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. 956 - AN ACT PROVIDING MEDICAL ASSISTANCE TO CERTAIN INDIVIDUALS 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.

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 Medicaid or CHIP are immediately eligible for coverage.

Federal matching funds are only available for treatment of an emergency medical condition experienced by an individuals who do not have any eligible 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.

If coverage were extended to all adults and children who are otherwise eligible for HUSKY A, B or D, regardless of immigration status, 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 the annual cost to support the state-funded expansion of coverage would be approximately $195 million.

Based on estimates of the "unauthorized" immigrant population provided by the Migration Policy Institute (see https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/CT), the Department estimates that 5,850 children could become eligible under HUSKY A, 13,350 adult parent/caretakers could become eligible under HUSKY A, 322 children could become eligible under HUSKY B, and 17,388 adults could become eligible under HUSKY D.

The Department notes that there is not detailed information about this population's health condition and willingness to access benefits (which could reduce the PMPM costs) and, as a result, there is some uncertainty in these financial projections. Additionally, fear and confusion caused by "public charge" designations could reduce the number of individuals who enroll and use services. 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.

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.

In closing, it is important to mention that Governor Lamont has proposed HB 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. 957 - AN ACT EXPANDING ACCESS TO IN-HOME COUNSELING.

Senate Bill 957 proposes to require DSS to add rates to the home health agency fee schedule for behavioral health counseling provided by a licensed social worker. Although DSS supports improving access to behavioral health services in home and community-based settings, DSS is unable to support this bill because it is inconsistent with federal Medicaid law, would increase costs, and is unnecessary.

This bill is inconsistent with federal Medicaid law because the federal home health benefit category does not include behavioral health counseling services. Specifically, the federal Medicaid regulation that defines the home health benefit category includes only the following categories of services: (1) nursing services, (2) home health aide services, (3) medical supplies,

equipment, and appliances, and (4) physical therapy, occupational therapy, and speech pathology and audiology services. 42 C.F.R. § 440.70(b). Therefore, behavioral health counseling services cannot be included in the federal Medicaid home health benefit category.

This bill would increase costs because it would add coverage for a new group of services. Funding for this additional category of services is not included in the Governor's budget. Even if additional funding were available to expand in-home access to behavioral health services, it is much more appropriate to develop a comprehensive approach to improving access to quality behavioral health services in home and community-based settings. This bill, however, would limit the additional coverage only to home health agencies.

Finally, this bill is unnecessary because the Medicaid program already covers mental health counseling services provided in the home. Under the Medicaid State Plan, licensed behavioral health clinicians enrolled in Medicaid as an individual or group practice (licensed psychologists, licensed clinical social workers, licensed marital and family therapists, licensed professional counselors, and licensed alcohol and drug counselors) already receive Medicaid payment for providing behavioral health counseling services to Medicaid members in any setting, including their homes. Those clinicians can already provide and be paid for providing those services in the home. There is no need to pay home health agencies for services provided by the clinicians, who can already enroll directly with Medicaid.

Similarly, in the Connecticut Home Care Program for Elders waiver currently and in the renewal of the Personal Care Assistance waiver that is being developed, mental health counseling provided by a licensed social worker or professional counselor is a covered waiver service. The service may be and currently is being provided by both individual practitioners as well as agencies. The need for the service and subsequent authorization is based on a need identified through the comprehensive, functional assessment of persons applying for or actively participating in the waiver. The service would need to be authorized by the care manager and included in the comprehensive waiver service plan.

For all of these reasons, DSS is unable to support S.B. 957.

S.B. 979 - AN ACT EXPANDING ACCESS TO MEDICAL SPECIALISTS FOR MEDICAID BENEFICIARIES IN SOUTHEASTERN CONNECTICUT.

This bill requires DSS to develop a plan to increase access to medical specialists in the southeastern part of the state by expanding telehealth services.

DSS shares the committee's interest and concern around timely access by Medicaid members to specialists in all areas of the state. That said, DSS believes that the bill is unnecessary because the aim of this bill is already being satisfied as evidenced by the following:

- DSS and its medical administrative services organization, Community Health Network of Connecticut (CHNCT), already carefully monitor and analyze member access to Medicaid-enrolled providers, including specialists, through geomapping, mystery shopper surveys, review of grievance and appeal data, and use of consumer experience (CAHPS) surveys.
- Participation of both primary care and specialty care providers has continued to increase over time, in contrast to many other states' Medicaid programs.

- Over the COVID-19 public health emergency (PHE), DSS has implemented a broad portfolio of telehealth coverage in HUSKY Health across many service areas, including specialists.
- DSS is paying for these PHE telehealth services at parity with in-person visits to enable use of telehealth.
- DSS has documented that over 390,000 HUSKY Health members have received one or more telehealth services, and over 18,000 providers have rendered services via this mechanism. These services are being provided to members located in all areas of the state, including southeastern Connecticut.

