): Yes, I don't have a question. I just want to thank you for what you do and know that your work is very much appreciated. Thank you so much for being here.

ASHER DELERME: Thank you.

REP. ABERCROMBIE (83RD): Anyone else? Representative Butler.

REP. BUTLER (72ND): Thank you. Thank you for your testimony. This line of questioning was peaking interest in other areas for me. For me, the opioid crisis you know from the last couple of years it's you know really peaked and it's gotten worse and you hear

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a lot of talk of it and it's becoming public but I want to know for your agency and your area what the trend is. Do you see a lot of new people? Just tell me in your area, how is this trending? Are you getting more people and over the last couple of years is it going up? It fluctuates or just overall description would be helpful.

ASHER DELERME: Yeah, yeah. That's a great question and it really is true that in the last few years we've seen some trends, primarily in the demographics of the individuals that we see. CASA was started in New Haven and in Bridgeport and we were dealing with primarily inner city populations, but now we have a high number of individuals that are coming from other areas, other geographic areas like the shoreline coming down to New Haven and seeking our services because they need them so you know while we are this multicultural agency, obviously we'll work with anyone, but geographically we're concentrating on New Haven and concentrating on Bridgeport. So that's one trend. The other trend is folks are younger. We're getting folks that are much younger coming into our services who, unfortunately, have established a significant period of addiction at that young age and we're seeing them and they need the methadone, they need methadone to be able to then resolve the physical dependency issues that they have and at the same time work on emotional and psychological issues to deal with.

REP. BUTLER (72ND): Thank you for your answers. Thank you, Madam Chair.

REP. ABERCROMBIE (83RD): Representative Santiago.

REP. SANTIAGO (84TH): Thank you, Madam Chair. Well thank you, Asher, for coming up here to testify. I think this is an important subject. I think that it's

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almost like the alcoholic who always has to go to AA in order to be sober. They could be out of, not drinking for 30 years but they still need that base where they can go back and get the help and the stability in order to be productive so I think that the methadone, even though they might, even if they are lifelong, but at least it stabilizes them enough to be productive citizens and be able to work cause I know of people that have done it and they've been able to you know work and get employed, buy a car, even buy a home so they're always gonna be addicted the same way as people that smoke cigarettes and the other stuff maybe, but that smoke cigarettes are always gonna be addicted and it's an addiction and it's a disease. So I want to thank you for coming up here and shedding some light on it. It's always good that members of the Human Services Committee learn more about what's happening in the community. Sometimes a lot of us don't know what's going on in the community and also to mention that Asher is an accomplished musician and he has a band [laughter].

ASHER DELERME: I do bar mitzvahs also.

REP. SANTIAGO (84TH): It's Afro-Latino music and a lot of functions that I go to his band is over there but thank you for what you do for the State of Connecticut and the people that you serve.

ASHER DELERME: Thank you for the plug. [laughter]

REP. ABERCROMBIE (83RD): Thank you, sir. Have a great day. Ben followed by Sabrina.

BEN SHAIKEN: Good afternoon, Representative Abercrombie, Senator Moore, Senator Logan, and members of the Human Services Committee. My name is Ben Shaiken and I work at the Continue Community Nonprofit Alliance. We're the statewide trade association for community nonprofits. All of you on this Committee

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know, community nonprofits serve half a million people across Connecticut every year. We also employ 117,000 Connecticut residents, about 12 percent of the state's workforce. They're an important part of what makes Connecticut a great place to live and raise a family.

I have to testify on three bills today so I sort of beg the Committee's indulgence. They do happen to fall right after each other on the agenda. So first I want address the two bills regarding methadone maintenance treatment that we've been talking about for the last several minutes, both House Bill 5232 and Senate Bill 193.

As you have heard, last year the budget implementer raised the minimum base rate for methadone providers which ended up raising the rate for several different providers across the state, anyone who was below that new minimum. It also included language that as you have heard, didn't receive a public hearing that established performance metrics and ultimately, if those metrics were not met, significant rate cuts, 5 or 10 percent for providers. We began working with the Department of Social Services and I want to acknowledge that they have worked really collaboratively with us throughout this process, all the providers, and especially acknowledge Bill Halsey from the Medicaid Department who's been really wonderful in helping develop these measures.

Ultimately, the timelines that were in the implementer last year were way too aggressive and the department wasn't able to meet them for a variety of reasons so I just want to, you have my written testimony but I want to address a few things that have come up in comments. The metrics that have been discussed and some of the examples the Commissioner gave earlier are all important and providers, all providers really work every day to improve the service that they offer and

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to constantly improve their practice and offer better outcomes to their program recipients. The metrics that have been discussed aren't always up to providers though so Michelle earlier mentioned sort of transportation maybe being an issue connecting with primary care or dental. Transportation is an issue that impacts these services a lot and as we sort of dove deep into the details of even retention and treatment as a metric, we learned that things like transportation as well as client choice were a variable that was very difficult to address on the data that the state has. So if a person starts going to one provider, stabilizes with that provider maybe for 60 or 90 days and then decides to go to a provider close to home, or maybe is told by the non-emergency medical transportation that they must go to a provider closer to home, a provider that would have their transportation covered to a farther away provider in the future, that person would leave treatment at one provider and show up at the door of another provider the next day and it was very difficult to capture that data with the available information that the department had.

So just to put a very fine point on what our concerns are with Senate Bill 193 and why we support the full repeal in 5232, [buzzer], there's the buzzer, we're not sure that those timelines are enough time to develop the metrics even though it pushes them out to a year and we're concerned that the language as it's proposed really forces the department to establish those metrics and measure them for a year and then implement the program the following year later and so we'd appreciate the flexibility to be able to continue to work with the department to develop these outside of having the legislature direct the department to develop them which is what the bill would do.

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REP. ABERCROMBIE (83RD): Thank you, Ben. Can you think of any other Medicaid program where we require these type of metrics?

BEN SHAIKEN: There are other Medicaid programs where there are value-based reimbursement structures, where there are performance incentives and payment incentives and also downside risks as the law is currently constructed, which both of these bills is trying to change. There's only downside risks, only a cut and to our knowledge, there is no other program within Medicaid that only has a downside risk for providers.

REP. ABERCROMBIE (83RD): Thank you. Questions or comments? Senator Moore.

SENATOR MOORE (22ND): Thank you for your testimony. So the Commissioner said January 1, 2022 as a date. What are you thinking?

