Testimony before the Human Services Committee
Roderick L. Bremby, Commissioner
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Good afternoon, Senator Moore, Senator Markley, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick L. Bremby, and I am the Commissioner of the Department of Social Services.

I am pleased to appear before you to offer remarks on several of the bills on today's agenda.

H.B. No. 7006 (RAISED) HUMAN SERVICES. 'AN ACT RESTORING OVERSIGHT OF THE CARE 4 KIDS PROGRAM TO THE DEPARTMENT OF SOCIAL SERVICES AND ALLOWING FOR THE TRANSFER OF FEDERAL BLOCK GRANT FUNDS TO THE PROGRAM'

This bill would designate the Department of Social Services as the lead agency for child care services and transfer the child care development block grant and the child care subsidy program from the Office of Early Childhood to DSS.

The Office of Early Childhood (OEC) has administered child care programs since 2014. With a vision and mission that supports the safety, health and education of young children, the Department supports that all child care services and programs stay within the purview of the Office of Early Childhood.

Further, it should be noted that any efforts to transfer funds that are beyond levels of support that are already designated for child care services under the Temporary Assistance for Needy Families (TANF) Block Grant and the existing Social Service Block Grant/TANF funding transfer will result in diminished resources for other programs that are currently supported with these funds.

The Department opposes this bill.

H.B. No. 7008 (RAISED) HUMAN SERVICES. 'AN ACT CONCERNING A MEDICAID-FUNDED PILOT PROGRAM FOR LONG-ACTING REVERSIBLE CONTRACEPTIVES

The Department is absolutely supportive of all measures and policies that remove barriers to the use of any family planning services and methods among Medicaid recipients of both genders. This administration implemented the family planning special coverage group in this spirit and implemented separate payment for long-acting reversible contraceptives (LARC) in the

immediate post-partum period, among other policy innovations. We furthermore believe that this approach, both locally and nationally, is responsible for our teen pregnancy rate being at its lowest point in several generations.

We are concerned, however, that this legislation will not further these successful efforts for multiple reasons.

First, many of the requirements described are already in place. Specifically:

- Separate reimbursement for LARC devices that are provided immediately after a participating Medicaid recipient gives birth in a hospital, was implemented on April 15, 2016.
- The Department also has no prior authorization requirement on any family planning device or method in settings where they are commonly dispensed or used.

Section (c)(3) of this legislation would require the Department to reallocate Medicaid dollars to fund a family planning pilot program that would include a direct reimbursement with a dispensing fee add-on to pharmacies that provide contraceptives to health care providers. If the intent of this enhancement is to entice pharmacies to provide contraceptives, the Department is hesitant that any such impact would occur. Providers are hesitant to insert LARCs dispensed by community pharmacies because it is extremely difficult to confirm that the device was handled in a sterile fashion when carried from the pharmacy to the clinician's office. Insertion of an unsterile LARC could cause severe infection with potentially permanent impact on the patient's fertility. Most providers receive LARCs directly from the manufacturer to ensure sterilization.

Section (d) of this legislation requires the Department to provide training and outreach for providers and their staff regarding the provision of LARCs. The Department understands the importance of providing supports and is interested in delivering such efforts statewide, expanding past the Hartford and New Haven area, targeted in this bill. We ask that the Department continue to review how these supports can be delivered statewide and to report to the Committee at a later date.

Lastly, the Department is concerned about the requirement that we "reallocate not more than eight hundred thousand dollars in any Medicaid funding used for family planning to fund the pilot program." Under federal rules, pilot programs such as this are strictly prohibited. To conduct this pilot will force the state to forego federal financial participation for these services, which are largely reimbursed 90% by the federal government.

The Department appreciates the intent of this bill, however many of the provisions duplicate current practices already implemented in Connecticut's Medicaid program. The Department also remains concerned that the language may actually impede access to services, by limiting funding. For these reasons the Department must oppose this bill.

H.B. No. 7009 (RAISED) HUMAN SERVICES. 'AN ACT CONCERNING DETERRING MEDICAID FRAUD'

This bill would prohibit the Department from withholding payments, assessing any penalties or extrapolating any overpayments due to errors related to the implementation of any electronic visit verification system (EVV) for a period of one hundred twenty days after implementation of such system.

The Department has serious concerns with this proposed legislation.

EVV is a telephonic and computer-based in-home scheduling, tracking and billing system. Specifically, EVV documents the precise time and type of care provided by caregivers right at the point of care. This anti-fraud verification and customer service enhancement system provides fiscal accountability while ensuring quality of care.