Rather than codify language specific to one geographic area of the state in statute, DSS recommends continuing a statewide approach to implementing telehealth services to focus on fostering access to telehealth services for all Medicaid members throughout Connecticut.

As in-person participation in health care visits is rebounding, DSS is carefully evaluating which aspects of its current telehealth portfolio should and can permissibly be maintained on a permanent basis. The current array of coverage is, however, expected to last for the duration of the federal PHE declaration.

For all these reasons, DSS believes that SB 979 is not necessary.

S.B. 980- AN ACT ELIMINATING INCOME AND ASSET LIMITS FOR THE MED-CONNECT PROGRAM FOR PERSONS WITH DISABILITIES.

The proposed legislation seeks to eliminate income and asset limits for working persons with disabilities to qualify for Medicaid.

Currently, the Medicaid program for employed disabled individuals, or "MED-Connect," allows certain Connecticut residents with disabilities who earn up to $75,000 per year to qualify for full Medicaid coverage under HUSKY C. As of February 2021, 4,044 individuals were enrolled in MED-Connect. Individuals above 200% of the federal poverty level pay a premium for the coverage. Currently, 763 MED-Connect enrollees have a premium obligation. MED-Connect also allows eligible individuals to work and retain assets greater than what is allowable under traditional Medicaid coverage groups. The program includes a $10,000 resource test for individuals and a $15,000 resource test for married couples. This resource test excludes home property, certain retirement accounts and accounts maintained for the purpose of increasing employability. MED-Connect also includes the "Medically Improved" group, a coverage component for individuals who have lost disability status through the Social Security Administration, but still have some severe medical impairment. The proposed bill would eliminate the income and asset limits for both groups.

The Department supports the intent to expand medical coverage options for working individuals with disabilities. Administrative efficiencies would bring some cost savings, however, they may not be enough to offset the costs of increased enrollment. It is difficult to project the financial impact of the proposed bill as removal of the income and asset limits raise uncertainty as to the number of individuals who may be eligible to enroll but do not qualify under current rules. The Department does not have data about this population readily available to assess. The proposed expansion of eligibility without a limit on income or assets may encourage some individuals

currently covered through employers and private insurance to move to Medicaid. For this reason and without the availability of appropriations, the Department cannot support this bill.

S.B. 981 - AN ACT CONCERNING PAYMENT PARITY FOR HEALTH AND HUMAN SERVICES PROVIDERS.

This bill requires DSS, in collaboration with the Department of Mental Health and Addiction Services and the Department of Housing, to study whether state-contracted providers of human services receive disparate payment rates. It defines "human services" as including, but not limited to, (1) physical and behavioral health services, and (2) housing and shelter services provided to homeless persons.

DSS pays for Medicaid and CHIP services using uniform statewide rates, with limited exceptions, and such rates do not differentiate based on region of the state. In addition, DSS does not provide housing and shelter services for homeless persons.

It is not clear if the term "human services" is intended to apply to any other programs funded by DSS. We are available to discuss the committee's intention in order to determine whether there is an appropriate role for the Department in such a study.

H.B. 6560 - AN ACT CONCERNING TIMELY PAYMENTS TO PERSONAL CARE ATTENDANTS.

This bill mandates that a fiscal intermediary (FI) shall provide timely communication to a personal care attendant (PCA) about payment discrepancies, payment confirmation or a change in consumer status that may affect timely payment. Such communication must include sufficient notice to allow a PCA to address any issues with the submitted time records, a specific means to address any issues, and a method for PCAs to receive the correct payment within 48 hours. The bill fines an FI $25 per day for each day timely wage payment has been delayed.

DSS strongly supports policymakers' aims in ensuring that people who provide state-funded services are paid timely and accurately by fiscal intermediaries. Specifically, DSS shares the interest in timely payment to workers who provide direct personal care assistance to Medicaid members who self-direct their care under Community First Choice (CFC). Under the Connecticut Medicaid State Plan, CFC enables Medicaid members at risk of institutionalization to use Medicaid funds to hire and manage PCAs to support them in such critical daily tasks as bathing and dressing. This work is vital to permitting those who receive care to remain independent in the community. A core tenet of self-direction is that the Medicaid member is the employer of the PCA who supports him or her. To further assist members, DSS contracts with a fiscal intermediary – Allied Community Services – that wraps around the member's role as employer to perform orientation and payroll functions.

