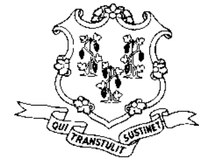

Testimony before the Human Services Committee
Deidre S. Gifford, MD, MPH Commissioner
March 4, 2021

Good Morning Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Deidre S. Gifford, and I am the Commissioner of the Department of Social Services (DSS). I am pleased to appear before you today to offer remarks on several of the bills on today's agenda.

H.B. 6446 - AN ACT CONCERNING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES.

Sections 1 and 2 eliminate the cost of living adjustments for recipients of the Temporary Family Assistance (TFA), State Administered General Assistance (SAGA) and State Supplement for the Aged, Blind and Disabled (State Supp) programs. Current statute provides recipients of TFA, SAGA, and State Supp a state-funded cost of living adjustment on July 1 of each year. State savings of $0.8 million in SFY 2022 and $2.1 million in SFY 2023 are anticipated.

Section 3 institutes an asset test under the Medicare Savings Programs. The Medicare Savings Programs (MSP) are Medicaid-funded programs that help Medicare recipients with income up to 246% of the federal poverty level (FPL) (currently, $2,641/month for individuals and $3,572/month for couples) pay their cost sharing obligations.

Individuals with income up to 211% FPL (currently, $2,265/month for individuals and $3,064/month for couples) may be eligible for the Qualified Medicare Beneficiary (QMB) program, which provides coverage of Medicare Part A and Part B premiums, deductibles, coinsurance, and copayments. Those with incomes above 211% but less than 246% FPL may be eligible for the Specified Low-Income Medicare Beneficiary (SLMB) or the Qualifying Individual (QI, also known as Additional Low-Income Medicare Beneficiary (ALMB)) programs, which provide coverage of Medicare Part B premiums.
Eligibility for MSP also confers eligibility for the federal "Extra Help" program which helps pay for Medicare Part D prescription drug costs.

Connecticut is one of only nine states that does not have an asset test under MSP. There are 38 states with an asset test equal to the federal minimum (currently, $7,860 for singles and $11,800 for couples). There are three states with limits that are higher than the federal minimum (Maine, Massachusetts and Minnesota). There are nine states that have no asset test (Alabama, Arizona, Connecticut, Delaware, Louisiana, Mississippi, New York, Oregon, and Vermont). Prior to SFY 2010, Connecticut's income levels were in line with other states and, similarly, an asset test was in place.

This bill would institute an asset test at a level that is more generous than asset tests utilized by most states. Connecticut's asset test would be double the federal minimum, aligning us with our neighboring state of Massachusetts.

Consistent with federal rules, countable resources would include money in a checking or savings account, stocks, and bonds. An individual's home, one car, a burial plot, up to $1,500 in a burial account, life insurance with a cash value of less than $1,500, and household and personal items would be excluded.

The asset test will be implemented effective August 1, 2022. This will give the Department sufficient time to operationalize the new test efficiently and to ensure that current recipients are able to retain access to the "Extra Help" benefit for as long a period as possible.

It is projected that this bill will reduce state Medicaid expenditures by $11.4 million in SFY 2023 ($22.8 million after factoring in the federal share). In addition, because the premiums are covered through the diversion of Medicaid revenue, less will need to be diverted to cover these costs, resulting in additional revenue of $18.8 million in SFY 2023. In total, after factoring in administrative costs, this proposal will result in net savings to the state of $26.6 million in SFY 2023 and $33.8 million when annualized in SFY 2024.

Section 4, subsection (g) would create prompt payment standards, which are common practice in Connecticut's health insurance industry. This proposal is expected to reduce state Medicaid payments by an estimated $2.0 million in SFY 2022 and $1.0 million in SFY 2023

When the Department or its agent bills a health insurance company for health care services or equipment that have been provided under HUSKY Health, and for which that insurance company is obligated to cover, there are times when the payment to the Department is delayed, sometimes indefinitely, or simply ignored. Section 4 would require a legally liable third party, within 90 days of receiving a claim from the Department (or its agent) for payment of a medical service covered under HUSKY Health, to adjudicate the claim and either make payment or request from the Department information necessary to determine whether it is obligated to pay the claim. The legally liable third party (i.e., the health insurance company) will then have an uncontestable obligation to pay the claim within 120 days of receipt.

