Testimony before the Human Services Committee
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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.

S.B. 1056 - AN ACT EXPANDING ACCESS TO MEDICAL ASSISTANCE

This bill proposes to raise the income limits for several categories of Medicaid coverage in Connecticut's Medicaid program. In particular, the bill would raise the eligibility level for most categories of Medicaid eligibility to 200% of the federal poverty level (FPL). Pregnant women would remain at 258% of the FPL.

Section 1 of this bill raises the income eligibility requirements to 200% of the FPL for those who qualify for Medicaid because they are over the age of 65 or disabled, part of the "HUSKY C" coverage in Connecticut. Currently, Connecticut covers aged, blind, and disabled individuals under HUSKY C using an income eligibility limit of up to 143% of the Temporary Family Assistance (TFA) payment standard. Because the income limit is based on the TFA payment standard, it varies across three geographical regions in recognition of the differing cost of living in the state. The proposed change would use a uniform, statewide income limit of 200% of the FPL that would greatly increase eligibility. To illustrate, the current income limit for a household of one is $523 per month in Region B (the most populous region). In contrast, 200% of FPL is $2,148 per month. With that being noted, in general, federal law only allows coverage of the "aged, blind and disabled" category up to 100% of the FPL, which is currently $1,074 per month. No state in the country currently has an income eligibility threshold for this coverage category above 100% of the FPL.[1]

Elderly and disabled individuals with higher incomes, including those above 100% of the FPL, may qualify for Medicaid on other bases, such as through a home and community-based services waiver or through a "spend-down" of their income to meet medical expenses.

[1] https://www.kff.org/medicaid/state-indicator/medicaid-eligibility-through-the-aged-blind-disabled-pathway/

As of February 2021, there were 41,362 individuals enrolled in HUSKY C coverage where income eligibility is based on the 143% of the TFA payment standard. 5,697 of these individuals had income over the current limit but became eligible by "spending down" their excess income on medical expenses.

Section 1 would also raise the income limits for children from 196% to 200% of the FPL. The limit for parents and caregiver relatives would be raised from 150% of the FPL to 200%. Because the Affordable Care Act includes a 5% disregard for all eligibility groups that are determined based on Modified Adjusted Gross Income (including HUSKY A, B and D), the effective FPL would be 5% higher. The current effective FPL for children in HUSKY A is 201% of the FPL, even though the statute currently uses the 196% figure.

Section 2 would change the lower limit for HUSKY B eligibility from 196% of the FPL to 200% of the FPL to conform to the changes in HUSKY A/Medicaid eligibility requirements for children.

Lastly, Section 3 changes the eligibility requirements for HUSKY D to those who have income not exceeding 200% of the FPL. Currently, HUSKY D covers low-income adults with incomes up to 133% of the FPL, which is the maximum level permitted under federal law in order to receive the enhanced (90%) federal medical assistance participation rate (FMAP). Federal law allows states to go beyond the 133% level, but only two states have done so. Those states increased coverage for low-income adults through a Basic Health Plan, rather than Medicaid. If Connecticut were to expand HUSKY D coverage beyond 133% it would not receive the enhanced FMAP for the population between 134% and 200% of the FPL.

Given that these proposed increases in eligibility would result in significant increases in enrollment and corresponding expenditures, and that these expenditures are not reflected in the Governor's budget, the Department cannot support this bill.

In closing, I want to inform you that Governor Lamont is proposing H.B. 6447, An Act Creating the Covered Connecticut Program to Expand Access to Affordable Healthcare. If passed, that bill will sustainably fund a $50 million per year program to reduce Connecticut's uninsured rate, including through focused Medicaid expansions like this proposal.

S.B. 1057 - AN ACT CONCERNING NURSING HOMES

Senate Bill 1057 seeks to:

- enhance current minimum nursing home direct care staffing ratios;
- require the Department to consult with the Department of Public Health (DPH) to review nursing home staffing levels, payment incentives related to promoting the practice of staff working in only one home, and hiring prohibitions; and
- require the Department to establish a minimum percentage of Medicaid reimbursement to nursing homes for the provision of direct care to nursing home residents.