BEN SHAIKEN: The language as it's drafted says that the performance measures and methodology shall be developed between July of this year and July of next year, and then they would be implemented six months after that. I think that's not an unreasonable timeline to have something put together and work on it. Our concern I think is that directing that they shall be done from this date to this date and that it shall be implemented starting on this date means that if something happens in the interim where it's not able to be implemented for whatever reason, we'll have to come back to the legislature to change the dates, change the shall when the department has the authority in current law to establish a value-based performance system without the legislature's action, to work with providers, to do something that they're proposing to do in statute.

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REP. ABERCROMBIE (83RD): Any other questions or comments? Seeing none, thank you, Ben. Sabrina followed by Selma Ward?

SABRINA TROCCHI: Good afternoon. Sabrina Trocchi, President/CEO of Wheeler. Wheeler is a comprehensive integrated primary care substance abuse, mental health service organization. We also provide community justice programs, juvenile justice programs, early childhood, prevention and wellness, programs and special education programs. We serve over 30,000 individual across the entire state each year.

Thank you for the opportunity to provide testimony in support of H.B. 5233, AN ACT CONCERNING PAYMENTS TO PROVIDERS OF SOCIAL SERVICES, which would fully implement the Innovation Incentive Program. The State's current contracting policies mandate that savings realized by nonprofits at the end of a contract period must be returned to the State. This policy is counterproductive and discourages innovation and efficiency. It encourages providers to spend all allocated funds by the end of the contract period. An efficient or innovative organization that succeeds in meeting all performance measures and all contractual requirements has no benefit within this system.

The Innovation Incentive Program would allow community nonprofits to retain any savings at the end of the contract term for purposes of re-investing those savings into the provision of additional services, enhancement of care, expansion of capacity within systems, and invest in recruitment and retention of the workforce we need to deliver the services that we're delivering to thousands of individuals across the state. As you're fully aware, Connecticut nonprofits provide highly essential services in every single city and town across Connecticut. We operate in an environment where we are constantly being asked

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to do more with less. This is not sustainable. We're sending that message and we've been sending that message over and over again. the Innovation Incentive Program would be one way to support nonprofits in light of years of our eroding state funding. Please do support the Innovation Incentive Program.

I also would like to provide testimony in support of House Bill 5233 that would allow Peer Support Specialists to bill under Medicaid. Many states across the country are billing for those services. Connecticut is not and because of that, we do not access of peer specialists. Peer specialists are individuals with lived experience. The benefit and value they bring to a treatment team and to engaging outreaching and engaging individuals is absolutely amazing. I can tell you as part of our teams, I can see the benefit. If one of my individuals in a medication assisted treatment program is attached to a peer specialist, he will stay in that program for a longer period of time and know that results in better outcomes. Thank you.

REP. ABERCROMBIE (83RD): Thank you, Sabrina. This is your first time before us as the new CEO of Wheeler Clinic so welcome. Congratulations.

SABRINA TROCCHI: Thank you.

REP. ABERCROMBIE (83RD): Can you give us an example under the provider incentive program what you would use those dollars on?

SABRINA TROCCHI: I would invest them in the staff in our workforce. When you look at the workforce shortages we're facing for all types of providers from clinicians to medical providers to psychiatric providers, our ability to really keep those staff in those positions when we're competing against hospital systems, we're competing against private providers, we

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need to do everything we can to ensure that we have the appropriate workforce to be able to meet the needs of the communities. Service enhancement is another one. There are components to services that we know we can do things differently if we had the flexibility and this would give us the flexibility to identify where those gaps are and to address those gaps.

REP. ABERCROMBIE (83RD): I couldn't agree more. I think it's an area that you know we've been struggling with through the years with not giving the providers the added income that they deserve for the work that they do. I think this is one way of the state saying thank you because it's not really a new appropriation right because we don't know how much you know there's gonna be so I totally agree with you. I think the time has come and I'm hopeful that we'll be able to keep this as part of the budget negotiations as we go forward. As far as the peer specialists, other states that recognize this service, do they for the most part have certification or a license? How do they address it to get the payments under the Medicaid program?

SABRINA TROCCHI: Many states have certifications. Connecticut actually has two certification programs already in existence. We have a workforce, a peer workforce that's ready and, ready to go. We just don't have the mechanisms to be able to pay them at this point.

REP. ABERCROMBIE (83RD): Are they certified?

SABRINA TROCCHI: Yes.

REP. ABERCROMBIE (83RD): So we certify peer specialists currently through DPH?

SABRINA TROCCHI: Not through DPH. So they're certified through two organizations in Connecticut.

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They're peer run organizations so Advocacy Unlimited and the Connecticut Addiction Recovery centers.

REP. ABERCROMBIE (83RD): Thank you. Questions from Committee members? She was asking me a question in my ear, I apologize. Sabrina, you sent us your testimony, right? We have it?

SABRINA TROCCHI: I will get it to you.

REP. ABERCROMBIE (83RD): Okay. That would be very helpful and if you could add those two areas where they do certification for the peer specialists, that'd be great.

SABRINA TROCCHI: Sure.

REP. ABERCROMBIE (83RD): Representative Wood.

REP. T. WOOD (141ST): Thank you, Madam Chair, and thank you, Sabrina, for your testimony. On the peer supports, I remember doing the gun safety bill and mental health part of the gun safety bill. We heard a great deal about the peer support and the good work they did because of their experience. Are they, how are they funded now or are they just not funded at all?

SABRINA TROCCHI: So they're not funded at all. I currently have two peer specialists that I was able to obtain time-limited three-year federal dollars to support those positions and the value they bring is absolutely amazing, absolutely amazing so we're trying to figure out any way that we can continue to support that. I can tell you it's a struggle to have two. We serve thousands of individuals each day and to have two means we need to make a decision on who we provide access to the peer support and who we don't and I know when I attach the peer support staff to an individual, they're more like to come back to care. They're more likely to engage. They're more likely to engage in

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community and community recovery supports and that's what we need.

REP. T. WOOD (141ST): The empathy and the credibility they can give a fellow patient is tremendous. Can't be underestimated. Why is it Connecticut chooses to this point not to fund this program?

SABRINA TROCCHI: I think it's a financial question at this point. It's a financial question but you know I would say when you look at the investment in a peer support staff and what we get back in savings from intervening early and reengaging and keeping folks into treatment, there's the cost benefit right there.

REP. T. WOOD (141ST): How many other states through Medicaid support their peer support network?

SABRINA TROCCHI: I don't have the number off the top of my head but I can certainly get that and include in the testimony and get it back to you.

