



*Testimony before the Human Services Committee
Deidre S. Gifford, Commissioner
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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.

SB 272 AN ACT ADDING ACUPUNCTURISTS AND CHIROPRACTORS TO THE LIST OF PERMISSIBLE REIMBURSABLE MEDICAID SERVICES

Senate Bill 272 would require the Department to add Medicaid coverage for licensed acupuncturists and chiropractors as optional services in the Medicaid State Plan.

Currently, the Medicaid program covers services provided by licensed acupuncturists and chiropractors who provide services through a Federally Qualified Health Center (FQHC). In addition, certain acupuncture services may be coverable if provided by a qualified physician. Chiropractor services are also covered through outpatient hospitals.

There is clinical evidence that acupuncture services are effective in addressing pain and other clinical conditions. There is clinical evidence that chiropractic services are effective in addressing acute and chronic back and spinal pain. Both services may be used as an alternative method of treatment to pain medications, including opioids.

Therefore, the Department appreciates the concept of additional Medicaid coverage for services provided by licensed acupuncturists and chiropractors in independent practice and other applicable covered settings. As with all Medicaid covered services, the Department would approve coverage only for services that are medically necessary for each individual in accordance with the statutory definition of medical necessity in section 17b-259b of the Connecticut General Statutes (CGS).

The Department estimates that adding licensed acupuncturist and chiropractor coverage would increase the state share of Medicaid expenditures by approximately \$98,000 and \$160,000 respectively. However, neither the enacted state budget nor the Governor's proposed budget adjustments include funding to add coverage of these services.

HB 5015 - AN ACT CONCERNING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES.

The Department supports passage of HB 5015, An Act Concerning the Governor's Budget Recommendations for Human Services. This bill makes changes to certain third-party liability provisions and adjustments to maintain current rates for Natchaug Hospital.

When the Department of Social Services, 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. Under Section 1 of the bill, the Governor is proposing to institute 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 SFY 2021.

This bill also requires legally liable third parties (i.e., health insurance companies) 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.

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.

Last session, funding was added to increase Natchaug Hospital's inpatient per diem rate from \$829 to \$975 beginning in SFY 2021. Under section 2 of this bill, the department will continue to reimburse for inpatient services at the hospital's current Medicaid inpatient per diem rate. This change is anticipated to result in a state savings of \$454,000 in SFY 2021.

Natchaug Hospital received a supplemental payment of \$250,000 (state share of \$125,000) in April 2018. Starting in early 2019, DSS established a pay-for-performance program to reward high quality services for children receiving services at Natchaug. Up to \$500,000 (state share of \$250,000) is available for Natchaug to earn in each year of the program as a performance payment payable six months after each measurement year (year 1: 2/1/18 through 1/30/19; year 2: 2/1/19 through 1/30/20). Based on Natchaug's performance in year 1, DSS paid Natchaug \$400,000 (state share of \$200,000) in September 2019. Depending on its performance in year 2, Natchaug could receive up to \$500,000 (state share of \$250,000), which would be paid in September 2020.

In total, the above initiatives will result in state savings of approximately \$2.4 million in FY 2021, which are reflected in the Governor's midterm adjustments budget.

HB 5306 - AN ACT CONCERNING TEMPORARY STATE SERVICES FOR VICTIMS OF DOMESTIC VIOLENCE.

The Department appreciates the intent of this bill, but has some concerns with the way the bill is currently drafted and, as it pertains to Section 1, potential conflicts with federal law.

This proposal would require DSS, to the extent permissible under federal law, to expedite Supplemental Nutrition Assistance Program (SNAP) eligibility determinations for a victim of domestic violence, as defined in section 17b-112a, CGS. 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. DSS appreciates the intent of this bill, as well as any measures aimed at improving access to SNAP benefits and retailers for Connecticut residents.

Unfortunately, federal law prohibits the agency from enacting the requirements set forth in the proposed bill in regard to SNAP. Current federal regulations at 7CFR 273.2 set forth the criteria in which eligibility is obtained for expedited SNAP processing. The standards maintain that only individuals whose income is less than \$150 and whose assets are less than \$100, whose combined monthly gross income and liquid assets are less than their rent/mortgage and utilities, or are migrant/seasonal farmworkers who are destitute and have less than \$100 in liquid assets qualify for expedited processing of SNAP benefits. 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 if there are outstanding verifications required by the agency to establish ongoing eligibility. If the agency does not require verifications, or if the verifications are provided with the initial application, the individual would be certified to receive SNAP benefits for a period of 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.