Subsection (h) of section 4 would require any legally liable third party (i.e., health insurance company) that has reimbursed the Department for health care services or equipment covered under HUSKY Health and who subsequently determines that they are not liable for those costs, to request a refund from the Department within twelve months of the date the disputed payment was made. By doing so, this provision limits the state's exposure to unforeseen and unbudgeted costs.

The proposed legislation's purpose is to require a health insurance company to determine its liability to pay for an insured member's Medicaid-paid health care costs and either pay or deny the Medicaid claim, within a finite period. This proposed legislation will not impose any financial liability upon a Medicaid client.

Sections 5, 6 and 8 remove rate increases for boarding homes. Under current statute, the Department is required to annually determine rates for various boarding homes. Per DSS' regulations, boarding home rate increases are based on actual cost reports submitted by facilities,

barring any legislation to remove rate increases for a particular fiscal year. This bill eliminates these rate increases over the biennium and, for boarding homes that choose not to submit annual cost reports, maintains the minimum flat rate at current levels. Savings of $2.0 million in SFY 2022 and $4.1 million in SFY 2023 are anticipated.

Section 7 implements DSS' longstanding plans to transition the way in which it pays for Medicaid-funded nursing home care from a cost-based method to a new acuity-based approach, phased in starting July 1, 2021. In brief, this will involve moving from a retrospective, cost-based, one-size-fits-all method to a method that specifically relates to the care needs of nursing home residents.

This chart illustrates key differences between the two approaches:

Current Payment System: Cost-Based	**New Payment System: Acuity-Based**
Pays the same for all Medicaid residents Does not reward homes for admitting complex residents Incents homes to admit low-acuity residents	Pays more for more complex patients Provides incentives to care for complex residents Promotes serving less complex people in the community
Does not address quality of care	Will incorporate payment incentives related to quality of care
Adjusted annually	Adjusted quarterly
Based on five components of cost, one of which is direct care staffing	Based on the five components of cost, with more explicit relationship to staffing needs of residents

While DSS is conscious of the impact of the COVID-19 public health emergency on the nursing home industry, events of the last year have, if anything, increased the urgency of the need to move from the historical, cost-based method of paying for Medicaid-funded nursing home care to an acuity-based model.

Specifically, transitioning to this model will:

- promote access and high-quality care for residents, especially for those with extensive needs (e.g., ventilators, bariatric care);
- enable Medicaid to pay nursing homes based on the complexity of the care that their residents require;
- follow the lead of 33 other states and the District of Columbia, all of which have already implemented this well-accepted, proven method;
- permit nursing home rates to be adjusted on a more timely basis (quarterly, as opposed to annually);

- enable Connecticut to move towards value-based payment (linking reimbursement to quality measures) for nursing homes; and
- enable policymakers to achieve stated goals of the recent executive/legislative branch Nursing Home and Assisted Living Oversight Working Group (NHALOWG) while avoiding pitfalls associated with investing additional funding that is not directly related to quality (e.g., increased administrative costs, costs for unused space).

The acuity-based method uses data on nursing home residents' care needs (their acuity level) and the amount of direct staff support that they are predicted to need to calculate and update the rates that nursing homes are reimbursed. Data collected from nursing homes, along with information on direct care staff levels, are used to develop a score for each resident. The score is translated into a reimbursement rate for each home, which is adjusted over time to reflect changes in residents' conditions.

Recognizing concerns raised by nursing homes, DSS and its contractor Myers & Stauffer are building in the following protections:

- an extensive stakeholder process that will (1) use a Myers & Stauffer tool to model financial impact on a facility-by-facility basis and (2) educate and respond to nursing homes' questions on the model;
- use of the town-by-town data previously produced by Mercer Government Consulting to document local need and access to nursing home care;
- an ongoing option for homes to request approval of a voluntary reduction in their number of licensed beds;
- phase-in of the new rates effective 7/1/21 and use of "corridors" that will limit reductions ("stop loss") and cap increases in rates;
- regional adjustment (recognizing the higher costs in Fairfield County as compared to the rest of the state);
- assessment of the need, if any, for specialty services;
- quarterly adjustment of rates, based on clinical Minimum Data Set information submitted by nursing homes;
- reporting of quality measure data by homes for 1 to 2 years and discussion of the proposed financial model prior to implementing any value-based payment arrangement; and
- a model that will be cost neutral, but can be readily be adjusted if overall appropriations for nursing home rates are either increased or decreased.

