Testimony before the Human Services Committee
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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 (DSS).

I am pleased to appear before you today to testify in support of **House Bill 7040 AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES PROGRAMS.** I would like to take this opportunity to speak on various sections of the bill.

Section 1 transfers the Transportation to Work program funds to the Department of Transportation. The Transportation to Work program assists low-income working families with transportation services. Currently, the Department transfers all Transportation to Work program funds to the Department of Transportation, which then administers the program through contracts with regional organizations. This section simply aligns CGS section 13b-69 with current practice.

Sections 2-4, and 30 consolidates the entire Birth to Three Program, 60% of whose participants are Medicaid members, under DSS. This will build on prior work to enhance claiming for federal Medicaid revenue in support of the program. Further, this will group the Birth to Three Program with complementary initiatives that serve individuals with autism spectrum disorder (ASD), including Medicaid State Plan services for children under the age of 21. Finally, it will enable the state to align the existing clinical ASD team that transferred from the Department of Developmental Services to DSS in 2016.

In January 2015, Connecticut became one of the first states in the country to expand its Medicaid State Plan to cover services for children with ASD up to the age of 21. Oversight of these services, and a clinical ASD team that was historically located at DDS, is now part of the scope of the Department's Division of Health Services.

In July of 2015, the Medicaid component of the Birth to Three Program was transferred from the Department of Developmental Services to DSS. A leading motivation for this transfer was to improve the financial sustainability of the program, and to respond to feedback from the Centers for Medicare and Medicaid Services that indicated that modernization of the Birth to Three Medicaid reimbursement methodology would be required. Review and revision of the reimbursement methodology is at an advanced stage of completion, in support of submission of the required State Plan Amendment (SPA). As an additional reference please see the timeline below regarding the reimbursement methodology.

Steps	Timing	Notes
Billing vendor in place	March 2017	
Final pre-review of SPA with CMS	March 2017	
HPE trains billing vendor	April 2017	
Public notice	June 2017	For a SPA effective 7/1/17
SPA submitted	By Sept 30th	
Billing starts	July 2017	Services after 7/1/17 can be submitted to the Medicaid Management Information System (HPE)
Payments start	Mid-July 2017	Claim cycles and payment are issued twice a month

As Medicaid participation in Birth to Three continues to grow, consolidating the program under DSS will ensure better oversight of Medicaid claiming and will align and promote parity in receipt of ASD services for Medicaid members and other program participants.

Section 5 removes the cost of living adjustment for Temporary Family Assistance and State Administered General Assistance. These adjustments were estimated to be 1.3% of SFY 18 and 2.5% in SFY 19. Funding is maintained at existing assistance levels. Savings of approximately $1.5 million in FY 18 and $4.5 million in FY 19 is anticipated. These figures also incorporate savings acquired from the removal of the cost of living increase to the payment standard under State Supplement for the Aged, Blind and Disabled found in section 6.

Section 6 removes the pass through of Social Security cost of living adjustment increases under State Supplement for the Aged, Blind and Disabled. Savings of approximately $1.2 million in FY 18 and $2.6 million in FY 19 are anticipated.

Section 7 reduces the personal needs allowance (PNA) for residents of long-term care facilities. Income received by Medicaid beneficiaries in a long-term care facility is applied toward their cost of care, except for a monthly PNA. Under this bill, the PNA would be reduced from $60 to $50. This new PNA figure is still $20 over the federally required minimum and is more in line with the average of other Northeastern states. (The PNA for surrounding states include: $50 for New York, $50 for Rhode Island, $35 for New Jersey, $40 for Maine.) Savings of $1.0 million in FY 18 and $1.1 million in FY 19 are anticipated.

Sections 8 and 9 reduce the burial benefit that the Department covers for indigent decedents with no ability to pay for the cost of a funeral, cremation or burial, and recipients of Temporary Family Assistance, State Administered General Assistance and State Supplement who have passed, from a maximum of $1,200 to $900. This reduction more closely aligns the burial benefits the State of Connecticut pays with those of some of our neighboring states. For example, New York City will pay up to $900 for burial expenses, as long as the burial expenses are no more than $1,700 for an indigent resident of the state. It is important to note, that in Connecticut, relatives, friends, organizations and veterans' programs can contribute up to $3,400 toward the funeral and burial expenses without reducing the state funeral benefit level. Savings of $580,250 in FY 18 and $633,000 in FY 19 are anticipated.