Both DSS and the Department of Developmental Services (DDS), working in partnership with the Office of Policy and Management, the PCA Workforce Council and Service Employees International Union (SEIU), which represents PCAs in Connecticut, have undertaken numerous actions to promote timely and accurate payment to PCAs:

- Extensive education through the Council and the SEIU on requirements for completion of timesheets;
- Transition from bi-weekly to weekly payment cycles; and
- A well-documented process that the FI uses for submission, notice of receipt of, and identification through robo-calls that there are errors with timesheets, for purposes of correction and payment.

Further, DSS and DDS are implementing a new electronic visit verification system that will ultimately replace use of paper timesheets and greatly reduce errors, which is the ultimate solution to an antiquated system.

As the contractor for DSS, Allied must meticulously review and process timesheets to document that services have been provided to support Medicaid payments being made. Allied cannot make payment on incomplete or inaccurate timesheets because they risk being disallowed for federal Medicaid reimbursement. Self-directed services continue to be a major focus of audit for the federal Office of the Inspector General.

In order to approve timesheets, Allied must (1) timely receive them and (2) document that they meet all identified requirements, including, but not limited to, signatures by employers to verify hours worked. Allied cannot approve any timesheet that is not received timely or that includes errors that require research and resolution with employers.

In January 2021, out of 46,900 timesheets received, only 446 (0.9%) were not paid within the weekly pay period because of errors that had to be resolved before Medicaid funds could be used for payment. Examples of typical errors include faxed timesheets that are illegible, have incorrect dates, include time that overlaps with another employee, or include time when the person receiving the care was hospitalized.

Over the past six months, DSS has fully reviewed all Medicaid policies to determine if any current practices could be modified in a way that does not compromise program integrity and associated federal participation in the Medicaid self-directed program. To date, this effort has resulted in a 50% reduction of pay delayed due to timesheet errors. DSS encourages the committee to support this improvement strategy which increases the timeliness of payment but does not compromise the Medicaid program's integrity, risk the federal match to the program, or result in an additional unbudgeted cost to the state. If the Medicaid agency does not ensure that hours worked by PCAs are properly documented for purposes of Medicaid reimbursement, DSS risks findings by the Centers for Medicare and Medicaid Services and the Office of the Inspector General and associated disallowance of the federal match that has been received by the state for the services, which would have to be paid back and covered exclusively using state General Fund dollars.

As detailed above, DSS and its contractor Allied already have procedures in place to fulfill the aims of this bill. As such, the Department opposes the imposition of blanket penalties that do not recognize the above obligations to ensure proper use of Medicaid funds.

H.B. 6561 AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR MARITAL AND FAMILY THERAPISTS PERMITTED TO PRACTICE WITHOUT LICENSES DURING A PUBLIC HEALTH EMERGENCY.

The Department of Social Services (DSS) strongly supports continued access to high quality behavioral health services for Medicaid members, especially during the public health emergency. Connecticut's Medicaid program covers a wide array of behavioral health services in various provider settings. During the COVID-19 pandemic, DSS has implemented telehealth coverage for many services, including behavioral health services, enabling continued access to these important supports for Medicaid members.

HB 6561 would require Medicaid to cover services provided by marital and family therapy (MFT) associates who do not have a license while they are authorized under the Governor's Executive Order 7V to practice without a license. Notably, DSS' current coverage of services provided by a licensed behavioral health clinic already includes services performed by qualified non-licensed clinic staff under appropriate supervision from applicable licensed practitioners. This coverage includes services provided by freestanding licensed behavioral health clinics, outpatient hospital behavioral health clinics, and federally qualified health centers.

As a long-standing policy, Medicaid covers outpatient behavioral health services provided outside behavioral health clinics only when they are personally provided by clinicians who are licensed to practice independently. That policy is designed to protect the quality and oversight of behavioral health services provided to Medicaid members. The state has seen a concerning increase in overbilling by practitioners who have a license to practice independently. Expanding that coverage further, even to licensed MFT associates, would likely be problematic because it would reduce the quality controls included in the requirements and oversight for a licensure that includes independent practice. That risk is even greater with this proposal, which would require such coverage for non-licensed MFT associates, which is a further risk because these individuals do not have any license. DSS is committed to ensuring that Medicaid members have access to high quality behavioral health services provided by licensed providers. DSS recommends against removing these controls, which are similar to the controls that are in place for medical providers, to ensure that behavioral health services are high quality..

In addition, the bill specifically cites, and incorporates by reference, Executive Order 7V, subsection 4, issued April 7, 2020, with respect to additional flexibilities to the statutory requirements to practice as a marital and family therapist associate during the course of the declared public health emergency. Executive Order 7V, and the modifications to statute contained therein, will expire at the conclusion of the declared emergency. As a result, the direct reference to an executive order in the raised bill will lead to future confusion and statutory conflict as the provisions of subdivision (4) of section 20-195 of the General Statutes will no longer be modified, pursuant to any executive order, upon expiration of the declared public health emergency. Lastly, the raised bill is also legally problematic under federal law because the relevant federal Medicaid State Plan benefit category, other licensed practitioner (authorized under section 1905(a)(6) of the Social Security Act and 42 C.F.R. § 440.60) requires that individuals under that category must be licensed under state law.