There will be no inflationary rate increases included in the rates established under the new system over the biennium, resulting in state savings of $11.1 million in SFY 2022 and $24.3 million in SFY 23. After factoring in the federal share, this proposal will reduce total Medicaid expenditures by $22.2 million in SFY 2022 and $48.6 million in SFY 2023.

<u>Section 8,</u> subsection (g), mandates that the established interim rate to become effective upon sale of any licensed chronic and convalescent home or rest home with nursing supervision for which a receivership has been imposed shall not exceed the rate in effect for the facility at the time of the imposition of receivership, provided DSS may, in the Commissioner's discretion, establish an increased rate if the Commissioner and the Secretary of OPM determine that such a higher rate is needed to keep the facility open.

Subsection (h) eliminates inflationary increases over the biennium for intermediate care facilities for persons with intellectual disabilities. except for costs associated with a capital improvement approved by the Department of Developmental Services, in consultation with DSS, related to the health or safety of the residents of the facility. This will result in state savings of $0.7 million in SFY 2022 and $1.5 million in SFY 2023. After factoring in the federal share, this proposal will reduce total Medicaid expenditures by $1.4 million in SFY 2022 and $3.0 million in SFY 2023.

Section 9 is only a technical amendment noting that what is currently subsection (h) of Conn. Gen. Stat. section 17b-340, will become subsection (i) of that section if this bill is enacted.

S.B. 955 - AN ACT CONCERNING OUTDATED DEPARTMENT OF SOCIAL SERVICES STATUTES.

Section 1: General Statutes § 16a-41a (a) (3) mandates the Department of Social Services to produce an annual report on the Weatherization Assistance Program. DSS no longer administers the Weatherization Assistance Program. Since the Department of Energy and Environmental Protection (DEEP) now administers the program, DEEP has taken over the most recent reporting. As such, we are requesting that DSS be removed from this subsection.

Section 2: Since 2004, General Statutes § 17a-485d(c) has required DSS "to amend the Medicaid state plan to provide for coverage of optional adult rehabilitation services supplied by providers of mental health services or substance abuse rehabilitation services for adults with serious and persistent mental illness or who have alcoholism or other substance use disorders" and to adopt regulations to support this state plan amendment. DSS currently 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 the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF). Accordingly, DSS has never amended the Medicaid state plan to add adult behavioral health services within the rehabilitation benefits services category. Because DSS may choose to add these services in the future, DSS is requesting that this statute be amended to make any amendment to the Medicaid state plan and the development of supporting regulations permissive.

Section 3: General Statutes § 17b-8(d) currently requires that DSS include with its application to the Centers for Medicare and Medicaid Services (CMS) a copy of a transcript of the joint standing committee proceeding when submitting to CMS either (a) a proposed application for a Medicaid waiver or renewal or amendment of such waiver, or (b) certain proposed amendments to the Medicaid state plan. However, CMS has no direct mechanism for the online submission of such transcripts when submitting Medicaid waiver applications or amendments to the Medicaid state plan and the receipt of such additional materials is not affirmatively required by CMS for considering such applications or amendments. As a result of CMS' current online filing mechanism and procedures, this proposal would amend C.G.S. Sec. 17b-8(d) to delete this provision.

Section 4: General Statutes § 17b-59a(b) requires DSS to work with the executive director of the Office of Health Strategy to, among other things, develop uniformity in various activities undertaken by the Department of Developmental Services, the Department of Public Health , the Department of Correction, the Department of Veterans Affairs), DCF and DMHAS. Included

among this list of aims is a requirement to "develop . . . uniform regulations for the licensing of human services facilities." The Auditor of Public Accounts recently informed DSS that it interprets this language as requiring DSS to promulgate uniform regulations for the licensing of human services facilities (a term not defined by the statute). While DSS understands how this reading of the statute could be reached, it does not believe it was the intention of the General Assembly to charge DSS with promulgating regulations concerning the licensing of facilities within the purview of the other agencies listed in the statute. Therefore, DSS is requesting that this unclear language be removed from the statute.