Section 10 resets the eligibility levels for the Medicare Savings Program (MSP). MSP is a Medicaid-funded program that helps Medicare recipients pay their Medicare cost sharing obligations. By reducing the income guidelines to 2009 levels, Connecticut is aligning program income guidelines with the majority of other states in the country. Even with this reset, Connecticut is still one of only five states whose income limit for MSP exceeds the federal minimum. In addition, Connecticut is one of only eight states that do not have an asset test for MSP. Net savings of $66.4 million in FY 18 and $81.6 million in FY 19 are anticipated.

Section 11 aligns income eligibility for HUSKY A parents and caretaker relatives with other states. This proposal reduces the income guidelines for HUSKY A parents and caretaker relatives from 155% of FPL to 138% of FPL. This means, for a family of four, the maximum annual income for eligibility would go from $38,130 to $33,948. This reduction not only aligns HUSKY A eligibility with the majority of states, but also aligns HUSKY A adults with the income guidelines for HUSKY D, or Medicaid for childless adults under the age of 65. Coverage for pregnant women and children enrolled in HUSKY A would not be affected.

Similar to the HUSKY A transition in 2015, the Department will collaborate with Access Health CT to assist individuals in enrolling in a Qualified Health Plan. Parents and caretaker relatives with earnings, who make up the vast majority of individuals impacted by this change, would be eligible to receive an additional 12 months of Transitional Medical Assistance coverage under HUSKY A. In addition, the Department will review cases where the individuals are at risk of losing HUSKY A coverage to determine if they are eligible for other HUSKY categories. Savings of $500,000 in FY 18 and $11.3 million in FY 19 are anticipated.

Section 12 requires individuals dually eligible for Medicare and Medicaid to be responsible for all Medicare Part D co-payments on covered drugs. In 2017, Medicare Part D co-payments range from $1.20 to $8.25. Savings of $80,000 in FY 18 and $90,000 in FY 19 are anticipated.

Section 13 amends Medicaid pharmacy statutes to comply with federal law. In February of 2016, the Centers for Medicare and Medicaid Services (CMS) published a regulation regarding a federal provision that mandates all states to implement a new reimbursement system for covered outpatient drugs in Medicaid by April 1, 2017. The reimbursement methodology currently detailed in state statute is no longer permissible under federal law. The proposed language in this section addresses and remedies any potential conflicts with federal law.

Background on Medicaid Pharmacy Reimbursement:

Medicaid generally reimburses pharmacies based on a two-part formula consisting of the ingredient cost and a professional fee.

Ingredient Cost: Connecticut has used a formula based on average wholesale price, as required by state statute, for the ingredient cost. The CMS regulation now requires states to base the ingredient cost on the "actual acquisition cost" (AAC). States were given the option to implement an AAC model or reimburse based on various pricing methodologies, including national surveys, such as the National Average Drug Acquisition Cost (NADAC). Connecticut has decided to move forward with utilizing the

NADAC survey results (sponsored by CMS) as the pricing list for AAC. NADAC's AAC are published monthly and can be found on CMS' website.

Professional Fee: As part of the new CMS regulations, states must also develop a "professional dispensing fee" to reflect pharmacists' professional services and costs to dispense a drug to a Medicaid client. The state's current professional fee is $1.40. The new dispensing fee will be based on actual pharmacy financials. DSS has participated in a regional survey with other New England states through the New England States Consortium Systems Organization (NESCSO) to determine this fee. The contractor for this regional survey is Myers and Stauffer. Along with the survey to pharmacies, Myers and Stauffer also reviewed pharmacy financial statements and performed random audits. DSS is working to determine the final professional fee.

Sections 14-16 and 29 remove statutorily required rate increases over the biennium for residential care homes, community living arrangements, and community companion homes. Savings of $1.5 million in FY 18 and $3.0 million in FY 19 are anticipated.

Section 17-20 requires local and regional school districts to enroll as providers in the state's Medicaid program and participate in the Medicaid School-Based Child Health (SBCH) program by submitting claims for Medicaid reimbursement to DSS.

In Connecticut, the Medicaid SBCH program is the mechanism by which a school district can seek federal Medicaid reimbursement for many of the Medicaid-covered services that are provided to an eligible student pursuant to the student's individualized education plan. These services include, but are not limited to, assessment, audiology, clinical diagnostic laboratory, medical, mental health, nursing, occupational therapy, physical therapy, respiratory care, speech/language, and optometric services. Federal reimbursement can also be pursued by the school district for administrative activities which support these Medicaid health services. Through their participation in Medicaid, towns will be able to mitigate special education costs by leveraging 50% of the Medicaid revenue received.