While the department cannot support the changes suggested in the proposed bill, it recognizes the uncertainty that arises as a result of these situations. Because of this, the department has begun to utilize what flexibility it does have in SNAP eligibility to allow discretionary exemptions from the SNAP able-bodied adults without dependents (ABAWD) work requirements for victims of domestic violence. While these ABAWD individuals would

normally be discontinued from receiving SNAP benefits after 3 months, these discretionary exemptions will allow them additional months' benefits to lessen the burden of these stressful situations.

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. The distinction is important, because we already exclude 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 the current iteration of this bill but is open to conversations about how to address the committee's underlying concerns.

HB 5307 - AN ACT CONCERNING DEPARTMENT OF SOCIAL SERVICES' PAYMENT SUSPENSIONS.

Passage of this proposed bill will put the Department of Social Services in violation of federal law and will jeopardize the Federal Financial Participation (FFP) for Medicaid claims.

Effective in March 2011, Section 6402(h)(2) of the Affordable Care Act, Suspension of Medicaid Payments Pending Investigation of Credible Allegations of Fraud, amended section 1903(i)(2) of the Social Security Act to make it mandatory that the Department suspend payments when it determines that there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an enrolled provider.

Pursuant to the federal regulation, 42 C.F.R. § 455.23, when implementing a payment suspension the Department must provide notice to the provider of the general allegations regarding the nature of the suspension and allow the provider an opportunity to submit written evidence for consideration of whether the suspension should be terminated or the amount of funds suspended should be reduced. Importantly, the notice must also state that the suspension is temporary, in that it will not continue if law enforcement determines there is insufficient evidence of fraud or legal proceedings related to the provider's fraud are completed. To be clear, this regulation does not apply to errors or overpayments discovered during the course of a routine audit.

The regulation does give the Department the discretion not to impose a payment suspension or to impose a partial payment suspension, if it determines that there is good cause. One example of good cause, as stated above, is when the provider submits written evidence that is acceptable to the Department. Other circumstances that may constitute a “good cause exception” include (i) a request by law enforcement not to suspend so as to not alert the provider of an ongoing investigation; (ii) if the Department determines that a payment suspension may jeopardize Medicaid recipients access to items or services, or (iii) the Department determines that a payment suspension (full or partial) is not in the best interests of the Medicaid program.

The rationale for the federal regulation is straightforward and noncontroversial—it is to protect critical Medicaid dollars from falling into the hands of providers suspected of engaging in fraudulent conduct.

The proposed bill, however, will require the Department to initiate a contested case hearing *before* it can suspend the provider’s payments. If passed, the bill will not only defeat the primary purpose of the federal payment suspension regulation by putting the Department and law enforcement in a position of having to arguably “pay and chase” the provider but more importantly, it will put the Department in a position of violating federal law and thus jeopardize the FFP. This is not something the state should take lightly. The Centers for Medicare and Medicaid Services has made it clear that it will thoroughly investigate and act by, among other things, deferring or disallowing FFP if program integrity reviews or other methods of ensuring State compliance with the regulation reveal the state is failing to suspend payments. This bill puts at risk millions of dollars in FFP that the State cannot afford to lose, and therefore we must oppose HB 5307.

HB 5308 - AN ACT REQUIRING THE DEPARTMENT OF SOCIAL SERVICES TO WORK WITH THE UNITED STATES DEPARTMENT OF AGRICULTURE TO EXPLORE CERTAIN SUPPLEMENTAL NUTRITION ASSISTANCE OPTIONS.

This bill would require DSS to consult with the Food and Nutrition Service (FNS) of the USDA about options to provide Supplemental Nutrition Assistance Program (SNAP) assistance, including, but not limited to, (1) state involvement in any future expansion of a federal pilot project allowing beneficiaries to purchase food online from authorized vendors, and (2) state participation in the Restaurant Meals Program.