Relevant to these focus areas, the Department is actively in process of collaborating with the nursing home industry to transition the manner in which Medicaid pays for nursing home care from a cost-based to an acuity-based method. 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. Specifically, the acuity-based method uses data on nursing home residents' care needs (their acuity), and the amount of direct staff support that they are predicted to need, to calculate and update the rates which 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.

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;

While the Department is generally supportive of the committee's interest in and attention to the relationship of nursing home staffing to quality of care for residents, we are respectfully offering the following comments for the consideration of the committee.

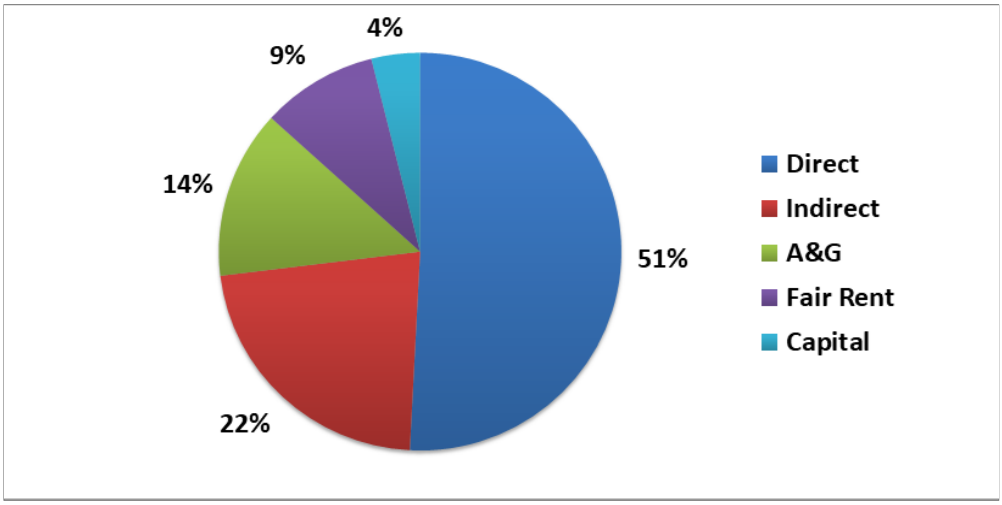
With respect to subsection (b), the Department notes the following cost implications of adopting the proposed higher minimum staffing levels. These costs are not covered in the Governor's proposed budget.

		Facilities	Average	Increase	Fringe	
	Standard	Below	Hourly	for Hours	Benefits	Total
RN	0.75	79	$43.38	$23,472,000	$5,566,616	$29,038,616
LPN	0.54	13	$32.26	$1,612,000	$390,749	$2,002,749
CNAs	2.81	139	$18.90	$38,209,000	$9,167,294	$47,376,294
	4.1			$63,293,000	$15,124,659	$78,417,659

With respect to subsection (c), while the Department defers to its sister agency, DPH, which serves as the CMS-designated survey agency, to oversee and ensure enforcement of statutorily established nursing home staffing levels and hiring prohibitions, DSS is fully supportive of the committee's interest in coordination between DSS and DPH on matters relating to alignment of public health and Medicaid financing strategies in support of quality of care delivered to nursing home residents.

With respect to subsection (d), the Department is generally supportive of establishing a minimum percentage of Medicaid reimbursement to be spent on direct care but also appreciates the latitude to develop this in consultation with DPH. For context, please note that 2018 cost reports submitted by Connecticut nursing homes indicate that, overall, only 51% of allowable costs went

towards direct resident care. The chart below shows the distribution of allowable costs. (A&G refers to Administrative & General costs.)



H.B. 6635 - AN ACT CONCERNING TEMPORARY FAMILY ASSISTANCE

This bill proposes numerous changes to the Temporary Family Assistance (TFA) program, which is the state's cash assistance program funded through the federal Temporary Assistance for Needy Families (TANF) block grant. The Department appreciates the intent of this bill and is interested in working with the legislature to make constructive changes to the TFA program, but is unable to support this bill at this time because the Governor's budget does not allocate funding for such changes.

This bill effectively makes four substantive changes to the TFA program. First, the bill changes the maximum length of time that a family subject to time limits can receive TFA benefits, going from the current 21 months to 60 months (the federal maximum), and eliminates the corresponding concept of benefit extensions after month twenty-one. This change would increase the possible number of months that currently enrolled families could receive benefits, and would also allow those families who previously used fewer than 60 months to re-enroll in the program.

