



*Testimony before the Human Services Committee
Commissioner Deidre S. Gifford, MD, MPH
March 10, 2022*

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. 280 - AN ACT CONCERNING NATUROPATHS

This bill requires DSS to amend the Medicaid state plan and add naturopaths as a reimbursable service. In accordance with the Medicaid state plan, the Department already pays enrolled naturopaths, licensed pursuant to Chapter 373 of the Connecticut General Statutes, sections 20-34 through 20-42, for services provided to Medicaid members under 21 years of age. The provision to limit coverage specifically to individuals under the age of 21 years was implemented in January 2003 as part of a legislative mandate to eliminate coverage for certain optional services for adults.

DSS would like to note that currently, only Vermont, Oregon and Washington provide similar coverage under Medicaid.

Given that the expansion of naturopathic services to Medicaid members ages 21 and older is not included in the Governor's recommended adjustments to the budget, the Department cannot support this bill.

S.B. 282 - AN ACT CONCERNING MEDICAL ASSISTANCE FOR BARIATRIC SURGERY AND PRESCRIPTION DRUG TREATMENT OF OBESITY

This bill would require DSS to provide medical assistance for bariatric surgery for Medicaid and HUSKY B beneficiaries with severe obesity, and prescription drugs to treat severe obesity for beneficiaries with a body mass index greater than thirty-five. DSS supports the overall approach of this bill, with recommended substitute language below.

As context, long-standing DSS regulation and policy have authorized Medicaid reimbursement only for "surgical services necessary to treat morbid obesity as defined by the [International Classification of Diseases] ICD that cause or aggravates another medical illness, including illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated

with the orthopedic system.” Regulations of Connecticut State Agencies § 17b-262-341(9). Based on more recent clinical practice and observation, it is likely that many individuals who have severe obesity will also have one or more complicating health conditions. Therefore, DSS supports the overall purpose of this bill.

However, the Department requires further opportunity to analyze existing claims and denials to understand whether the bill would result in an increase in utilization that would need to be included in the budget.

The Department would like to recommend the following **substitute language** (also including an effective date change) in order to enable the Department to have the flexibility to implement this policy change efficiently and to have sufficient time to make the operational changes necessary to implement this policy change.

Sec. 1. (NEW) (*Effective April 1, 2023*) Subject to federal approval and compliance with applicable federal requirements, and notwithstanding any provision of department regulation or policy adopted prior to the effective date of this act, the Commissioner of Social Services may provide Medicaid and Children’s Health Insurance Program reimbursement for covered surgical services, including, but not limited to, related hospital services, and covered outpatient prescription drugs to treat severe obesity that are determined to be medically necessary as defined in section 17b-259b of the general statutes.

For these reasons, DSS supports the purpose of this bill, with adoption of the above substitute language, and the caution that further research may determine the need for additional appropriations to implement this change as no funding has been included in the Governor’s recommended budget adjustments. Thank you for the opportunity to testify on this bill.

S.B. 284 - AN ACT INCREASING THE AGE FROM EIGHT TO EIGHTEEN YEARS FOR AN INCOME-ELIGIBLE PERSON TO OBTAIN MEDICAL ASSISTANCE REGARDLESS OF IMMIGRATION STATUS

The Department appreciates the intent of this proposed legislation, which seeks to provide health care coverage to more adults and children. It would expand coverage of Medicaid (HUSKY A, C, and D) and the Children’s Health Insurance Program (also known as CHIP or HUSKY B), regardless of immigration status, to any child or young adult under the age of nineteen.

Medicaid and CHIP currently cover all lawfully residing immigrant adults and children. This includes citizens and qualified non-citizens, such as legal permanent residents, or “green card” holders, asylees, and refugees. Federal law subjects most qualified non-citizens to a five-year waiting period before they may qualify for Medicaid or CHIP.

Connecticut is one of a number of states that has opted to implement section 214 of the Children’s Health Insurance Program Reauthorization Act (CHIPRA), which allows coverage to be extended to lawfully residing immigrant children and pregnant women who have been in the country less than five years. This means that all lawfully residing immigrant children and

pregnant women who otherwise qualify for the Medicaid or CHIP are immediately eligible for coverage.