Sections 21 and 22 provide specific provider types, including, but not limited to, hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities, an opportunity to seek rate-setting corrections and additional review based on cost report information to ensure the provider-specific rate is accurate. This section will also reduce excessive appeals of broad, statewide rates that continue to expose the state to substantial unbudgeted liability, as well as impose an excessive administrative burden for DSS.

In order to align with the changes to section 17b-238, this bill removes the rate appeal language from the home health rate statute. The removal of this language will ensure that DSS is able to set rates in accordance with both federal requirements and available state appropriations without the risk of exposure to unbudgeted increased expenditures.

This bill reduces the state's ever-increasing potential exposure to unbudgeted expenditures, while still ensuring that providers with individually calculated rates based on cost report information will continue to have an opportunity for those rates to be reviewed and corrected.

Section 23 prohibits a homemaker, companion or home health services agency from enforcing a covenant not to compete in its employment agreements with staff members who are caregivers. Covenants not to compete directly interfere with the continuity of care for clients and disrupt relationships critical to client well-being. Under the Medicaid program, clients must be assured freedom of choice of provider. Client choice is a hallmark of each of our Medicaid waiver programs. Clients have the right to accept or reject any component of their proposed care plans, and to indicate preferences about the agencies and staff from whom they wish to receive services. Non-compete arrangements impede clients from continuing to work with longstanding staff who may change employers. The Department has experienced an agency aggressively using non-compete covenants to try to prohibit the Department and its contracted Access Agencies from assisting and advocating for waiver clients who seek to retain staff who wish to change employer. Non-compete agreements are not justified for direct care workers who provide personal care and home health services in clients' homes. These covenants inhibit the rights and mobility of caregivers and directly impair the rights and thwart the preferences of Medicaid clients.

Section 24 implements an annual cap on adult dental services at $1,000 per person with exceptions for medically necessary services. This section provides a fiscal safeguard to review dental services for adult Medicaid members to ensure that costly services and extensive dental treatment is medically necessary. Dental disease is slow to develop and progress. There are situations, in which it can be more serious, and procedures must be done immediately; in these instances, the need would be considered urgent or emergent. Any care that prevents a condition from becoming urgent or emergent would also be considered medically necessary. Dental providers will be required to submit prior authorization requests for any services after an adult has reached their $1,000 annual cap under Medicaid. Providers are familiar with, and currently use, the prior authorization process for a range of existing services. Determinations for dental prior authorization requests are posted online within two weeks, unless determined to be a dental emergency, in which case the turn-around time is faster.

This section reflects dental service caps found in many private insurance plans. It is also important to note that the Connecticut State Dental Association is in support of this proposal. Savings to the state of $2.0 million in FY 18 and $2.5 million in FY 19 are anticipated.

Relevant Background:

How does DSS define a dental procedure versus a medical procedure?

There is considerable overlap between procedures and conditions considered dental versus medical depending upon the condition and the training and experience of the treating clinician. The newer term applied to dentistry is oral health because the mouth and supporting structures are not separate entities from the body. Dental procedures are considered those procedures involving the teeth and their supporting structures. Supporting structures include the ligaments, soft tissue (salivary glands, muscles, tongue, lips) and the structures of the upper and lower jaws (tempero-mandibular joint, meniscus, ligaments and attached muscles). In contrast, a medical

procedure is a procedure which involves any other part of the body not included in the definition and procedures relegated to dental medicine. Most dentists will treat specific tooth conditions but will also treat conditions which affect other structures. Frequently, the more serious conditions are referred to oral and maxillofacial (medical) surgeons who will treat conditions that involve more than the teeth.

How is medical necessity determined?

Medical necessity is defined in Connecticut General Statutes, section 17b-259b. For purposes of the administration of DSS' medical assistance programs, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are:

(1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors;
(2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease;
(3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers;
(4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and
(5) based on an assessment of the individual and his or her medical condition.

Section 25 makes adjustments to enrollment for the CT Home Care Program for Elders (CHCPE). CHCPE provides home and community-based services to individuals who are age 65 or older, who are either at risk of institutionalization or meet nursing home level of care. Clients must meet functional and financial eligibility criteria. The CHCPE includes a Medicaid waiver (Level 3) that serves the great majority of participants, and also two state-funded components (Levels 1 and 2) for individuals with less urgent need and more financial resources.