REP. T. WOOD (141ST): We all have so much on our plates [laughs]. I was just curious as a point of reference, that's all. Thank you for your thoughts and thank you, Madam Chair.

REP. ABERCROMBIE (83RD): So, Representative, just for a little bit of clarification. So I think that one of the things that we've been talking about on this Committee right is that you know our Medicaid program has been very lean through the years, right? All the budget cuts we know have come from the Human Services and one of the things that we've been talking to the agency about is that it's time to look at our Medicaid program and see if there are other initiatives that we should be providing Medicaid dollars for, and I think that peer specialists, we've been doing a lot of talk about that. I think you know we were hoping to do a Medicaid [sneeze] bless you, a

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Medicaid 101 which we've had to change that a couple of times but that was one of the things that we asked DSS to talk about you know is where do they fall in line. I think that where peer specialists are also paid for, not by the state but by the hospitals are in the ER for opioids. Right? They have the peer specialists there and we know that they have the data to support how successful it's been so there's a lot of conversation about what role they play and there's so many different avenues that peer specialists are used so I think it's something that we as a state really need to start to look at and as we look at our Medicaid program, what role do they play. I think a lot of other states because they don't offer as many benefits as we do under our Medicaid program, they've probably had the ability to add that service but I think as a state, it's something that we really need to start to look at and see what areas we get for lack of better wording, our best bang for our buck. So with that, any further questions or comments? Seeing none, thank you, Sabrina. We appreciate it. Selma Ward followed by Susan Kelly.

SELMA WARD: Good afternoon distinguished member of the Human Services Committee. I appreciate you allowing me to testify before you today with regards to House Bill 5233. I could reiterate verbatim what my colleague, Sabrina, said. I work for Perception Programs. We're headquartered in Willimantic, Connecticut. We serve about 6000 people a year. We're a multiservice agency. Our business lines include behavioral health, substance use treatment, we work with the Department of Corrections for work release programs, we do outreach and case management meeting people where they are in order to get them to a better point in life.

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I'm coming before you today because we have dedicated and caring staff who not only provide these services, but think about what it means to spend taxpayer dollars and they're so thoughtful about it that sometimes at the end of a contract year, we have dollars left over and as Chief Financial Officer, I say whoo hoo and then I very quickly say oh crap because I have to return those dollars to the state. The services that we provide don't necessarily end with our contract year. There are bridges to those services that we can continue to provide if House Bill 5233 were to move forward. So I ask that you continue to take that into consideration and let me give you an example.

We have people graduating from rehabilitation programs that would be better served if at the end of their graduating these programs we're able to provide them housing, case management, bridge them. Using these dollars would not be done frivolously but would be done with the mindful set to reduce recidivism to reduce a relapse in their recovery and other things along those lines. So you know I want you to understand that we at our social service agency, we develop our budgets with the highest level of accuracy and when we see a surplus at the end of the year, I'll say again it's a great thing to know that the people directing the individual programs are doing what they're supposed to do and have high fidelity with the dollars that are graciously provided to them by to the State of Connecticut but to have to turn around and truncate someone's services to return that is really a disservice to the most vulnerable of our citizens and I did that in less than three minutes.

REP. ABERCROMBIE (83RD): You did a great job! Thank you, ma'am. We appreciate it. Questions? Seeing

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none, thank you so much for your testimony. We appreciate it.

SELMA WARD: Thank you.

REP. ABERCROMBIE (83RD): Susan Kelly followed by George Reid-Perry.

SUSAN KELLY: Good afternoon, Senator Moore, Representative Abercrombie, Senator Logan, and members of the Human Services Committee. My name is Susan Kelley. I am associate counsel of Clifford Beers Guidance Clinic, which is a 501(c)(3) nonprofit providing behavioral health services in greater New Haven to children and families and also autism and related developmental services at our Marne Street Clinic.

Thank you very much for the opportunity to be here to provide testimony in support of House Bill 5233, AN ACT CONCERNING PAYMENTS TO PROVIDERS OF SOCIAL SERVICES. This is the part of the bill that we are here to support.

So why is retention and reinvestment of savings by nonprofit providers necessary? I believe that behavioral health providers, like Clifford Beers, struggle to provide needed services and the need for those services are on the rise, and they need greater financial backing and commitment from the state. You know Clifford Beers is a top behavioral health provider as is Wheeler and a lot of providers and it's hard to imagine that we're struggling. But we are struggling and we are being asked to do more with less every year and it's been going on for a long time.

I'm just gonna kind of tick through a couple of issues of why that is and one is that we get very poor low reimbursement rate for Medicaid and that hasn't changed for a long time. The community providers'

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association has basically put it into perspective monetarily and behavioral health providers lose a combined \$27 million dollars each year in the funding of the most utilized services. There's also a low rate having to do with developmental services as well. So this program isn't going to be the solving solution. It's not gonna solve the problem of the deficits that we operate from but allowing them to retain and reimburse funds will help. The program is creative and it's a step in the right direction.

Clifford Beers creates budgets for its state contracted services based on finding efficient ways to use every state dollar funding its programs. If savings are realized and the monies are returned, there really is no downside; it's only upside. The savings are going to be reinvested for the benefit of the public. That's our mission. All non-profits are bound by their mission and contract providers are required, this is really important, to account for monies spent and they have to reach benchmark and they have to provide data metrics. I mean there is so much that goes into state contracts that they have to follow so the idea of giving money back, I don't believe there is any concern about unjust compensation.

So I know I've hit the bell, the infamous bell [laughs] but I wanted to just also mention that in contract rates, DCF provides a lot of funding, which we're very grateful for, for provider services. However, since 2007 or I'm sorry, for the last 18 years, those contract monies that we get have remained static. Eighteen years. There was a cost of living adjustment of 1 percent in 2014 I believe. So this is a small step but a meaningful one and we urge you to do the right thing. I think it makes financial sense and good policy sense to do it. Thank you.

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REP. ABERCROMBIE (83RD): Thank you and thank you for what Clifford Beer's done. You have a wonderful facility and especially for kids on the spectrum so thank you very much for what you guys do. Questions? Seeing none, thank you very much for your testimony. I appreciate it. George Reid-Perry followed by Kathy Flaherty.

GEORGE REID-PERRY: Good afternoon, Senator Moore, Representative Abercrombie, Senator Logan, and members of the Human Services Committee. My name is George Reid-Perry and I am from Sarah, Inc. I am the director of our enrichment services there. We provide birth to three services as well as adult based services and employment day and residential services. We serve approximately 1300 families and individuals during a fiscal year.