Federal matching funds are only available for treatment of an emergency medical condition experienced by individuals who do not have a qualifying immigration status (most commonly, “undocumented” individuals), but who meet all other Medicaid eligibility criteria in a state (such as income, residency, etc.). CHIP does not allow for coverage of children without a qualifying immigration status.

While DSS recognizes the importance of expanding medical services to a greater population, if coverage were extended to all adults and children who are otherwise eligible for HUSKY A, B or D, regardless of immigration status between the age of 8 and 18, the state would be unable to claim federal financial participation for the provision of these services to those ineligible under federal law. Standard federal medical assistance percentage (FMAP) for HUSKY A is 50%, HUSKY D is 90% and HUSKY B is 65%. This federal assistance would not be available to the expansion population proposed in this bill and, therefore, the significant additional program costs would be incurred entirely by the state. Using current per member per month (PMPM) rates for HUSKY A, B and D, the Department estimates that adding coverage for children between the ages of 8 and 18 regardless of immigration status would result in an increase in state costs of \$10.2 million annually.

The Department notes that there is not detailed information about this population’s health condition and willingness to access benefits and, as a result, there is some uncertainty in these financial projections. The Department further notes that this cost estimate does not include system implementation and other related administrative costs.

The Department would also like to raise a concern about the provision of medical assistance “within available appropriations” to individuals with immigration statuses that fall outside federally permissible Medicaid and CHIP coverage. It is unclear whether the Department would be expected to limit the scope of services provided to this population or cut off or terminate eligibility to keep expenditures within the appropriations available. Medical assistance costs can be projected based on average per person expenditures but, in any given period of time, costs can fluctuate significantly. Keeping expenditures within available appropriations would likely create a distinctly different coverage compared to current HUSKY A, B and D coverage and would increase administrative costs.

Additionally, Public Act 21-176 passed by the Connecticut legislature in 2021 authorized state-funded medical assistance for any child eight years of age or younger, regardless of immigration status. This change will not go into effect until January 1, 2023. The Act also required the Office of Health Strategy, in consultation with DSS, the Office of Policy and Management, the Connecticut Insurance Department, and Access Health CT, to do a feasibility study on expanding coverage to the population indicated by this bill, which is due July 1, 2022. The agencies will not have an opportunity to conclude this review before the second expansion proposed in this bill.

The Department believes it would be prudent to begin the program created by the 2021 legislation before considering further expansion. At this time, the feasibility study is not complete, and as a result we are not aware of the administrative complexities that may arise. If there is to be further expansion of the program it would be beneficial to utilize the experience gained from the 2021 expansion when considering a further expansion of the program.

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

S.B. 287 - AN ACT CONCERNING MEDICAID

This bill requires the Department to study and report by January 1, 2023, on the efficacy of Medicaid programs and determine whether the state can expand health care services to low-income individuals through additional Medicaid waiver programs.

The Department of Social Services commends the Committee for its attention to the expansion of health care services. The Department's Medicaid waiver programs are an important source of assistance provided to members of the community. DSS has appreciated the legislature's partnership in ensuring valuable waiver services are provided in Connecticut and looks forward to future collaboration in this area.

However, the Department would suggest that this bill is not needed.

The Long-Term Care Planning Committee addresses long term care issues, policy development and establishes a long-term care plan for all persons in need of long-term care. The plan must include home and community-based services and looks at the current number of persons receiving services, the types of services available, recommendations for addressing service gaps, and the resources necessary to accomplish goals for the future. Additionally, the Long-Term Care Planning Committee studies issues relative to long-term care including community-based service options and access to long term care. They submit a long-term care plan to the legislature every three years with the last plan being submitted in December 2021. The body of the Plan can be accessed at: https://portal.ct.gov/-/media/OPM/HHS/LTC_Planning_Committee/2022-LTSS-Plan_FINAL_Submission.pdf and the appendix which includes more detailed data by State agency can be accessed at: https://portal.ct.gov/-/media/OPM/HHS/LTC_Planning_Committee/LTC-Plan---2022-Appendices_FINAL.pdf.

As such, the Department cannot support this bill.

