STATE OF CONNECTICUT

OFFICE OF POLICY AND MANAGEMENT

TESTIMONY PRESENTED TO THE HUMAN SERVICES COMMITTEE
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Testimony Supporting House Bill No. 6446

AN ACT CONCERNING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES

Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee, thank you for the opportunity to offer written testimony on House Bill No. 6446, An Act Concerning the Governor's Budget Recommendations for Human Services.

The initiatives in this bill will result in savings of $15.4 million in FY 2022 and $40.8 million in FY 2023 ($31.3 million in FY 2022 and $79.5 million in FY 2023 after factoring in the federal share), as well as additional revenue of $0.5 million in FY 2022 and $18.8 million in FY 2023. For your reference, I have included an explanation of the various sections of the bill at the end of my testimony.

The pandemic has taught us how critically important it is for state health care funding to be provided to those in greatest need and for our payment systems to be aligned accordingly. For today, I would like to focus my testimony on the sections of this bill that relate to two such areas – the Medicare Savings Program and the transition to an acuity-based reimbursement system for nursing homes.

The Medicare Savings Program (MSP) is a Medicaid-funded program that helps Medicare recipients pay their cost sharing obligations. Connecticut's income eligibility for this program far exceeds that of other states. Governor Lamont's budget maintains the MSP income eligibility levels, which will remain the highest in the nation.

In order to target benefits to the individuals that need them most and recognizing that Connecticut is one of only nine states that does not have an asset test, the Governor is proposing in section 3 of this bill to reinstitute an asset test effective August 1, 2022. Instead of reverting to the federal minimum, which 38 states rely on and which was the level in place in Connecticut prior to FY 2010, the asset test will be double the federal minimum, aligning with the level in our sister state of Massachusetts (currently, $15,720 for individuals and $23,600 for couples). Consistent with federal rules, countable resources 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 will be excluded. This proposal will reduce state Medicaid expenditures in FY 2023 by $11.4 million ($22.8 million after factoring in the federal share). These savings figures reflect the state's share of Medicaid expenditures, which cover the costs of deductibles, coinsurance, and copayments under the Qualified Medicare Beneficiary program, which is by far the largest of the three components of MSP. In addition, because Medicare premiums are covered through the diversion of Medicaid revenue, less revenue will need to be diverted to cover these costs, resulting in additional revenue of $18.8 million in FY 2023. In total, after factoring in administrative costs, this proposal will result in net savings to the state of $26.6 million in FY 2023 ($33.8 million when fully annualized in FY 2024).

In addition to ensuring that we are targeting benefits to those most in need, it is important that we update Medicaid reimbursement to better align with the acuity of those receiving care, enabling a meaningful continuum of long term care services and preparing providers for value-based payment approaches. We have modernized our hospital reimbursement system and we need to do the same for nursing homes. Section 7 of this bill builds off of the enabling legislation from the 2015 legislative session, which authorizes DSS to modernize and improve its current means of reimbursing nursing homes by transitioning from a retrospective, cost-based, one-size-fits-all method to an acuity-based "case mix" method that is linked to the care needs of nursing home residents. By moving to a reimbursement system that recognizes the additional resources required for nursing homes serving higher acuity residents and by rewarding high quality providers, a case-mix reimbursement methodology will help to promote access and improve care, particularly for those with more complex care needs. Thirty-three states and the District of Columbia have already implemented an acuity-based reimbursement system for nursing homes. It is our turn to adopt this well-established, proven model by moving forward with a thoughtful, phased-in approach beginning July 1, 2021.

It is also important to note that an acuity-based reimbursement will better enable policymakers to achieve the goals of the Nursing Home and Assisted Living Oversight Working Group (NHALOWG). As you know, the recommendations included establishing not only minimum staffing levels but also the minimum percentage of Medicaid reimbursement to be spent on direct care. Acuity-based rates will achieve these goals by directly supporting staffing levels required for the acuity of the residents being served. It is essential that the recommendations that move forward be aligned with the implementation of an acuity-based reimbursement system to ensure that we are not paying more for indirect or unallowable costs that do not contribute to resident care.

I respectfully request that the committee support this bill. I would like to again thank the committee for the opportunity to present this written testimony.

Section-by-Section Explanation. House Bill No. 6446 makes the following changes:

Sections 1 and 2. Eliminate Cost of Living Adjustments under Public Assistance Programs. Current statute provides recipients of Temporary Family Assistance, State Administered General Assistance and State Supplement for the Aged, Blind and Disabled a state-funded cost of living

adjustment on July 1 of each year. This bill maintains the existing assistance levels. It should be noted that Connecticut is one of the few states that allows TFA recipients to retain their full cash assistance benefit if their employment earnings are less than or equal to the federal poverty level. Savings of $0.8 million in FY 2022 and $2.1 million in FY 2023 are anticipated.