Section 5: Enacted in 2009, subsection (c) of General Statutes § 17b-306a mandated the Department, in collaboration with the Council on Medical Assistance Program Oversight and subject to available appropriations, annually prepare a report concerning health care choices under HUSKY A. The report was to include a comparison of the performance of each managed care organization, the primary care case management program and other member service delivery choices. The statute was written when the Department used a managed care approach, with multiple managed care companies operating at the same time and far fewer public reports available. Today, we have one administrative services organization (ASO) for each of our core healthcare services: physical, behavioral health, and dental. In addition, those three ASOs provide a significant amount of data to the public on a regular basis. As such, this subsection is no longer relevant and should be repealed.

Section 6: General Statutes § 17b-349(a) suggests that, like federally qualified health centers, freestanding medical clinics are paid rates based on cost reporting. This is incorrect. Freestanding medical clinics always have been and continue to be paid rates based on a fee schedule. DSS is therefore requesting that this statute be amended to remove references to freestanding medical clinics.

Section 7: Enacted in 2008, subsection (n) of General Statutes § 38a-479aa clarifies that preceding subsections in the statute concerning financial requirements for preferred provider networks do not apply "to a consortium of federally qualified health centers funded by the state, providing services only to recipients of programs administered by the Department of Social Services." It requires DSS to "adopt regulations . . . to establish criteria to certify any such federally qualified health center …." However, no such consortium of federally qualified health centers is operating as a "preferred provider network" today.

DSS, therefore, is requesting that the requirement that the Department adopt regulations contained in the subsection be repealed. We respectfully ask that the language in this section of the bill be modified slightly, by moving the opening bracket as follows:

(n) The requirements of subsections (h) and (i) of this section shall not apply to a consortium of federally qualified health centers funded by the state, providing services only to recipients of programs administered by the Department of Social Services. [The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to establish criteria to certify any such federally qualified health center, including, but not limited to, minimum reserve fund requirements.]

Section 9 repeals three provisions: General Statutes §§ 17b-184, 17b-274a and 17b-610.

General Statutes §17b-184 created a client advisory board to further the ability of recipients of Temporary Family Assistance (TFA) to become self-sufficient. This board has not been convened for at least the past two commissionerships, and we would submit has been replaced, in effect, by the 2Gen Advisory Board that includes 25% parents, the Department and other agencies with which the Department closely interacts. In particular, DSS is engaged with the 2Gen Workgroups focused on benefit cliffs, workforce development, and TANF. Parent representatives are active participants in these workgroups, and the 2Gen Council can bring together all the relevant stakeholders to develop TFA program recommendations and legislative proposals. The 2Gen Board and Workgroups provide an effective arena for considering parent voices and making program recommendations. As such, we request repeal of this statute.

General Statutes §17b-274a requires a state "Maximum Allowable Cost" (MAC) list for multi-source drugs reimbursed under the Medicaid program. The Department of Social Services no longer maintains such a list. The former State MAC used by the Department is no longer needed under the new drug pricing reimbursement methodology implemented by the Department to comply with federal regulations that were issued by CMS in 2016. As such, the statute should be repealed.

General Statutes §17b-610, enacted in 1989, requires that DSS and the Department of Labor provide an ongoing assessment of the needs of the business community and the ways persons with disabilities could fill such needs. It also requires the agencies to "assess skills needed by businesses, necessary training, available jobs, specific work sites, and the programs offered by technical high schools and comprehensive high schools." In addition, the law requires that DSS annually report to the Human Service committee on these assessments. This is not a typical mandate of the Department of Social Services and, as such, we are asking that this be repealed.

S.B. 958 - AN ACT ALLOWING CERTAIN SUPPLEMENTAL NUTRITION ASSISTANCE BENEFICIARIES TO USE ELECTRONIC BENEFIT TRANSFER CARDS AT PARTICIPATING RESTAURANTS.

This bill would require DSS to develop and implement a plan to commence participation in the federal Restaurant Meals Program (RMP), which would allow Supplemental Nutrition Assistance Program (SNAP) recipients to use SNAP benefits to purchase meals at restaurants, beginning October 1, 2021. The Department would be required to identify restaurants that can offer meals to eligible beneficiaries at concessional prices and to allow beneficiaries to use their Electronic Benefit Transfer (EBT) cards to purchase such meals.