Our organization as a whole has been around for approximately 60 years starting with a group of three families to the current status of where we are right now. One of the things that's really important for us is that we employ about 100 individuals providing all of those services within a year in about five of the counties. We're in New London County, we're in Windham County, we're in Hartford, New Haven and in Middlesex. So thank you for the opportunity to provide testimony in support of H.B. 5233, AN ACT CONCERNING PAYMENT TO PROVIDERS OF SOCIAL SERVICES which would fully implement the Innovation Incentive Program.

The important program allows community providers to retain any savings at the end of the contract term. As the current practice does not allow for us to do that, we don't have the ability to operate like any other business where you can plan for the future and plan for those downturns in the economy. One of the things that if this is expanded into practice, it will

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allow us to make purchases such as wheelchair assessable vans. Transportation throughout our state is problematic. One of the things that we work with families on is being able to get their family members and loved ones into our program. As we're a community-based program, if we don't have access to those vehicles which are \$40,000 and \$50,000 dollars apiece, it prevents families from being able to go off to their employment and so really what we're seeing is a cycle that not only impacts the services we provide but it prevents individuals and their families from going off to their places of employment.

Staff training is also currently limited to those that are just required by the state so it doesn't allow for us to reinvest in our staff to enhance the services that we are providing so that we can really look at how can we not only meet the needs of the individuals that we're serving, but then go beyond that and that's really something that we're invested in doing and have been for the last 60 years of our existence. So what I'm looking at the Incentive Program is a great way to support non-profits considering the state's fiscal challenges. So monies earned, like I said, could be used to invest in technology that would foster the learning of the individuals that we are providing as well as increase their independence which is one of our missions. The ability to have funds that cover our expenses really is paramount so whether or not our individuals come to programs, we have a fixed cost and so if we're not able to cover those costs, we thus can't provide the services on an ongoing basis and that's something that the way the program is structured right now doesn't allow for us to account for. Any opportunity that we can have to reinvest in our programs, just like the other providers is always something that we do first and foremost and a big piece of that is being able to invest in our workforce

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ensuring that the individuals that we are employing have the skills that they need. Thank you.

REP. ABERCROMBIE (83RD): Great job. Thank you. [laughter] Questions or comments? No? Seeing none, thank you so much for your testimony. Kathy Flaherty followed by Suzi Craig.

KATHY FLAHERTY: Good afternoon Senator Moore, Representative Abercrombie, Senator Logan, and members of the Human Services Committee. My name is Kathy Flaherty and I'm the Executive Director of Connecticut Legal Rights Project. I also identify myself in my written testimony as co-chair of Keep the Promise and a member of the steering committee of the Cross Disability Lifespan Alliance, but I need to make clear for the record that my testimony with regard to section 2 of 5233 is really my personal testimony and doesn't represent either KTP or Cross Disability Lifespan Alliance.

I find myself in a very odd position today because I'm actually opposing 5233 but there is a reason that several of us from legal services have submitted that testimony. Our concern is that we think the more appropriate for the state to deal with the problem that the non-profit providers are facing is to fund them appropriately and to provide their rate appropriately to reflect the true cost of giving care. Especially because this language is drafted includes the word incentive, it really could potentially and I'm not saying anybody would do this with any ill intent, but could pit the provider versus the clients they're supposed to serve and you know yes, they're talking about reinvesting the money. I run a non-profit. I get a state contract. We look at our numbers constantly during the year. If there's savings, figure out a way to spend the money on either one-time expenses so that you can address it, or

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providing additional services to people during the current year.

My understanding is there's currently a pilot program that's looking at this incentive process and they've picked providers. Do we even know what the results of that pilot are? Why is there a rush to expand it if we don't know if the pilot's accomplishing what it's supposed to accomplish and I just want to say with regard to peer support services, there's no question. I'm a person living in recovery from a diagnosis of a mental health condition and it's been the support of peers that's led hugely to my own recovery and being able to maintain that and it's very clear that we need to find a way other than pure grant funding to pay for those services so that they are available to more people. I previously served on the board of Advocacy Unlimited which is one of the certification programs and I know, I participate in the training of the people taking that certification class and people get that and then there may not be jobs for them at the end of that certification process because the providers don't have the funding to pay for it but we all do have a concern that making it a Medicare-reimbursed service means that it's medicalizing something because it has to be medically necessary. And the real true peer support is not supposed to be a medical thing and I know other states have figured out how to get beyond that but there are concerns when you're talking about documentation, when you're talking about supervision that it becomes this very medical model and peer support really isn't supposed to be that. I know there's another bill pending before the legislature that will create a task force to look at insurance reimbursing for that and maybe we ought to hold off and make sure that we understand all the consequences.

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REP. ABERCROMBIE (83RD): Thank you, Kathy. That was very informative. Thank you. I appreciate that. Questions or comments? Senator Moore.

SENATOR MOORE (22ND): Thank you for your testimony. So you said that it would pit the client against the organization?

KATHY FLAHERTY: It's a concern that we have. If you think about incentives, if, and I'm not saying this happens intentionally but the way the current program is set up is the service provider retains half the money that they save and it's also a pilot and I think when we've done other kinds of shared savings programs, we've seen the outcomes were not necessarily what the hope was that they would accomplish, if you look at PCMH Plus. The idea was it would expand access to care for more people. Yes, this is not exactly the same thing and I understand that having read several of my colleagues' testimony, but the fear that we have is if they get all of the savings, my question is why are you getting so much savings during the year? I mean innovation efficiency gets you to a certain point but why aren't you using that money in the current year to provide more services? How are you getting to the end of the year with a whole bunch of money left over? Are you looking at your numbers during the course of the year to see where you're at in terms of your expenditures? I definitely appreciate the challenge that the community non-profit providers face. I run one of them and you know all of you have been asking us to do more with less for a really long time. There needs to be something done but that's a combination of the state having adequate revenue to fund the services that it cares about and if you guys really care about these services, we need to come up with the money somehow.

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SENATOR MOORE (22ND): I've run a nonprofit for 20 years so I understand doing more for less all of the time even for private funders and philanthropy that they want your last drop of blood you know and then let's see if there's anything else left in the body they didn't get. I totally understand that concept but I don't and maybe I'm not hearing correctly, but I'm wondering how does that work the client against your organization?