First, the section continues to freeze enrollment for Category 1 under the CHCPE. Category 1 is a state-funded component of the program for elders in need of limited home care, with the lowest risk of hospitalization or short-term nursing home placement. Savings of $2.2 million in FY 18 and $6.3 million in FY 19 are anticipated.

In addition, this section maintains category 2 enrollment at the June 2017 levels. Category 2 of CHCPE is also fully state-funded, and is for elders who are determined to be in need of short or long-term nursing home care, but whose levels of income and/or assets make them ineligible for Medicaid. Savings of $730,000 in FY 18 and $2.3 million in FY 19 are anticipated.

To be clear that this provision will not impact enrollment of individuals residing in affordable housing under the assisted living demonstration project, the following technical change is recommended on line 1092: after "home" insert ", except that the number of individuals eligible for the program residing in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e shall not be limited."

Section 26 secures coverage of family planning services. If action by the federal government results in ineligibility of a family planning clinic to receive federal Medicaid matching funds, or restricts the right of a Medicaid recipient to obtain family planning services from a family planning clinic, this section will allow such services to be covered by State funds. The Department strongly supports all measures and policies that protect coverage of family planning services.

Sections 27 and 28 remove inflationary rate adjustments for nursing homes and intermediate care facilities for individuals with intellectual disabilities. Savings of $28.4 million in FY 18 and $44.8 million in FY 19 are anticipated.

The Department respectfully requests that the Committee take favorable action on HB 7040, An Act Implementing the Governor's Budget Recommendations for Human Services Programs.

In addition, The Department offers remarks on several other bills on the agenda.

H.B. No. 6885 AN ACT CONCERNING MEDICAID REIMBURSEMENT LEVELS FOR PROVIDERS

This bill requires DSS to allocate available funding so that provider reimbursement rates are sufficient to ensure an adequate pool of providers is available to meet the needs of Medicaid recipients.

The Department appreciates the intent of this bill; however the bill is unnecessary because federal requirements already require DSS to ensure the CT Medicaid provider network is sufficient. Federal statute has long required state Medicaid programs to "provide such methods and procedures relating to the utilization of, and the payment for, care and services … [that] are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area". 42 U.S.C. 1396a(a)(30)(A).

More recently, effective January 4, 2016, the Centers for Medicare and Medicaid Services (CMS) adopted federal regulations that provide very detailed requirements for state Medicaid programs to ensure that Medicaid members have sufficient access to services. 42 C.F.R. 447.203(b) and 447.204. Those new rules require DSS to analyze access to many service categories and prepare a formal Access Monitoring Review Plan (AMRP). The current AMRP is posted to the DSS website at this link: http://www.ct.gov/amrp, which must be fully updated

every three years. In addition, the rules require DSS to perform a formal access analysis every time a provider's rates are reduced. The rules also require enhanced monitoring and complaint procedures to ensure ongoing access to services.

In sum, the federal access rules already provide a thorough and comprehensive set of safeguards to ensure the Medicaid provider network remains sufficient to give Medicaid members access to the services they need. Moreover, adding new requirements would be administratively burdensome to implement if they differed from the existing detailed federal rules.

Specific to the Connecticut Medicaid program, in FY 2016 DSS served over 750,000 residents and had over 20,000 providers enrolled in the program (including over 17,000 specialists). During this time, the HUSKY member services line received a total of 255 member calls (.034% of the CT Medicaid population) detailing difficulty locating a provider. Data analysis shows that, on average, 59% of such grievances were resolved during the first call to member services. More important, in all cases a provider was identified who could meet the member's needs.

The Department is committed to continuously improving the provider network for all Medicaid beneficiaries. However, because federal requirements already require DSS to ensure access, this bill is unnecessary.

H.B. No. 7122 (RAISED) AN ACT CONCERNING FAIR RENT FOR NURSING HOMES

The bill proposes to remove reductions to a nursing home's rate due to a decrease in the fair rent component of the rate calculation, based on a fully amortized property that is no longer eligible for reimbursement.

Fair rent is a rental value allowance for facilities that is calculated to yield a constant amount each year in lieu of interest and depreciation costs. The allowance for the use of real property (non-moveable equipment) other than land is determined by repaying the base value of property over its remaining useful life. The allowance is calculated by using the Hospital Fixed Asset Guide Book, and a rate of return on the base value is applied. This funding mechanism is defined in both the CMS approved Medicaid State Plan and in the Connecticut State Regulations.