DSS is aware of concerns expressed from the industry regarding the capacity, accuracy and provider engagement around the implementation of EVV. The Department strongly disagrees with these characterizations. The Department is providing ongoing, direct support to all providers to ensure successful system implementation. Further, the Department has data to demonstrate that providers utilizing the system are being paid. The Department has also implemented an interim payment process for providers who may still be learning how to utilize the system. DSS has taken steps to ensure smooth transition to EVV. Specifically:

- Beginning in November 2015, DSS launched an extensive and fully transparent stakeholder process regarding the implementation of EVV. This process included an in-person launch meeting, numerous conference calls, ongoing provider bulletins and provider Important Message issuances, email contacts, phone calls, the above-referenced forum, and extensive documentation of the same in Q&A documents and training materials that have been updated and posted on a rolling basis on a publicly available web page: http://www.ct.gov/dss/evv.

- DSS has successfully launched EVV with the non-medical homemaker/companion agencies and is processing claims with a claim denial rate of only 3% (in contrast to the historical pre-EVV rate of 9%). Over 200 providers are currently participating in EVV. As of 1/27/17, 193,267 invoices have been submitted and over $18 million in claims have been paid.

- Providers who are learning to utilize the system are being held harmless when it comes to payments. The Department has implemented an interim payment process for providers, as requested. As of 1/30/17 DSS has processed $320,900 in interim payments.

- The Department has continually engaged with, responded to, and provided solutions to providers regarding reported EVV implementation challenges. Recognizing that some Medicaid waiver populations are more mobile than others, the Department has already submitted an updated Advanced Planning Document (APD) to CMS requesting funding for additional enhancements to the system that will enable providers to add additional locations to the client record.

In addition, section 17b-99 of the Connecticut General Statutes already has safeguards in place that protect providers during the audit process when a provider transitions to a new billing system. Subsection 17b-99(d)(5) allows the provider to provide documentation in connection with any discrepancy found as part of the audit. In addition such documentation can include evidence that "errors concerning payment and billing resulted from a provider's transition to a new payment or billing service or accounting system." The statute goes on to state that DSS is prohibited from "calculating an overpayment based on extrapolation or attempt to recover such extrapolated overpayment when the provider presents credible evidence that an error by the commissioner, or any entity with which the commissioner contracts to conduct an audit… caused the overpayment, provided the commissioner may recover the amount of the original overpayment."

By removing the Department's ability to audit claims for a period of one hundred twenty days after implementation, the state could be forced to pay fraudulent claims with state dollars, without any mechanism to review, investigate or collect on overpayment dollars. The Department has over 400 home health and home care providers enrolled in Medicaid. The EVV system has been implemented for those home-based care providers that deliver services to DSS waiver clients in the Connecticut Home Care Program for Elders and for the Acquired Brain Injury waivers. In SFY 2016, the expenditures for such waiver programs totaled over $430 million. As the steward of state dollars, the Department has a commitment to the taxpayers of Connecticut that such dollars are properly administered. This bill makes it difficult for the Department to keep this commitment.

The Department initiated EVV to ensure our Medicaid clients are getting the services they need, deserve and are authorized to receive. Older adults and individuals with disabilities may sign misrepresentative time sheets because they rely on, care about or fear retaliation from their caregivers. EVV relieves them of these burdens. In contrast, EVV also provides caregivers with a mechanism to accurately demonstrate they have attended their scheduled visit for the appropriate amount of time.

It is also important for the Department to highlight that, since January 1, 2017, EVV has already identified and successfully blocked instances of fraud.

- EVV has identified and stopped payment for claims submitted for services rendered after the date a client has passed.
- Clients are more cognizant of the check-in process through EVV and have reported incidences when caregivers check-in, leave and then come back to check-out.
- Clients have reported that caregivers are now coming on time and not leaving early.

EVV is an effective, anti-fraud verification and customer service enhancement system that provides fiscal accountability. This bill, however, removes the Department's ability to uphold such accountability measures. Not only will this bill result in a fiscal impact, as it would prohibit collection of overpayments, it will allow fraudulent activity to go unpenalized.

For these reasons, the Department opposes this bill.

S.B. No. 773 (RAISED) HUMAN SERVICES. 'AN ACT CONCERNING ADVANCE NOTICE BY THE DEPARTMENT OF SOCIAL SERVICES OF GUIDELINES AND BULLETINS'

This bill would require DSS to provide all guidelines and bulletins related to any Department programs to the Human Services Committee for review 60 days prior to distributing such information.

The Department has numerous concerns with this proposed legislation.

First, the Department believes this legislation is overly broad and is unsure what type of communication the language is requiring the Human Services Committee to review. The Department issues numerous bulletins, guidelines and communications to staff, program partners, providers, and the general public on a regular basis. The Department is proud of the ongoing communication with all of our partners and our staff. We believe sharing information and guidance leads to a better understanding of the programs the Department administers and ensures the highest quality of customer service.