H.B. 5334 - AN ACT CONCERNING A STUDY OF LONG-TERM SERVICES AND SUPPORTS

The Department of Social Services commends the Human Services Committee for its attention to the need for strategic planning for Medicaid long-term care services. Strategic planning is critical given the strong preferences of older adults and individuals with disabilities to live in home and

community-based settings, the state's interest in controlling escalating costs, and support for town-level tailoring of strategies to meet local needs. However, DSS respectfully states that this legislation is not needed.

In keeping with the legislation enacted by the General Assembly, DSS developed and implemented the Strategic Plan to Rebalance Long-Term Services and Supports in 2013. The Strategic Plan is updated every three years and captures the data and planning strategies that are contemplated by this bill. The DSS strategic plan was last updated in 2020 and is available for review here: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/Medicaid-Long-Term-Care-Demand-Projections/strategic_rebalancing_plan-2020.pdf. The Strategic Plan guides the activities of the Department.

In addition, Connecticut General Statutes section 17b-337 requires the Connecticut Long-Term Care Planning Committee to prepare a long-term care plan every three years based on the fundamental principle that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting. The most recent plan, titled Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut, was revised in 2021 and submitted to the legislature in December 2021. It can be accessed at: https://portal.ct.gov/-/media/OPM/HHS/LTC_Planning_Committee/2022-LTSS-Plan_FINAL_Submission.pdf. The work of the Connecticut Long-Term Care Planning Committee informs DSS' Strategic Plan to Rebalance Long-Term Services and Supports.

H.B. 5335 - AN ACT REQUIRING LONG-TERM CARE FACILITIES TO CONDUCT SEX OFFENDER BACKGROUND CHECKS ON STAFF AND RESIDENTS

Section 2 would require the Department to alert the administrative head of any nursing home facility if a Medicaid beneficiary seeking admission to such facility is listed on the registry established and maintained pursuant to C.G.S. section 54-257 of the National Sex Offender Public Website.

DSS does not regularly perform the background checks proposed by this legislation and would not generally be apprised – as a matter of course – that a beneficiary of Medicaid is on the registry. Further, as DSS does not receive this information, the Department would not have a process to inform facilities as envisioned under the proposal.

Based on the census report for February 2022, there are 18,414 residents in nursing home beds in Connecticut. DSS would like to highlight this number and the impracticality of DSS checking the registry on all admissions to long-term care facilities.

As a result, passage of the bill would likely result in the Department's need for additional staff to conduct the work proposed and would entail additional administrative costs. As such costs are not included in the Governor's budget, the Department cannot support this bill.

H.B. 5337 - AN ACT CONCERNING A "FOOD IS MEDICINE TASK FORCE" AND HEALTHY EATING INCENTIVES.

DSS appreciates and supports the intent of this bill. DSS is currently engaged in workgroups with a variety of organizations – including with the Department of Agriculture, Office of Healthcare Strategy, and others – around food as health initiatives with the intent of utilizing locally grown products to improve health outcomes for Connecticut residents through improved access to fresh fruits and vegetables and nutrition education. The Department would welcome a larger task force to continue the work on this important topic. However, the Department has concerns with Section 2 of this bill, which requires DSS, as well as the Department of Public Health and the Department of Agriculture, to develop a strategy to increase the number of needy individuals and families who purchase fresh fruit and vegetables at farmers’ markets and report back to the legislature. DSS has concerns with prematurely determining a specific strategy for encouraging participation, which may be best left for the task force to govern.

The Department would like to suggest allowing the task force itself to set the parameters and goals of improving health outcomes for needy individuals and families through nutritional assistance, which could include strategies to increase the numbers of needy individuals and families who purchase fresh fruit and vegetables at farmers' markets.

As the work of the task force is not set to end until January 2023, the Department also believes the requirements and parameters of Section 2(b) and 2(c) – which seek to establish a healthy incentives program and require a report back to the legislature on the results of implementation of the strategy – would be difficult to successfully implement without additional funding and within the timeframes established, as it would not be able to utilize any of the findings of the task force in its strategy. Instead, the Department would like to suggest that the work of implementing any strategies would commence after the task force report is submitted and allow for a robust evaluation period prior to submitting any findings.