Every year several buildings and property items become fully amortized, meaning the Department paid a fair rent amount over 5 to 30 years to reimburse the purchase of property items including the building. When an asset is fully amortized in the fair rent system, the fair rent reimbursement for that property item is removed from the Medicaid rate the following year. This means that fair rent would be decreased in the calculated Medicaid rate. The approved Medicaid State Plan recognizes the affect that these reductions may have on the nursing home industry, as property items fall off especially the building itself and, in response, the Department pays a minimum fair rent per-day amount for ongoing maintenance of the facility once the property is fully repaid. The minimum fair rent payment is an industry-specific calculation, averaging $5.00 to $6.00 per day.

This bill would remove the Department's ability to remove fair rent reimbursement when a property is fully amortized, which will create an additional financial burden to the state and will create inconsistent reimbursement levels within the industry. The Department estimates this bill would cost an additional $11.1 million over the biennium. Additionally, the current language will apply this change retrospectively to FY 2016 and FY 2017. For these reasons, the Department must oppose this bill.

H.B. No. 7166 (RAISED) AN ACT REQUIRING AN ANNUAL REPORT ON SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM BENEFITS

This bill requires the Department to submit an annual report to the legislature regarding the participation of able-bodied adults without dependents (ABAWDs) in the Supplemental Nutrition Assistance Program (SNAP).

In 1996, federal law put special work requirements in place for ABAWDs receiving SNAP benefits. An ABAWD is a person who is 18 to 50 years of age who is fit for employment and has no dependents under the age of 18 living with him or her. An ABAWD can only receive SNAP benefits for 3 months out of a 36-month period if he or she does not meet special ABAWD work requirements or an exemption to those requirements.

In October 2016, Food and Nutrition Services (FNS) (under the U.S. Department of Agriculture) approved a Connecticut-based waiver that excused 123 jurisdictions from the ABAWD requirements, based on their unemployment rates, beginning January 1, 2017.

The language proposed in HB 7166 requires that the Department include in the report the number of ABAWDs in each region of the state that were allowed to exceed the three-month SNAP participation limit, and the reason that each ABAWD was permitted to exceed this limit. However, federal requirements, set by FNS, dictate when an ABAWD can exceed the time limit. These requirements are detailed as such:

- A person is exempt from the ABAWD time limit and ABAWD work requirements if he or she:
    - lives in one of the exempt towns;
    - is under the age of 18;
    - is age 50 or older;
    - lives in a SNAP household with a child under 18 years old;
    - is physically or mentally unfit for employment;
    - is pregnant; or
    - is exempt from general SNAP work requirements (examples include being responsible for an incapacitated person, a student enrolled at least half-time, or a participant in a drug or alcohol rehabilitation program).

- ABAWDs residing in one of the 46 non-exempt jurisdictions are only allowed to exceed the time limit if they meet one of the following federal ABAWD requirements:

- work 20 or more hours a week;
- participate in and comply with requirements of a work program for 20 or more hours a week;
- combine work and participation in a work program for 20 or more hours a week; or
- participate and comply with the requirements of a workfare program.

It is the Department's mission to increase the security and well-being of all Connecticut residents. To this end, the Department offers an Employment and Training (E&T) program to assist SNAP households with gaining skills that will increase self-sufficiency. SNAP E&T provides SNAP recipients with the opportunity to participate in a variety of work-related activities, including but not limited to: obtaining a general equivalency diploma, adult basic education, work experience and structured job search skill training.

The Department is happy to provide any statistical information regarding SNAP and ABAWD requirements on an as-needed basis. However, as the SNAP ABAWD requirements are dictated by federal law, and an additional annual report requirement would strain already limited staff resources, the Department must oppose this bill.

S.B. No. 873 (RAISED) AN ACT CONCERNING A TWO-GENERATIONAL INITIATIVE

This bill seeks to expand the two-generational service delivery model to achieve school readiness and workforce success that was initiated as a pilot program in the last legislative session.

The Department recognizes the importance of supporting two-generational efforts that assist families with reaching their full potential. DSS has worked to integrate the two-generational model into program delivery as an effective way to increase the overall security and quality of life for families, children and communities.

The Governor's budget does not provide continued funding for a separate initiative; however, the Department will continue to integrate similar concepts into the core principles of our work but cannot support this bill.

S.B. No. 874 (RAISED) AN ACT REQUIRING ELECTRONIC NOTIFICATION BY THE DEPARTMENT OF SOCIAL SERVICES

This bill places requirements on DSS to release all guidelines, changes in law and regulations, 60 days prior to implementation to: 1) the Human Services Committee, 2) any provider who requests electronic notifications, and 3) any person signed up to provide eRegulation system alerts about proposed department regulations.