Section 3. Institute an Asset Test under the Medicare Savings Program. The Medicare Savings Program (MSP) is a Medicaid-funded program that helps Medicare recipients with income up to 246% of the federal poverty level (FPL) pay their cost sharing obligations. Depending on their income levels, individuals with income up to 211% FPL 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 or they 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. 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 individuals and $11,800 for couples), three states with limits that are higher than the federal minimum (Maine, Massachusetts, and Minnesota) and nine states that have no asset test (Alabama, Arizona, Connecticut, Delaware, Louisiana, Mississippi, New York, Oregon, and Vermont). Prior to FY 2010, Connecticut's income levels were in line with other states and, similarly, an asset test was in place. Effective August 1, 2022, this bill aligns Connecticut with the majority of other states by instituting an asset test but instead of setting it equal to the federal minimum, it will align with the level in Massachusetts (currently, $15,720 for individuals and $23,600 for couples), which is double the federal minimum. Income eligibility for MSP will remain unchanged – still the most generous in the nation. 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. This bill will reduce state Medicaid expenditures related to the costs of deductibles, coinsurance and copayments under the QMB program by $11.4 million in FY 2023 ($22.8 million after factoring in the federal share). In addition, because Medicare premiums are covered through the diversion of Medicaid revenue, less revenue will need to be diverted to cover these costs, resulting in additional revenue to the state of $18.8 million in FY 2023. In total, after factoring in administrative costs, this proposal will result in net savings to the state of $26.6 million in FY 2023 with annualized savings of $33.8 million. (For context, Connecticut's total program costs were approximately $551 million in FY 2020, and the state's share was approximately $272.5 million.)

Section 4. Implement Third Party Liability Prompt Pay Requirement to Adjudicate Health Care Claims and Establish Statute of Limitations on Refunds. When the Department of Social Services (DSS), or the department's agent, bills a health insurance company for health care services or equipment that have been provided under HUSKY Health, the processing of these claims can be delayed, sometimes indefinitely, or simply ignored. With no statutory mandate in place, the health insurance company may take no action either to deny or pay the claim. This bill addresses this by instituting a prompt pay requirement such that a legally liable third party, upon receipt of a claim submitted by DSS (or its agent) for payment of a medical service covered under HUSKY Health, will be required to adjudicate the claim and either make payment or request information

necessary to determine its legal obligation to pay the claim within 90 days of receipt of the claim. The legally liable third party will then have an uncontestable obligation to pay the submitted claim within 120 days of receipt of this claim. This proposal is consistent with prompt payment standards that are common practice in the health insurance industry and is expected to reduce state Medicaid requirements by $2.0 million in FY 2022 and $1.0 million in FY 2023.

This bill also requires legally liable third parties that have reimbursed DSS for health care services or equipment covered under HUSKY Health and have subsequently determined that they are not liable for those costs, to request any refund from DSS within twelve months of the date of the department's initial payment. By doing so, this provision limits the state's exposure to unforeseen and unbudgeted costs.

Note: This bill impacts private health insurance companies only – it does not impact legally liable individuals.

Sections 5, 6 and 8. Remove Rate Increases for Boarding Homes. Under current statute, DSS 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 FY 2022 and $4.1 million in FY 2023 are anticipated.

Sections 7 – 9. These sections of the bill implement several provisions included in the Governor's budget related to nursing homes:

1. Remove Inflationary Adjustment for Nursing Homes. Under current statute and regulation, DSS is required to rebase nursing home costs no more than once every two years, but no less than once every four years, and provide funding for an inflationary increase for years in which rebasing is not occurring. This bill eliminates these increases over the biennium. Savings of $11.1 million in FY 2022 and $24.3 million in FY 2023 ($22.2 million in FY 2022 and $48.6 million in FY 2023 after factoring in the federal share) are anticipated.
2. Implement Acuity-Based Reimbursement System for Nursing Homes. This bill builds on enabling legislation from the 2015 legislative session, which authorizes DSS to modernize and improve its current means of reimbursing nursing homes by transitioning from a historical cost-based method to an acuity-based "case mix" method. By moving to a reimbursement system that recognizes the additional resources required for homes serving higher acuity residents and by rewarding high quality providers, a case-mix reimbursement methodology will help to improve care, particularly for those with more complex care needs. This is a proven methodology that has been endorsed by the nursing home industry and is being used by 33 states and the District of Columbia. The new reimbursement system will be phased-in beginning July 1, 2021, and will be cost neutral in the aggregate.

Section 8. Remove Rate Increases for Intermediate Care Facilities. To comply with DSS' regulations, the baseline budget includes an inflationary adjustment in each year of the biennium for intermediate care facilities for individuals with intellectual disabilities. This bill eliminates

these increases over the biennium. Savings of $0.7 million in FY 2022 and $1.5 million in FY 2023 ($1.4 million in FY 2022 and $3.0 million in FY 2023 after factoring in the federal share) are anticipated.