KATHY FLAHERTY: Our concern is that one way is that people and this may not be the nature of this particular incentive, my concern really is the legislature established the pilot. Why would you not want to wait, find out what the results of that pilot program are before you expand it. So my suggestion is really understand what you're already existing pilot is actually accomplishing and if it's not getting to your goal, but in terms of pitting people what we've seen in other programs is either you find people who are easier to serve or you just serve less, fewer people but my, what I don't understand and you know all of our organizations are very different but if you're going through your budget during the course of the year and you're finding out that the math is lining up that you're gonna have this big amount of money at the end of the year that you might have to return to the state, my question would be why and why aren't you using it to deliver services currently?

SENATOR MOORE (22ND): And so when was the pilot?

KATHY FLAHERTY: My understanding is and this is just like looking at the history of the statute, is that that section passed in 2017. When the pilot actually started, I don't know. I think Melissa McCaw from OPM said that they're in the middle of the pilot right now and it's only been going for eight months but I honestly don't know.

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SENATOR MOORE (22ND): Okay. So that's something we can do some followup on and find out is there a pilot and where are they. Thank you for your testimony.

KATHY FLAHERTY: You're welcome.

REP. ABERCROMBIE (83RD): Representative Wood.

REP. T. WOOD (141ST): No, I just really wanted to thank you. I mean this is the value of public testimony is it's a perspective that I think has a lot of merit and I know I certainly am going to give it strong consideration. I think everybody on this Committee will. Thank you.

KATHY FLAHERTY: You're welcome.

REP. ABERCROMBIE (83RD): Further questions or comments? Thank you, Kathy. We appreciate you being here. Suzi Craig followed by Dr. Robert Keder.

SUZI CRAIG: Good afternoon Representative Abercrombie, Senator Moore, Senator Logan, members of the Human Services Committee. I'm Suzi Craig and I am from Mental Health Connecticut. We are a 112-year-old nonprofit. We started out as an advocacy organization. We also deliver on community education. The bulk of what we do is around direct service so I am in support of H.B. 5233 and actually have a little bit more continuing on the conversation that Ms. Flaherty started so good timing for me to follow up from Kathy's testimony.

So when we're contracted with the state. We have many, many state contracts. We are locked into the dollars as they are allocated for specific uses so let's say in every budget, it doesn't matter what business you're in, in every budget you estimate how you're gonna use your dollars and when those dollars come in and you start actually using them and applying them, then things don't always shake out the way that

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they, that you think they will right? And recovery is a long and windy road. Folks could come into our program and we could anticipate that they'll be there a certain time but maybe they accelerate in their recovery and they leave earlier. But if we have dollars locked into let's say a housing program or wraparound services, and we're doing our job well and we're helping people through their recovery, now we have dollars sitting and they're locked in one budget and we can't move them to another budget.

So with being able you know look at the unused funds and we look at our budgets daily and weekly. We have our own electronic health record. We collect data on every single person that comes in and out of our programs. We make sure that our staff is ensuring that they understand how the dollars work and how they're applied to ensure they support peoples' recoveries but if the dollars are lost, and, like I said, if we're doing our job well and people are moving out of our program then it's just money that's sitting there when we could be putting it back into infrastructure or we could be waiting for a rainy day fund in case we do get funding cuts so this would allow us the flexibility to be able to run like every business is run.

And one note on peer support, I also agree on looking at the taskforce but for different reasons. So there are two different accrediting bodies in Connecticut. My experience is they're not on the same page. We would like the taskforce to look into having one accrediting body looking at the addiction side of the house and the mental health side of the house and so there's unity there. Mental Health America who is our mother ship does a national peer certification which does not compete with state certifications. It's more to help someone who wants to be a part of the peer

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workforce improve on their professional development. It allows them to be a peer in any state across the country so I'd like to see some synergy around the state certification and the national certification and I have tons of stats on the importance of peers and how they work within teams that I can send everyone.

REP. ABERCROMBIE (83RD): Thank you. Thank you for your testimony. Questions or comments?
Representative Cook?

REP. COOK (65TH): Thank you for being here. I do have a question. When you're talking about the flexibility of the funds and being able to move those around, if those funds were not able to be moved, are you allowed to carry those over from year to year or we have to take those back, correct?

SUZI CRAIG: We have to give it back or we have to spend it down. We have to figure out a way to use it effectively.

REP. COOK (65TH): So if we give you the flexibility to move, let me retract that. So on average how much money without the ability to move things around are you seeing, is being sent back annually?

SUZI CRAIG: It depends. It varies from program to program and from year to year. I mean it could be a little amount. I mean we try to use our funds as effectively as we possibly can but if people are, you know if beds aren't being filled and like I said if people are moving on, it really depends on where the need is. I can get you more information on that.

REP. COOK (65TH): No, I mean that's fine. I was just more curious about the fact that I mean I hear this has been done. We obviously know this has been done and sometimes I hate that because it finds us doing

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things that maybe we don't necessarily need to do and it can be used in better ways so thank you.

REP. ABERCROMBIE (83RD): Any other questions or comments? Seeing none, thank you very much for your testimony. Dr. Robert Keder? You know I kept looking at you trying to figure out how I remembered you. You were part of the DD work group.

DR. ROBERT KEDER: Correct.

REP. ABERCROMBIE (83RD): That's right. Thank you.

DR. ROBERT KEDER: Good afternoon. Thank you Representative Abercrombie and Senator Moore, and the rest of the committee for hearing my testimony. My name is Dr. Robert D. Keder and I am a Developmental-Behavioral Pediatrician. Not everybody's familiar with who or what we are. I am a pediatrician with an advanced three years of training and board certification in working with, diagnosing and managing developmental disabilities including autism, ADHD and learning disabilities and what I do is I work with children, but also their families, their school systems, and their other providers to help them understand how to work around their own needs and disability. I'm also a graduate of the Association of University Centers on Disabilities, Leadership for Education in Neurodevelopmental Disabilities Program. That's the LEND program if anyone is familiar and what that is it's an interdisciplinary funded program through the maternal child health bureau that helps us look at how we can analyze and improve the health care delivery system for children with developmental disabilities. It really emphasizes the importance of the integration of services from state and local agencies and organizations, private providers, and communities. I'm also on staff at Connecticut Children's Medical Center and we are the not-for-

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profit only children's hospital driving in the State of Connecticut and we are really looking at working with our families, the majority of which are on Medicaid to help better services for them.