It should be noted that most families in Connecticut who are subject to and reach the 21-month limit become eligible for two 6-month extensions that effectively create a 33-month state time limit (and under limited circumstances, extensions beyond 33 months). As of February 2021, there were 2,582 families enrolled in TFA and currently subject to the 21-month time limit, and 4,923 families currently exempt from the time limit.

Assuming that Connecticut's average benefit duration would rise to the national average over time, we would expect an annual additional annual cost of at least $5 million based upon the current number of time-limited TFA families. It should be noted that there are at least two major

factors which lead us to believe that this is at the very low end of any possible fiscal impact. First, we are at extremely low levels of enrollment from a historical perspective, and potential future enrollment increases will result in increasing costs associated with this change. Second, it is also highly likely that former clients who were discontinued at less than 60 months may now re-enter the program, resulting in additional costs. There would also be systems and operational costs to implement the new policy.

Second, in lines 22-26, the bill excludes months of benefits received during the current public health emergency from counting towards the newly proposed 60-month state time limit. The Department notes that all months of benefits received during the public health emergency have, to date, been excluded from counting towards the current 21-month state time limit pursuant to Executive Order 7N.[2] The Department also notes that all non-exempt families receiving TANF-funded assistance are still subject to the federal 60-month time limit and the state cannot exclude these months from that federal count. While the Department believes the legislature's intent is to exclude the TFA benefits received during the current public health emergency from counting towards state time limits, as written, this language seems to indicate the exclusion only applies with respect to benefits received under the TFA-predecessor program, Aid to Families with Dependent Children (AFDC). If the legislature believes that a statutory exception is required, perhaps in order to secure a longer period of exclusion in the event that the Executive Order authority expires prior to the end of the public health emergency, the Department would recommend a slight drafting modification to have the new language inserted elsewhere in subsection (a) of section 17b-112 as a separate sentence in order to avoid confusion with historical language related to AFDC. As this provision has already been accounted for and operationalized through the Governor's Executive Order, there are not expected to be additional costs unless the Governor's Executive Order authority expires prior to the end of the public health emergency.

Third, in lines 121-125, the bill eliminates the "family cap." The family cap provision roughly halves the benefit to children who were conceived while their parent was receiving TFA assistance. This provision would modestly increase the benefit of families with at least two children by about $50 per month, and bring their benefits into line with other families with multiple children. Based on an examination of the number of families affected by the "family cap" in November 2020 (approximately 600 families at that time), the Department estimates that the cost of eliminating the family cap would be about $400,000 annually. The Department could only support the repeal of this policy if funds are made available to support this change.

Fourth, in lines 157-166, the bill would require the Department to provide a cost-of-living adjustment (COLA) equal to the most recent percentage increase in the consumer price index whenever funds appropriated for TFA lapse and are sufficient to cover such adjustment. There would be some minor annual costs to operationalize this provision, and it is also unnecessary as CGS 17b-104 already provides for COLA increases without conditioning increases upon a lapse..

While the Department appreciates the intent of the policy changes identified in this bill, we cannot support them at this time due to the potential costs that have not been included in the

[2] https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-7N.pdf

Governor's budget. The Department would further like to recommend that the Department, legislature, and other program stakeholders work together to identify how best to reform the TFA program within available resources.

H.B. 6636 - AN ACT CONCERNING COVID-19 AND ENHANCED FEDERAL MEDICAID FUNDING

House Bill 6636 requires the Department to use enhanced federal Medicaid funds to increase rates for Medicaid providers. Enhanced federal Medicaid funds are defined as an increase of six and two-tenths percent in federal matching funds.

Under the public health emergency, since the quarter ending March 31, 2020, states have been provided with an additional 6.2% in federal matching reimbursement under Medicaid for services other than those provided to low-income adults covered under the Medicaid expansion (which are already reimbursed at 90%). This provides approximately $107 million per quarter in additional reimbursement against eligible Medicaid expenditures. Approximately 70% of this additional reimbursement results in a reduction of the state share of Medicaid costs, with the balance of the funding deposited as General Fund revenue (certain other state agency expenditures can be claimed under Medicaid and that Medicaid reimbursement is traditionally deposited as revenue). It is now anticipated that the Biden administration will continue this enhanced reimbursement through December 31, 2021.