Requiring the Department to send all bulletins and guidelines to the legislature 60 days prior to distribution will make it impossible for the Department to efficiently communicate time sensitive and important information with staff and the public.

This bill includes language that excludes guidelines and bulletins from the 60 day timeframe, if the communication is to address an immediate health or safety concern or if there is a federal requirement that specifies the guidance must be implemented before such timeframe. Even with such exceptions, however, the bill would still severely hinder the Department's ability to communicate process improvements, business changes, program guidance, provider updates and other important notices that are essential to the day-to-day functions of an agency that delivers vital public benefits to more than 1 in 5 Connecticut residents.

Additionally, the Department maintains an agency public website, www.ct.gov/dss that is updated regularly with important information regarding program changes and latest news postings for service partners. The Department also hosts a second website, www.ctdssmap.com, specifically for Medicaid providers. On this website, one can find every provider bulletin issued to Medicaid providers since the year 2000, along with provider newsletters, provider enrollment information, fee schedules, etc. On both sites, contact information for DSS staff is also provided, giving the public yet another option to request any information that they may not be able to find on our public websites.

The Department also meets regularly with numerous legislative oversight committees including, but not limited to, the Council on Medical Assistance Program Oversight and the Behavioral Health Partnership Oversight Council, to advise DSS on program process and monitor program implementation.

The Department believes the General Assembly and the committee of cognizance already exercise substantial oversight of DSS. In addition, the legislature also can request any additional information that it requires, that is not currently reported in accordance with law or immediately available on our websites. The Department believes this bill is unnecessary and is in opposition for the reasons noted above.

S.B. No. 774 (RAISED) HUMAN SERVICES. 'AN ACT EXTENDING TEMPORARY FAMILY ASSISTANCE BENEFITS TO ENCOURAGE EMPLOYMENT'

This bill would require DSS to grant a six-month extension for a family who has exhausted their 21-month Temporary Family Assistance (TFA) cash benefit if an adult in the household is working and his or her income exceeds 90 percent of the payment standard.

The Department estimates this bill would allow, on average, approximately 136 new families to be eligible for the six-month extension each month. The TFA benefit for a 3-person household is $483 per month. Utilizing a three person household as the base, this bill could increase expenditures by an estimated $3.7 million in the first year of implementation and then an estimated $4.7 million each year ongoing.

The Department appreciates the intent of this bill. However in this difficult fiscal climate, the Department is unable to support this bill.

S.B. No. 776 (RAISED) HUMAN SERVICES. 'AN ACT REQUIRING FAIRNESS FOR FAMILIES IN MEDICAID ELIGIBILITY AND REIMBURSEMENT DETERMINATIONS'

This bill implements three provisions that affect various eligibility and reimbursement factors under Medicaid.

Section 1 requires the Department to set payment rates for authorized family caregivers equal to the rates set for non-family professional caregivers. The Department is unsure of the intent of this language. Caregiving provided by a family member and caregiving provided by a professional receives the same Medicaid rate, as defined by the service being provided. Rates are based on the client's identified needs, not who provides the services. Specifically, Personal Care Attendants are paid the wages negotiated by the union. There is no differentiation between family and non-family providers.

Section 2 of this bill would provide retroactive eligibility coverage for applicants for the Connecticut Home Care Program for Elders (CHCPE). For waiver applications, services cannot begin until the application is processed. Retroactive eligibility is not permissible under the structure of our current waiver programs. Private services that clients/families arrange prior to the determination of financial eligibility may be provided by a non-Medicaid provider at any range of rates. The Department is only able to pay providers enrolled in the Connecticut Medicaid program. These providers must go through a credentialing process before they are

enrolled as a home care provider. In addition, there are provisions in the waiver for the requirement of the completion of a criminal background check for providers and monthly monitoring by the Access Agency.

In contrast, the Department would like to note that clients who are active participants on the state-funded Connecticut Home Care Program for Elders and who become Medicaid active with a retroactive effective date, are able to have their services retroactively billed to Medicaid. This is feasible because they have met all of the waiver's programmatic requirements.

Waivers such as the Connecticut Home Care Program for Elders, include assurances to the Centers for Medicare and Medicaid Services, 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.

Section 3 of this bill proposes that an institutionalized individual cannot be denied Medicaid based on an undisclosed or unliquidated asset.

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. This bill also would 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. This section would increase Medicaid expenditures by allowing applicants to be eligible for Medicaid services earlier.

For these reasons, the Department opposes this bill.