So I would like to speak briefly about House Bill 5234, which is AN ACT CONCERNING THE AUTISM SPECTRUM DISORDER ADVISORY COUNCIL. One of the concepts I wanted to bring up was the concept of disability inclusion and what that really means is that we understand the relationship and nature between the way that people function and how they participate in society and what this does is allow individuals with disabilities the same opportunities with reasonable accommodation to participate and that includes government. In understanding how autism works in general, the Center for Disease Control now says that we believe that 1 in 59 children have or meet criteria for autistic spectrum disorder. If we look at how that might play out in all of Connecticut, just looking at our general population, that suggests that there could be as many as 60,000 individuals in the State of Connecticut with autism spectrum disorder.

Autism spectrum disorder is a complex neurodevelopmental disability and is a wide range. Like all mental health disorders, it's a spectrum or continuum but there are many individual with average to above average intelligence or IQ. There are many individuals who also meet criteria for intellectual disability. The challenge of autism is that especially for children with autism, they don't have the ability to affect change or have a voice provided in the processes that take care for them and has a physician, I can work and do as much I can with families in the clinical and exam room, but it really has come to a point where we need to look at the

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symptomatic implementation of change to better the lives of these children and their families.

So what I ask is that you support House Bill 5234. It would allow for the inclusion of not only adults with autism, but the parents of individuals with autism, that would allow for a voice of a child with autism through their own parents to be heard, and this might allow for better access to services through this participation, perhaps even consideration of inclusion of members HUSKY B to autism services for which they currently do not have access and that would be in effect, an estimated 490 children across the state.

REP. ABERCROMBIE (83RD): Thank you and thank you for taking the time to come and testify. I know your schedule is really tight so we do appreciate your expertise in this area. Questions or comments? And I agree with you, adding the parent portion to the Autism Advisory Council is kind of a no-brainer but because of the way the structure is set up, we have to do it legislatively so I don't see that there's gonna be anyone that's not in favor of it but thank you so much for giving us your expertise on this. We do appreciate it. Have a great day.

DR. ROBERT KEDER: Thank you, likewise.

REP. ABERCROMBIE (83RD): Rob Baril followed by Matt Barrett and then Meg Morelli.

ROB BARIL: Good Afternoon Senator Moore, Representative Abercrombie, and members of the Human Services Committee. I'm Rob Baril and I am President of the New England Healthcare Workers Union. Our union represents about 7,000 nursing home employees in 65 nursing homes across the state, CNA's, LPN's, other nursing staff and other support staff that care for our elderly, our senior citizens, folks dealing with Alzheimer's disease and all manner of challenges.

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We're here to testify on two bills that have the potential to really significant impact the nursing home industry here in Connecticut, and as the union that represents the largest portion of the industry, we have concerns about the end result of these two bills. We support the first, House Bill 5236, but we believe that it doesn't go far enough in determining some of the components of the state's new proposed Medicaid state payment statement. We are against House Bill 5235 in its current form.

Just a comment about Commissioner Gifford's testimony earlier. The Commissioner obviously has incredible expertise on Medicaid and the way that we want to deal with care for this state's elderly. She did offer some testimony that she felt that nursing homes were not the appropriate place for most folks who are dealing with treatment on substance abuse and some mental health issues and we would just offer a couple of things on that point.

Number one, there's a number of nursing homes that really specialize in treatment for folks with substance abuse issues. Many of the folks that have substance abuse issues also have significant physical challenges and need care themselves. There's a shortage of beds that are available for folks with substance abuse in terms of Medicaid payment and so nursing homes play a critical role in making sure that those residents can get the treatment that they need, particularly in urban communities, black and brown communities that are underserved in other ways, we want to make sure that folks can continue to get the substance abuse and mental health treatment that they need so we just would offer that as a comment to the Commissioner's testimony.

House Bill 5236 is going to create an oversight structure to the acuity-based payment system that

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allows for more stakeholder to have a voice in the conversion from the current Medicaid payment system to the case-mix index system. We support this bill but we believe that there's some additions that are important for our state as we're transitioning towards this new payment system, the most important of which is that labor organizations be added to the oversight structure that's in Section (1)(a), line 15 and so adding a role for organizations such as 1199 to make sure what we're a part of that conversation.

Our written testimony talks about specific changes to the bill that adds language like an analysis of the impact on union and non-union labor standards and working conditions. Change to the payment structure obviously are going to impact the ability of homes to be able to meet their obligations to their employees. More language, an analysis of the staffing levels and turnover and you know just generalization, making change to the bill that take account for counties and geographic regions in Connecticut as we analyze the rates.

House Bill 5235 is the bill that deals with again, the implementation of the system. It's been talked about for a long time. In most states, the implementation has been problematic and so what we would ask for is that the implementation for a year be revenue neutral so no home gains money, no home loses money as we're looking at the impacts of the conversion to the case-mix index system for payment.

REP. ABERCROMBIE (83RD): Thank you for your testimony. So how do you keep, so if the whole idea of acuity based right is to increase rates for nursing homes that are doing more high needs, how do you keep that, what's the incentive to go an acuity base then?

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ROB BARIL: Well I think the challenge is that it's not always a way of looking at what the current acuity level is. It's a look back. So right now the Medicaid repayment rates are standard for a nursing home, say it's \$275 dollars. If we're looking at the acuity and the look is going back, you know there's fluctuation in what the acuity is based on the population. So in some cases it may go up, in other cases it may go down. How do states figure out how they balance the books with the amount of fluctuation that's taking place? The other concern is that in many cases it looks like the new payment system may actually lead to a reduction in Medicaid reimbursement based on what are the current allowable cost measures in terms of what people's acuity is and even small changes in payment can lead to nursing home closures, reduction of Medicaid, and long-term care services in skilled nursing facilities, etc so again, we just want to understand, what is the impact of the new case-mix index system going to be on homes before we rush to implementing something where there is still significant data that the state needs to provide for homes to understand how they're going to plan for the future.

REP. ABERCROMBIE (83RD): And did you, do we have your testimony? Did you send your testimony in?

ROB BARIL: There's additional written testimony that covers some points that I wasn't able to get to.

REP. ABERCROMBIE (83RD): Good. And then just a followup question, are you familiar with residential care homes?

ROB BARIL: Some familiarity.

REP. ABERCROMBIE (83RD): Okay. So are you familiar with the proposal that is being put forth that perhaps that become a waiver service? Currently, residential

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care homes are paid 100 percent state funded. There's a proposal to turn them into a waiver service so that the individuals that they have in their homes now, we can get a match from the feds. Are you familiar with that at all?