H.B. 5338 - AN ACT CONCERNING INCREASING THE RATE OF MEDICAID REIMBURSEMENT FOR HOME CARE SERVICES

This bill amends the home health agency fee schedule statute to require the Department to increase the fee schedule for home health services provided under the Connecticut Home Care Program for Elders (CHCPE) only by an amount equal to the most recent increase in the consumer price index for all urban consumers (CPI-U).

CHCPE provides home and community-based services to individuals who are 65 years of age or older, are at risk of institutionalization or meet nursing home level of care and meet financial eligibility criteria. Risk of nursing home level of care means the individual requires assistance with critical needs such as bathing dressing, eating, toileting and taking their medication. CHCPE services include adult day health, bill payer, care management, care transitions, homemaker, agency-based personal care assistant, adult family living, chore services, chronic disease self-management program, companion, environmental accessibility adaptations, home-delivered meals, respite, assisted living, assistive technology, mental health counseling, personal emergency response system, recovery assistant and transportation. CHCPE will also cover home

health services when not covered by Medicare, including skilled nursing, home health aide, occupational, physical and speech therapy.

It should be noted that while the bill requires the Department to only increase home health fees for services provided under CHCPE, the home health fee schedule customarily applies to all services under Medicaid and it would not be appropriate to increase the schedule for home health under CHCPE only. While estimates for a CHCPE only increase are provided below, this is not consistent with practice.

The current estimate for home health services provided under the Medicaid and state-funded CHCPE programs is \$25 million. Therefore, for each one percent increase in the CPI-U, an annualized total cost of \$250,000 is expected to result. Based upon the most recent 12-month change in the CPI-U of 7.5%, a total cost of \$1.9 million would result. The state share of this cost is estimated to be approximately \$0.8 million.

As the Department utilizes the same fee schedule for all home health services and does not specify a different rate structure for CHCPE home health services versus all other home health services, this increase should be applied to all home health services. With an aggregate expenditure baseline of \$205 million for all home health services, each one percent increase would cost \$2.05 million annually. Therefore, with a CPI-U 12-month change of 7.5%, a total cost of \$15.4 million would result. The state share of that expense is estimated at \$6.6 million.

The Department cannot support the bill at this time, given the costs identified above that are not included in the Governor's recommended budget adjustments. It should also be noted that both home health and waiver rates are being increased as part of the ARPA HCBS reinvestment plan.

H.B. 5339 - AN ACT EXPANDING ACCESS TO THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY

This bill requires DSS to change the calculation of assets for applicants for the Connecticut Home Care Program for Elders (CHCPE) from 150% of the federal minimum community spouse protected amount (CSPA) to \$45,000 for a single person, an increase of 9.2% over the current level of \$41,220, and from 200% of the federal minimum CSPA for married couples to \$65,000 an increase of 18.3% over the current level of \$54,960. The bill also changes from 4.5% to 3.5% the contribution rate for the cost of care under the state-funded program.

CHCPE provides home and community-based services to individuals who are 65 years of age or older, are at risk of institutionalization or meet nursing home level of care and meet financial eligibility criteria. Risk of nursing home level of care means the individual requires assistance with critical needs such as bathing, dressing, eating, toileting and taking their medication.

CHPCE has four categories and is funded by both state and Medicaid dollars. Categories 1 and 2 are funded by the state, Category 3 is a 1915(c) home and community-based waiver, and Category 5 is a 1915(i) state plan amendment which receives 50% federal reimbursement. Individuals who receive services and supports through Category 3 or 5, must meet both the functional eligibility requirements established by the state and also qualify financially under one

of the Medicaid coverage groups which are established by the Centers for Medicare and Medicaid Services (CMS). The 1915(c) offers the option of serving individuals under the Special Income Group criteria, which permits individuals to qualify at higher income limits than is typical under HUSKY C. The Connecticut waiver income limit is \$2,523 per month, which is the highest income limit permissible under Medicaid for individuals who are not employed. The waiver asset limit is \$1,600. The state-funded CHCPE is designed to include less restrictive financial eligibility criteria than permitted by CMS, thereby helping older adults receive services and supports without spending down to a Medicaid coverage group. In general, participants of the state-funded program use Medicare for typical medical services, while the state pays for the long-term services and supports.