DSS both appreciates the intent of this bill, as well as any measures aimed at improving access to SNAP benefits and retailers for CT residents.

Online Purchasing Pilot: The 2014 federal Farm Bill mandated a pilot be conducted, prior to national implementation, to test the feasibility and implications of allowing retail food stores to accept SNAP benefits through online transactions. Benefits cannot be used to pay for fees of any type, such as delivery, service, or convenience fees. In September of 2016, FNS released a request for retailer volunteers (RFV) to solicit applications for the two-year SNAP Online Purchasing Pilot as well as to list the individual states they wished to partner with under the pilot program. Based on selections made by each retailer during the RFV process, as well as

subsequent agreement by the corresponding state agencies, eight states nationwide were chosen to participate in the pilot (Alabama, Iowa, Maryland, Nebraska, New Jersey, New York, Oregon, and Washington). This two-year pilot was launched in April of 2019 in the State of New York and has since expanded to the State of Washington. The pilot is scheduled to conclude in April of 2021. Eventually, the goal is for this to be a national option for SNAP participants, once the pilot phase is complete and USDA can incorporate lessons learned into program rules. While we were not chosen as one of the eight states that would be participating in the Online Purchasing Pilot, DSS is eager and willing to work with FNS, our Electronic Benefit Transaction (EBT) vendor, and any participating retailer to implement online SNAP purchasing in Connecticut once the pilot project concludes and the option is implemented nationwide.

Restaurant Meals Program: The Restaurant Meals Program (RMP) is a state option that allows homeless, elderly (age 60 or over) and disabled SNAP households 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, offer meals at concessional prices, and cannot charge a service gratuity or sales tax. Currently, five states operate an RMP on an extremely limited scale. For example, Rhode Island has operated an RMP since 2011 but has only nine Subway restaurants that have chosen to participate statewide. In order to implement this program, DSS will incur significant costs around contracting and reviewing for eligibility all individual restaurants willing to participate in the program. Currently, retailer onboarding, oversight, training, compliance and monitoring is performed directly by and at the cost of FNS. However, should the state decide to pursue this option, these functions and the costs associated with them 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 its EBT vendor;
- Modifying the EBT vendor contract to identify and limit participation to only clients who are eligible;
- Developing a system to monitor transactions at participating restaurants for program compliance; and,
- Providing training to staff, clients, and participating restaurants.

Absent additional appropriations and staffing, DSS cannot support this bill.

HB 5310 - AN ACT ELIMINATING STATE RECOVERY OF PUBLIC ASSISTANCE EXCEPT AS REQUIRED UNDER FEDERAL LAW.

While the Connecticut Department of Social Services (DSS) appreciates the intent of this bill, there are several issues with the bill that are serious enough that DSS cannot support it. These concerning issues are related to its fiscal impact on the State—which DSS and the Department of Administrative Services (DAS) estimate at approximately **\$18.3 million** annually based on an examination of recoveries over the past five fiscal years, its failure to comply with federal Medicaid requirements in at least one respect, and its impact on some one-parent households to whom overdue child support is owed. DSS is also concerned by the short period of time in

which DSS and DAS are expected to implement these sweeping changes, which will require a variety of system, business-practice, and forms changes.

This bill would amend the General Statutes to eliminate State claims and recoveries of properly paid public assistance except where required by federal law. As a result, state recoveries of cash assistance would be limited to retaining child support payments received by DSS' Office of Child Support Services where the custodial parent and child received or are receiving Temporary Family Assistance (TFA) or its predecessor program Aid to Families with Dependent Children (AFDC). No recovery of any form of properly paid cash assistance by other means would be permitted.

With respect to medical assistance, no recovery would be permitted based on services provided by purely state-funded medical assistance programs, such as State Medical Assistance for Non-Citizens (SMANC) or the state-funded portion of Connecticut Home Care Program for Elders (CHCPE). With respect to coverage provided by Medicaid, the State could only recover the cost of (1) nursing home care, home and community-based services, and related hospital and prescription drug services provided to a beneficiary while he or she was at least 55 years of age, and (2) institutional care provided for certain persons of any age if DSS determines the person is permanently institutionalized. Under existing federal law, recovery is still not permissible in these situations if there is a surviving spouse or other qualifying relative who would otherwise have a claim to the estate assets.