ROB BARIL: I'm not. I would want to study that and take a look. It may be that that's a positive thing. Of course, we want to make sure that its meeting both the care needs of the long-term care population and also taking into account [crosstalk].

REP. ABERCROMBIE (83RD): If you had the opportunity, if you could take a look at that, I would really appreciate your insight onto that. The reason for it is they take a lot of the opioid residents and because we're paying 100 percent through the state funds, I think that it's a proposal that we really need to give serious consideration to. I know there's been, I know the residential care homes have fear about the rate, but the reality is they haven't gotten a rate increase in years and I think that if we can make the numbers work, I think it's beneficial to them and also some of our residents who are now currently in nursing homes that wouldn't have to be in nursing homes, right? Because they are taking care of this population in these homes so if you have the opportunity I'd really love to have your thoughts on that. Questions from committee members? Oh, yes, Senator Logan.

SENATOR LOGAN (17TH): I'm just curious, would you want to elaborate on some of those points you weren't able to get to?

ROB BARIL: Again, it's in the written testimony. I mean I think that there's a number of concerns. There's been a squeeze on nursing homes in terms of payment. Currently there is an under-compensation in terms of disallowable costs, things like occupational

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therapy, speech therapy, physical therapy, none of those costs are factored into a nursing homes Medicaid payment rate so I mean that's one major concern and going forward, we think that this may even exacerbate some of the underpayment that goes to nursing home costs so that's the biggest issue.

SENATOR LOGAN (17TH): I appreciate that. I share some of those same concerns as well. Thank you.

REP. ABERCROMBIE (83RD): Thank you. Any further questions or comments? Thank you so much for your testimony. I appreciate it. Matt Barrett followed by Meg Morelli.

MATT BARRETT: Good afternoon Chairman Abercrombie and to the distinguished members of the Human Services Committee. My name is Matt Barrett. I am the President and CEO of the Connecticut Association of Health Care Facilities and also the Connecticut Center for Assisted Living. We're a trade association of 150 members of skilled nursing facilities and assisted living communities. I'm pleased to be here this afternoon to testify in support of House Bill 5235, AN ACT CONCERNING THE TRANSITION TO A Medicaid NURSING HOME FACILITY CASE-MIX PAYMENT SYSTEM.

The proposed legislation requires the submission and the approval of the Connecticut General Assembly's legislative committees of cognizance with jurisdiction over Medicaid which is the Appropriations and Human Services Committee, approval of the case-mix Medicaid state plan to CMS, and the adoption of state regulations before the Department of Social Services may implement the final case-mix payment system for Connecticut nursing facilities. Further, the proposed legislation requires the disclosure of public information data used in the development of the case-mix payment modeling to the nursing home industry and

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to the nursing home finance advisory committee for the purpose of making recommendations on the developing case-mix payment system. The proposed legislation also requires that the state plan amendment submission to the legislative committees and to CMS include the major components of the case-mix payment system and the insurance that the case-mix payment system is adequately funded to assure access to quality nursing facility care and these are enumerated in detail in the bill and mentioned in my testimony.

Just in summary, the bill does describe a detailed process for approval of the state plan and implementation of case-mix, but we believe it's necessarily so. These are probably the most significant changes to the nursing home payment system since the system was created in 1991 and they are not at all without precedence. In fact, some of the precedence was mentioned in the Department of Social Services testimony, that state planned amendments have gone through a similar process through the process by which Medicaid waivers go through submission to the legislative committees of cognizance where the committees actually have the authority to approve or modify or disapprove those public policies.

So again, not at all without precedence and certainly within the clear purview and prerogative of the legislature to decide how it will determine policies associated with \$1.2 billion dollars in Connecticut state spending but more importantly, an open and transparent process is of the utmost importance to the 17,000 Medicaid recipients who call nursing facilities their homes and the operators and the more than 30,000 workers there and so we urge adoption of the approval process that's outlined in this bill and with your permission, Representative Abercrombie, can I just briefly mention the regulatory provision that is

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included in House Bill 5235, but also mentioned in this bill, House Bill 5236, and that's the provision that allows the Department of Social Services to implement these important public policy initiatives under policies and procedures pending the final adoption of regulations. I think the legislative history on this provision is very clear, that the agency needed that sort of authority to implement budgetary provisions. If you had to have an elongated regs review process and a savings initiative was adopted in the Connecticut state budget, then those savings would be undermined while you are waiting for the regulations to pass, but those facts are not present here. There are no fiscal implications in FY21 related to case-mix whatsoever so that wouldn't be a reason to sort of bypass a traditional regs review requirement. The other reason would be federal mandates. If the program were waiting adoption of regulations under a federal manner, then the program could potentially be out of compliance with federal law and that would be another reason to bypass the regs review requirement. But that's not present here also and so we urge the committee not to move forward with bypassing the regs review requirement and for this most significant change, follow a full blown regs review process in implementing case-mix in Connecticut. With that, I thank you for the opportunity to go over my allotted time and I'd be happy to answer any questions that you might have.

REP. ABERCROMBIE (83RD): Thank you, Matt. Questions or comments? Seeing none, thank you very much. We appreciate it. Meg Morelli?

MAG MORELLI: Hello. Good afternoon Representative Abercrombie and members of the Committee. My name is Mag Morelli and I am the President of LeadingAge Connecticut, a statewide membership organization

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representing not-for-profit provider organizations serving older adults across the continuum of aging services, including not-for-profit skilled nursing facilities. On behalf of LeadingAge Connecticut I am pleased to be your last speaker today and to provide testimony on House Bill 5235, and House Bill 5236.

As you know, the Department of Social Services is currently developing a new case-mix rate nursing home reimbursement system designed to replace our current cost-based system. The new case-mix system will add an acuity-based component and one or more value-based performance incentives to the payment rates and our association has been supportive of these concepts. The State has a target implementation date of July 1, 2020 and we have been pleased to be working with the Department and their consultants as they develop the new system.

While we support the idea of a case-mix system, we also recognize that this will be a major change in the reimbursement system, a change that has the potential of significantly impacting the financial landscape of the entire nursing home sector. It will therefore be extremely important for us to work together to ensure that quality, well-staffed nursing home care is not disrupted in this transition. Both bills that I'm speaking on today are related to the implementation of this new case-mix system, and we're pleased to comment on both.