Based on the growth trend of new participants in the state-funded CHCPE, and an anticipated 25% increase in new participants due to the proposed change in the asset test, combined with a decrease in cost share from 4.5% to 3.5%, DSS estimates a \$5.9 million dollar increase in annual costs for the program. The increase in costs would be the sole responsibility of the state, as this proposed change would impact those served by Category 2 of CHCPE which is strictly state funded. It is also worth noting that effective July 1, 2021, the cost share was reduced from 9.0% to 4.5%, pursuant to PA 21-2, June special session.

While expanding the program would benefit additional vulnerable older adults, this was not included in the Governor's budget, and thus the Department cannot support the bill.

H.B. 5340 - AN ACT CONCERNING EQUITABLE MEDICAID PAYMENTS AND ELIGIBILITY DETERMINATIONS FOR APPLICANTS, RECIPIENTS AND FAMILY CAREGIVERS

Section 1 requires DSS to set equal payment rates for family caregivers authorized to receive compensation from DSS as compared to the rates set for non-family professional caregivers.

The Department shares the Committee's interest and concern in supporting family caregivers, whose contribution of in-kind services to their loved ones is a mainstay of the public-private partnership that is reflected in our nation's continuum of long-term services and supports. To the extent permitted under federal law, the Department has enabled people who are participating in the Medicaid State Plan Community First Choice option and Medicaid home and community-based services (HCBS) waivers such as the Connecticut Home Care Program for Elders to self-direct their care by hiring and managing personal care attendants (PCAs). With certain limitations, these PCAs may be family members of the person receiving care. In Connecticut, self-directed PCAs have the benefit of collective bargaining, which has resulted in a standard, statewide schedule of wage rates and fringe benefits. Outside these parameters, the Department generally does not have the authority to reimburse family members for Medicaid-covered services.

Section 2 proposes to provide up to three months of retroactive Medicaid eligibility to individuals applying for home and community-based services.

Medicaid programs must provide coverage for up to three months prior to the month of application for any time during the three months prior that the applicant met the eligibility requirements, however the Centers for Medicare and Medicaid Services (CMS) does not allow retroactive coverage when an applicant requests coverage of HCBS.

For Medicaid services provided pursuant to a HCBS waiver, coverage is prospective-only from the date on which the state Medicaid program approves a HCBS service plan. There are provisions in the waiver that require, for example, the completion of a criminal background check for providers under the waiver. If retroactive payment were possible, there could be no assurance that such CMS requirements were met. In addition, there are specific rates and approved providers in a waiver. Private services that clients or families arrange *prior to the determination of financial eligibility* may be provided by a *non-Medicaid provider* at any range of rates. Neither of these would be permissible under a waiver program.

A waiver, such as the Connecticut Home Care Program for Elders waiver, specifies to CMS that clients are provided a choice of providers and that they receive care management services that include ongoing monthly monitoring of the clients' status and the effectiveness of the person-centered plan. This standard cannot be met retroactively. In addition, federal financial participation cannot be claimed for waiver services that are furnished prior to the development of the service plan or for waiver services that are not included in an individual's service plan. Simply put, a service plan cannot be "backdated."

Because CMS guidance and federal law does not allow for the changes sought by this proposal, the Department cannot support Section 2 of this bill.

Section 3 of this bill would prohibit institutionalized individuals from being denied Medicaid on the basis of a single unliquidated asset, provided the applicant can show evidence that the asset is inaccessible. Section 3 would also prohibit institutionalized individuals from being denied Medicaid on the basis of an asset discovered during the application process, provided the applicant reports the discovery, takes steps to liquidate the asset and spends-down the proceeds in accordance with Medicaid policy. Both proposed changes pertain to a single disqualifying asset that causes the institutionalized individual's total assets to exceed the Medicaid limit.

Federal regulations define a countable asset as cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and can convert to cash to be used for his or her support and maintenance. If the individual has the right, authority or power to liquidate the asset, it is countable towards the Medicaid limit.

The exclusion of a single disqualifying asset would effectively allow institutionalized individuals to have assets in excess of the Medicaid asset limit, and still qualify for assistance. This would remove any incentive for individuals or their representatives to reduce their assets in a timely manner by paying nursing facilities and would increase Medicaid expenditures by allowing applicants to be eligible for Medicaid services earlier.

For these reasons, the Department opposes this bill.