Under the bill, DSS would also be precluded from placing pre-death liens, as permitted (but not required) by federal law, on the real property of permanently institutionalized Medicaid beneficiaries.¹ Many other states opt to use these liens, which allow states to recoup the cost of providing Medicaid long-term care services to permanently institutionalized beneficiaries prior to their death, and also ensure that, if the property is sold, the state Medicaid agency is aware and the sale proceeds are not improperly transferred to a third party.

DSS and DAS have analyzed recoveries over the past five fiscal years and estimate that the bill would result in a loss of approximately \$18.3 million in direct public-assistance recoveries each year. Additional losses may be realized based on the State's inability to offset these debts against liabilities when the State itself is sued by a public-assistance beneficiary, though this loss is difficult to quantify. *See generally* Conn. Gen. Stat. § 52-139. Losses of this size are not contemplated in the adopted budget for the biennium or in the Governor's budget proposal, and as a result DSS cannot support the bill, but welcomes further discussion of the effectiveness, efficiency, and efficacy of our current recovery policies and practices.

¹ It is notable that a separate bill introduced this legislative session, House Bill 5209, An Act Concerning the Uniform Real Property Transfer on Death Act, would permit the use of revocable, transfer-on-death deeds by which real property could be conveyed to third parties without passing through a decedent's estate. If both bills were enacted this session, DSS would be unable to place pre-death liens to secure Medicaid debts, and a Medicaid beneficiary would be permitted to execute a deed that would transfer his or her primary asset to a third party upon death, outside of the probate estate. The net effect of this would be that even those Medicaid estate recoveries permitted by this bill would be reduced and the fiscal impact to the State would likely be greater than the estimate provided in this testimony.

Aside from the fiscal impact of the bill, DSS has additional concerns. Most notably, the amendments to section 17b-94 of the General Statutes are problematic in two ways. First, this language would limit the State's lien against a cause of action brought by a Medicaid beneficiary to the total amount of recoverable medical assistance that was provided, *or fifty percent of the proceeds of the judgment or settlement received by beneficiary, whichever is less*. However, federal Medicaid law makes it "unmistakably clear that, to the extent possible, states should not use Medicaid funds to pay for a recipient's medical services if a third party has been deemed responsible for those costs, and the state must seek reimbursement of amounts for which the third party is liable *to the full extent of such liability*." *Rathbun v. Health Net of the Northeast, Inc.*, 315 Conn. 674, 690, 110 A.3d 304, 313 (2015) (citing 42 U.S.C. § 1396a(25)(A)-(B)) (emphasis added). For this reason, our Supreme Court has declined to interpret the existing language of section 17b-94 of the General Statutes as limiting the State's lien on the proceeds of a Medicaid beneficiary's cause of action against a third party liable for the cost of his or her medical care to fifty percent of the proceeds of that cause of action, because such an interpretation "would prevent the state from complying with its obligations under federal law." *Id.* at 696. However, the bill's amendment to section 17b-94 would make this fifty-percent limitation *explicitly applicable* to Medicaid liens asserted in these situations and would thereby jeopardize the State's Medicaid funding.

Second, under the amended language, the same fifty-percent limitation would apply in cases where the State's lien against the plaintiff's cause of action is for overdue child support, some of which may be retained by the State in cases where the custodial parent and child received TFA or AFDC, but some of which may be passed on to the custodial parent and child to whom support is owed. Under current law, the State's lien is not so limited, and the State's long-standing policy is to recover the full amount of overdue support owed to the child and custodial parent. *See generally* Conn. Gen. Stat. § 52-362d(d).

Finally, DSS notes that the effective date for the changes outlined in the bill is July 1, 2020. Preliminary conversations with DSS and DAS staff involved in State recovery efforts suggest that a number of changes would likely need to be made to business practices, forms and computer systems to effectuate these changes, and that it is unlikely that these changes could be completed prior to July 1, 2020.

For the foregoing reasons, we respectfully request that the committee take no action on this bill.

Thank you for your consideration. We would be happy to answer any questions you may have.