First, we want to thank the Committee for raising House Bill 5236 which sets out requirements for the new system and of the state plan amendment. These requirements will ensure continued transparency and integrity in the process. The bill also includes a provision to incentivize a one-time voluntary bed reduction. The other bill, House Bill 5235, outlines in very general terms how the new rates will be

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calculated within the new system. We have some very specific comments on those general terms listed later in our testimony.

The most concerning aspect of House Bill 5235 is that it would give the Department of Social Services broad discretion, with only general guidelines to implement the new rate system before any regulations are finalized and without any other state oversight or approval. While we understand that the state plan amendment (SPA) would be required and would need to receive federal approval, we believe that the State Legislature should also have a role in reviewing the plan for the new reimbursement system before the SPA is submitted for federal approval. We are hopeful that legislative attention to the process will ensure that the final system design will deliver the resources needed to provide consumer access to quality nursing home care, to retain and recruit our workforce, and to meet the quality of life and physical environment expectations of consumers and regulators.

House Bill 5236 includes a role for the state legislature in the plan review process. The bill calls for a process similar to what is done with Medicaid waivers where the joint standing committees of cognizance first receive a report on the implementation plan before it is sent to CMS. This additional check and balance in the process regarding the SPA for the new reimbursement system would be both constructive and reassuring.

House Bill 5236 also recognizes the restrictions of the extremely short timeline. The new system will be implemented on July 1, 2020, after the legislature has adjourned, and the actual financial modeling of the new system will not be completed until March or April. It may be May before the nursing home associations

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will be able to fully analyze the modeling. We therefore support the requirement in the bill that specific information be made available in the state plan amendment process so that the State Legislature and the nursing home sector can be made aware of the impact of the final plan which is being submitted for SPA approval and be able to comment accordingly.

Just in conclusion, while there are two separate bills before you, we believe that the two can work together, and it is therefore our hope that resolution can be reached on appropriate legislation. As we stated earlier, this process thus far has been very collegial and we have appreciated the opportunity to work with the Department of Social Services as they develop the new system. Nevertheless, since the implementation is on a fast track, we request that the provisions contained in House Bill 5236 which would implement safeguards and keep the Legislature apprised of the details and potential outcomes of the system remain in any resulting legislation. Thank you. I'd be happy to answer any questions.

REP. ABERCROMBIE (83RD): Thank you, Meg. Any questions or comments? Seeing none, thank you for what you do. We appreciate it. So that concludes everyone that has signed up to comment at this public hearing. Is there anyone out there who did not sign up who would like to add to this conversation? Come on up and just state your name for the record, please.

LYNN WOLF: Hi. My name is Lynn and I represent a non-profit in the community non-profit and I wanted to at least just share with you that the legislators should appropriate \$461 million dollars over five years for community non-profits and since 2007, state funding shortfalls mean community non-profits have fallen by \$461 million dollars. Therefore, our cost of services is already way behind. It was mentioned

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earlier through various different conversations how since 2007, community non-profits have lost these funds and that's a long time. That's 18 years of us not keeping up with the pace of inflation, never mind you know the many other increases that have occurred. So the community non-profits provide essential services in every city and every town and that's through community you know residential services that you had mentioned earlier, and we employ tens of thousands of individuals and the workforce is changing and that's a whole other facet that I won't even get into but we have great stresses and strains regarding that.

Community non-profits are a vital part of Connecticut's economy, providing services that make our state safe, healthy and vibrant, and our community non-profits serve and someone else had shared this, over half a million people every year with a wide range of human services, employment, and cultural programs. We employ 12 percent of the workforce. We are the front lines of the opioid crisis. We help people return to their communities from prison. We support people with developmental disabilities, shelter and feed families in need. We enrich communities with cultural and artistic programs and more. Just to mention the opioid crisis has increased the need for substance abuse treatment yet grant funds have decreased since 2012. More than 2000 people with developmental disabilities languish on a waiting list for state-funded services and so the question might be why now? Connecticut's budget outlook is the strongest it's been in years and you know it's time for us to realize that Connecticut's economy is finally on the road to recovery and that money that is available to help people in need and provide the staff who support them. So thank you very much for your time.

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REP. ABERCROMBIE (83RD): So Lynn, you're testifying in support of 5233 which is to allow providers to be able to keep a portion of their dollars at the end of their contract, correct?

LYNN WOLF: I am.

REP. ABERCROMBIE (83RD): Okay. Just for clarification because this isn't Appropriations so the \$461 million dollars is in that Committee. We're Human Services so we're more like the policy so I just want to make sure that people if they're watching this understand that you're testifying in favor of 5233, correct?

LYNN WOLF: Yes. [crosstalk]

REP. ABERCROMBIE (83RD): Thank you. Questions or comments? Yes, Representative Wood.

REP. T. WOOD (141ST): Thank you, Madam Chair, and a question. Thank you for your testimony. You mentioned towards the end that our economy is the strongest it's been in I don't know how many years.

LYNN WOLF: A decade, yeah.

REP. T. WOOD (141ST): Give me some ideas of why you think that is true.

LYNN WOLF: I think that we are investing in the State of Connecticut in our workforce. We've increased the wages you know that was one thing coming from a non-profit we appreciate and due to the fact that the wage has increased and we're able to hire additional staffing, etc, cause that was at a crisis there for a while due to the workforce crisis that we had within the non-profits. So I think that as a whole I think that in different sectors we're girding up those things that have been not able to be as strong as it's showing signs now.

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REP. T. WOOD (141ST): No, I mean you made a pretty strong statement and there are a number of people across the state that would not feel that's so, so I was just curious.

LYNN WOLF: That is true. That is true. Yes, you are right but I do feel that now that we're showing in the rainy day fund for instance you know that we are finally you know making a turn, I think we're showing signs. Maybe I was a little forceful there you know like you said, but I do believe that we are making a turn.

REP. T. WOOD (141ST): I'm not gonna engage in a long debate. We're still lagging. We're the only state in the country that has not regained all the jobs lost in the 2008 recession, the only state, and metrics just came out where our job growth was 0.4 percent, I think the last year, and every other state in New England was well above 1, between 1 and 3 percent so anyway, it doesn't really have a bearing but when you make a statement like that, I'm just curious how you were basing that. It's not a judgement, it's just a curiosity so thank you.

REP. ABERCROMBIE (83RD): Thank you for your testimony. Any further questions or comments? Seeing none, thank you so much for testifying. We appreciate it and we appreciate your work as a non-profit. Is there anyone else that did not sign up that would like to comment? Seeing none, I will close this public hearing for Human Services and we will see you next week. Thanks everyone.