For all these reasons, DSS must oppose HB 6561.

H.B. 6562 - AN ACT CONCERNING CHILD SUPPORT ENFORCEMENT.

This bill establishes a task force to study technological and other initiatives that could be implemented to maximize the collection of child support.

While the Department appreciates the intent and goal of this bill, we would argue that it is not necessary.

The Department's Office of Child Support Services, in collaboration with program partner Support Enforcement Services of the Judicial Branch, determined that replacement of the Connecticut Child Support Enforcement System (CCSES) is necessary to improve, enhance and modernize the technology required for establishment and enforcement of child support cases. CCSES has been in continual operation since 1987 and must be replaced. Child support automated systems are a federal program requirement and reimbursed at the rate of 66%.

In recent years, the Department has received federal approval and financial support to conduct a detailed system feasibility study, develop and implement a request for proposal to procure system replacement services, and select a contractor to replace the system. When system replacement is complete, Connecticut will have greater technological capabilities and capacity to provide child support services. Services include the establishment of paternity and financial support, collection and disbursement of funds, and enforcement of court-ordered support.

Regarding status of the system replacement project, a contractor has been selected and negotiations should be underway soon. We hope to finalize negotiations and begin the replacement project with the selected contractor this summer. Procurement has been delayed in part by the COVID-19 pandemic. State IT projects fall under DAS contract authority, and DAS has had to augment their schedules to meet COVID-19 requirements.

Full system replacement, along with testing and federal certification, is expected to be a four - year process. The project timeline will begin following formal approval of the contract.

For the foregoing reasons, the Department cannot support this bill, but the Department would be happy to further discuss our ongoing efforts to enhance child support collections.

H.B. 6563 - AN ACT ELIMINATING ADMINISTRATIVE BARRIERS TO A COMMUNITY'S PARTICIPATION IN THE FEDERAL EMERGENCY FOOD ASSISTANCE PROGRAM.

This bill proposes that the Department of Social Services (DSS) not require community food providers located in communities with schools that provide free meals to students through the Community Eligibility Provision to collect, submit or retain forms requiring persons receiving food to report income information in order to receive assistance through The Emergency Food Assistance Program (TEFAP).

TEFAP is a federal program administered by the United States Department of Agriculture (USDA) that provides foods directly to states to supplement the diets of low-income Americans in need of short-term hunger relief at no cost. The USDA also provides states the administrative funding needed to operate TEFAP. In Connecticut, DSS contracts with Connecticut Food Bank/Foodshare, Inc. to distribute TEFAP foods to eligible food pantries, shelters and soup

kitchens that serve meals and provide take-home food commodities to households. These commodities include items such as vegetables, fruits, meat, grains, and dairy products.

Federal law at 7 CFR 251.5(b) requires that administering state agencies (DSS in Connecticut) establish income-based eligibility criteria for TEFAP recipients to ensure that only households in need of assistance receive commodities. Specifically, the criteria must:

> (1) enable the State agency to ensure that only households which are in need of food assistance because of inadequate household income receive TEFAP commodities; (2) include income-based standards and the methods by which households may demonstrate eligibility under such standards; and (3) include a requirement that the household reside in the geographic location served by the State agency at the time of applying for assistance, but length of residency shall not be used as an eligibility criterion.

Additionally, federal law at 7 CFR 251.10(a)(3) and (4) requires that participating providers collect and retain records on households receiving TEFAP commodities. Specifically, the law states:

> (3) Each distribution site must collect and maintain on record for each household receiving TEFAP commodities for home consumption, the name of the household member receiving commodities, the address of the household (to the extent practicable), the number of persons in the household, and the basis for determining that the household is eligible to receive commodities for home consumption;
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> (4) All records required by this section must be retained for a period of 3 years from the close of the Federal Fiscal Year to which they pertain, or longer if related to an audit or investigation in progress. State agencies may take physical possession of such records on behalf of their eligible recipient agencies. However, such records must be reasonably accessible at all times for use during management evaluation reviews, audits, or investigations.

The Department would also like to note that it has established forms and processes that, while meeting federal requirements, are intended to minimize the amount of paperwork that providers are required to collect. The Department has established broad eligibility parameters to support easy enrollment, and recipients are allowed to verbally attest to eligibility.

For the forgoing reasons, the Department cannot support this bill.