DSS appreciates the specific intent of this bill and the general goal of improving access to SNAP benefits and retail options.

The RMP is a state option that allows homeless individuals, older adults (age 60 or over), and disabled recipients to use their SNAP benefits to purchase prepared meals using their SNAP EBT card at participating restaurants. The restaurants must agree to participate in this program and offer low-cost or discount meals for breakfast, lunch and/or dinner during regular hours. Low-cost meals are defined as meals that cost less than what would be charged to customers not using SNAP, and discount meals are defined as meals already offered to certain consumers or advertised special (i.e., breakfast, lunch and/or dinner combination meals) or sale

priced meals offered to all customers. In addition, these restaurants cannot charge a service gratuity or sales tax, and must have a seating area for patrons to consume their meals.

Currently, only three states operate an RMP. Arizona is the only state with a statewide program. The other two states, Rhode Island and California, operate on an extremely limited scale. In Rhode Island, which has operated an RMP since 2011 in only two counties, only nine Subway restaurants and one pizza restaurant have chosen to participate. In California, which has operated an RMP since the early 2000s, the state itself does not operate the program; rather, individual counties may opt to participate. Each participating county then staffs and manages the program for its respective area. As of February 2021, only 17 of the state's 58 counties were participating in the RMP. The vast majority of restaurants participating are considered fast food chains such as Carl's Jr., Jack in the Box, McDonald's, or Pizza Hut. In a 2013 review conducted by UC Berkeley, San Francisco county examined strategies to expand the range of vendors and recruit food establishments that could offer healthy and culturally diverse meals through RMP. At the time, 49 of the county's 64 RMP vendors were fast food chain establishments and the remaining 15 were independent local restaurants. As of October 2020, that number stands at 25 fast food chain establishments and 17 local restaurants. Finally, in Arizona, there are approximately 618 participating restaurants, of which approximately 520 would be considered fast food chain establishments.

To operate an RMP, a state must have an "EBT-based solution," meaning that both the participating vendors (i.e., the participating restaurants) and the recipients who are permitted to redeem benefits at restaurants must be identified within the EBT system in order to limit participation to eligible SNAP recipients. This would require a significant system modification to both the Department's eligibility system as well as the state's EBT vendor system. In addition, the program has rigorous federally-required oversight, monitoring and reporting requirements, which the Department does not currently have the staffing to fulfill.

In order to successfully implement this program, DSS would need to incur significant costs around contracting and reviewing eligibility for each restaurant interested in participating in the program. DSS does not currently engage in retailer onboarding, oversight, training, compliance, and monitoring, because those functions are performed directly by, and at the cost of, the federal Food & Nutrition Service (FNS). Should the state decide to pursue the RMP option, however, these functions and their associated costs would fall solely upon the state agency. In addition, the state will incur significant costs associated with:

- Modifying the ImpaCT integrated eligibility system to identify eligible participants and transmit this information to the EBT vendor.
- Modifying the ImpaCT eligibility system to send a change of household status to the EBT vendor to restrict access should the household become ineligible.
- Modifying the EBT vendor contract and system to identify and limit participation to only clients who are eligible.
- Modifying the EBT vendor contract and system to identify and limit participation to only authorize transactions made at approved restaurants.
- Developing a system to monitor transactions at participating restaurants for program compliance.
- Developing a system to monitor restaurant compliance to ensure they are abiding by the provisions of the approved MOU.

- Dedicated DSS staff to administer the program during its start up as well as provide ongoing monitoring; and
- Providing training, outreach, and support to staff, clients, and participating or potential restaurants.

Absent additional appropriations to support the costs outlined above, DSS cannot support this bill.

H.B. 6518 - AN ACT PROVIDING MEDICAID COVERAGE FOR CERTIFIED DIETITIAN-NUTRITIONISTS.

This bill would require the Department to include dietician-nutritionists as an optional service under the Medicaid program. The Department appreciates the intent of this bill and recognizes the benefit that dietitian-nutritionists provide. Currently, the services of a certified dietician or nutritionist are available in federally qualified health center and outpatient hospital settings when such services are prescribed by an enrolled physician, advanced practice registered nurse (APRN), or physician assistant (PA). In the outpatient office setting, nutritional counseling services rendered by a physician, APRN or PA are covered as part of the overall evaluation and management service performed. The Department would also approve the services of a certified dietician or nutritionist, as specified in accordance with the statutory definition of medical necessity in section 17b-259b of the Connecticut General Statutes, for services that are deemed medically necessary based on individual assessment.