It should be noted that this reimbursement increase is available for expenses incurred and does not represent a new source of grant-type funding that can be utilized for new Medicaid investments without corresponding state obligations. The additional reimbursement is applicable only to underlying expenses incurred – the state is still required to contribute 43.8% towards the cost of any new expense. Thus, this new funding cannot be freely distributed without corresponding state obligations. While any new Medicaid investments can leverage this enhanced reimbursement, such investments still require state funding of 43.8% of the new expense.

It should be further noted that enhanced federal reimbursement (EFMAP) is time-limited and its duration is not fully predictable. EFMAP funds also have eligibility-related maintenance of effort (MOE) requirements related to the continuation of Medicaid enrollment, which have significantly increased state costs. EFMAP funds were not only meant to support additional MOE and other state Medicaid emergency relief actions, but were also intended to help mitigate the need for state Medicaid budget reductions.

Per a recent National Conference of State Legislatures (NCSL) report (https://www.ncsl.org/Portals/1/Documents/Health/Medicaid-State-Budgets_snapshot_35149.pdf), when enhanced federal reimbursement was provided during the Great Recession, the use of such funds included the following:

- Closed or reduced Medicaid budget shortfalls
- Covered increased Medicaid enrollment
- Closed or reduced state general fund shortfalls

- Avoided benefit cuts
- Avoided reduced provider reimbursement rates
- Avoided or restored eligibility cuts

Per that same NCSL report, examples of reductions implemented or considered in other states as a result of the pandemic's impact on state budgets included:

- Nevada and Colorado adopted across-the-board rate decreases of 6% and 1%, respectively
- Michigan plans to cut $250 million from Medicaid largely by reducing rates paid to managed care organizations
- Florida's governor vetoed planned increases to reimbursement for services provided to people with disabilities
- Washington and Colorado proposed reductions to adult dental benefits
- New York proposed changes to eligibility criteria for personal care services
- Colorado proposed increasing copayments for prescriptions and physician visits and adding new copays to dental and non-emergency medical transportation

This EFMAP has significantly reduced budget pressures on the Medicaid program and the broader human services support system, along with other areas of the budget. In Connecticut, there have been significant investments of additional resources into the human services system, with much of the Medicaid provider relief funded through the state's allocation of federal Coronavirus Relief Funds (CRF). Over $225 million in federal CRF funding has been provided to DSS and targeted for Medicaid provider relief ($159 million) and community testing ($66 million). In addition, the maintenance of effort requirement is estimated to cost as much as $630 million through June 2022, of which as much as $185 million is the estimated state share of those costs.

In addition, funds related to the state share of Medicaid costs have been invested in several different areas, including Medicaid rate relief for nursing homes and intermediate care facilities for individuals with intellectual disabilities, enhanced reimbursement on COVID-related inpatient costs, and COVID-related coverage for uninsured individuals.

Due to the investments already made and acknowledging that the proposed increase is not reflected in the Governor's budget, the Department cannot support this bill.

H.B. 6637 - AN ACT CONCERNING STATE-WIDE MENTAL HEALTH SERVICES FOR DEAF, DEAF-BLIND AND HARD OF HEARING PERSONS

Section 3 requires the Department to participate in a state-wide mental health services program for deaf, deaf-blind and hard of hearing persons. To implement this program, the bill requires that the Department assign not less than one staff member. Section 4 requires the Department to participate in an advisory committee to address the mental health service needs of this group.

The Department applauds the intent of the proposed bill and believes that we need to ensure that individuals who are deaf, deaf-blind and hard of hearing have equal access to high quality

behavioral health services. However, this bill presents a problem for DSS in that the Department does not currently have the required staff that is necessary to support the activities specified in this proposed bill.

While the Governor's budget does not include specific resources for staffing, within the current budget, the Department is willing to work with other state agencies, the Statewide Deaf and Hard of Hearing Advisory Council, and Disability Rights Connecticut, to analyze this issue and ensure that this population has access to high quality mental health services.