Additionally, the Department has implemented programs through the medical administrative services organization such as the Diabetes Prevention Pilot Program and intensive care management (ICM) supports for patients with diabetes and obesity, which include dietary counseling. As part of the ICM program, there is access to two full-time registered dieticians and two full-time certified diabetes educators for any member for whom a need is identified.

The Department recognizes the clinical benefit that dietician-nutritionists provide, however, in place of adding immediate fee-for-service coverage for dietician-nutritionists, the Department proposes to review the addition of such services in the context of moving further towards value-based payment reform. This will allow for these services to be provided to members under a flexible payment methodology in an effort to incentivize higher value care that includes a focus on equity for all members.

The Department anticipates that adding coverage for certified dietician-nutritionists would result in a significant increase in Medicaid expenditures. Neither the enacted state budget nor the Governor's proposed budget include funding to add coverage of these services. For these reasons, the Department cannot support this bill.

H.B. 6520 AN ACT CONCERNING THE PROVISION OF TEMPORARY STATE SERVICES TO VICTIMS OF DOMESTIC VIOLENCE.

The Department appreciates the intent of this bill as well as any measures aimed at improving access to Supplemental Nutrition Assistance Program (SNAP) benefits and other assistance for victims of domestic violence, but has some concerns with the way it is drafted and believes that it conflicts with federal law.

This proposal requires the Department, to the extent permissible under federal law, to expedite SNAP eligibility determinations for victims of domestic violence, as defined in General Statutes section 17b-112a. The bill requires that the Commissioner provide an eligible victim temporary SNAP benefits for not less than ninety days before re-determining eligibility for benefits and, when conducting an expedited initial eligibility determination, to subtract from such victim's household income the income of any spouse, domestic partner or other household member credibly accused by such victim of domestic violence.

Unfortunately, federal law prohibits the Department from enacting the requirements set forth in this bill in regard to SNAP. Current federal regulations (7 CFR 273.2) set forth the criteria in which eligibility is obtained for expedited SNAP application processing. Pursuant to these regulations, the only individuals that qualify for expedited processing of SNAP applications are those (1) with less than $150 in income per month and less than $100 in liquid assets; (2) whose combined monthly gross income and liquid assets are less than their rent/mortgage and utilities; or (3) who are destitute migrant/seasonal farmworkers that possess less than $100 in liquid assets.

In addition, expedited SNAP benefits are limited to either one month or two months depending on whether the individual applied before or after the 15th of the month and if there are outstanding verifications required by the agency to establish ongoing eligibility. If the agency does not require additional verification of eligibility or if the verifications are provided with the initial application, the individual would be certified to receive SNAP benefits for a period of not less than one year.

Additionally, only household members living together at the time of application would have their income counted towards the determination of expedited eligibility. Therefore, if an individual presents himself or herself as a victim of domestic violence at the time of application and is no longer residing with the spouse, domestic partner or other household member credibly accused, the non-household member’s income would be excluded for expedited eligibility. If the applicant is still residing with the spouse, domestic partner or other household member credibly accused of domestic violence, federal law prohibits us from excluding their income.

Section 3 of the bill proposes to exclude an alleged abuser’s income when a domestic violence victim applies for SAGA assistance. The Department notes that the new language does not distinguish between situations where the victim of domestic violence is living with the person accused of domestic violence. This distinction is important because DSS already excludes the income of spouses not living with the applicant. To the extent that it is assumed that the victim is no longer living with the person accused of domestic violence, the statute is unnecessary and more restrictive than current policy.

Given this background, if the committee is still interested in pursuing this legislation, the Department is open to working with the committee to draft language that could address scenarios where a victim still lives with the alleged abuser. The Department recommends that existing program eligibility rules and processes related to applications and renewals be leveraged to the extent possible in order to minimize administrative and systems costs, while also ensuring that the income and assets of an alleged abuser living with a victim are excluded from the eligibility determination.

For the forgoing reasons, the Department does not support this bill as written but is open to conversations about how to address the committee’s underlying concerns.