The Department has numerous concerns with this legislation.

First, the Department is unsure what type of guidelines the language is requiring DSS to release. The Department issues numerous guidelines, provider bulletins, policy changes and regulations on a continual basis. The Department releases each of these documents pursuant to state and federal law. The Department also takes several additional steps to ensure transparency and ongoing, shared communication with all stakeholders and partners.

The Department maintains a 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. The website also offers a subscription email option for anyone interested in receiving electronic notifications of all provider communications. 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.

Specific to regulations, the Department already follows a lengthy process that includes many opportunities for public input and review. This process is outlined in the Administrative Procedures Act, Conn. Gen. Stat. section 4-166. DSS first publishes notice on the e-Regulations system of our intent to amend or adopt a regulation (NOI), along with the language of the proposed regulation. As the eRegulations system includes a subscription mechanism, any member of the public who has requested notification of DSS' NOIs will automatically receive an email alert from the eRegulations system when the NOI is posted.

After the NOI is posted, DSS must give the public at least 30 days to submit comments in response to the proposed regulation. If comments are received, DSS must respond to these comments and then publish the response, along with any changes made to the proposed regulation, and then submit the proposed regulation to the Office of the Attorney General (OAG) for review. The OAG has 30 days to review the proposed regulation for legal sufficiency. If the OAG approves the proposed regulation, DSS submits it to the Legislative Regulations Review Committee (LRRC) for review (if the OAG does not approve the proposed regulation, DSS must make necessary changes and start the process over). DSS must also provide the Human Services Committee with notice of its submission to the LRRC, which is done automatically through the eRegulations system.

The LRRC then holds a public meeting on the proposed regulation. At the meeting, the LRRC will either approve or reject the regulation. If it is rejected without prejudice, DSS must make necessary changes, resubmit the proposed regulation to the OAG, and then resubmit it to the LRRC. When approved by the LRRC, the approved version is filed with the Secretary of the State (SOTS) within 14 days of the LRRC's approval. Once SOTS posts the regulation on the eRegulations system, it becomes officially effective and can be implemented.

In some instances, the Department has the authority, statutorily, to implement and operate under a new policy outlined in a proposed regulation, prior to formal adoption. There are a few statutes that provide this type of authority in limited situations, but the one most often used by the Department is section 17b-10(b). This section allows DSS to implement and operate under the

new policy as soon as the NOI is posted on the eRegulations system, but it can only be used if the proposed regulation is "necessary to conform to a requirement of an approved federal waiver application initiated in accordance with section 17b-8" or if the "new policy [is] necessary to conform to a requirement of a federal or joint state and federal program administered by the department . . . ." DSS is permitted to operate under the proposed regulation because the new policy is required by federal law. However, the proposed regulation must still go through the public review and LRRC approval process.

The Department believes this bill is unnecessary. The Department already has numerous mechanisms for the public to access electronic versions of Department guidelines and regulations. In addition, the Human Services Committee and any member of the public (including providers) already receive or have an avenue for receiving advanced notice of DSS regulations. For these reasons, the Department opposes this bill.

S.B. No. 875 (RAISED) AN ACT CONCERNING RIGHT-SIZING, REBALANCING AND REPURPOSING NURSING FACILITIES FOR THE TWENTY-FIRST CENTURY

Section 1 of this bill requires the Department to develop and implement an acuity-based methodology for a portion of nursing facility reimbursements.

The Department is in the process of studying the possibility of an acuity-based system for nursing facilities. The Department understands the importance of such a methodology and has been reviewing the modernization of the nursing home reimbursement system.

While the bill proposes implementation of an acuity-based system on or after July 2019, there are numerous fiscal implications that would make implementation impossible under the current budget situation. Development and start-up costs are estimated at $750,000, which includes approximately $400,000 for consulting and the development of an acuity-based reimbursement system and $350,000 for nursing facility training. Additionally, an annual cost for such a system is estimated at $1,310,000. These ongoing costs include approximately $510,000 for consultant costs, $200,000 for nurse audit staff, and $600,000 for additional costs incurred at the nursing facility.

Sections 3 and 4 of this bill provide nursing facilities with the opportunity to voluntarily decrease its total licensed bed capacity by way of a temporary bed reduction. The Department has significant concerns with this language.

First, the language would allow nursing facilities to "manufacture" a higher occupancy rate, by artificially inflating an occupancy rate. The facility would be able to reduce beds temporarily, while also being able to reintroduce the additional beds at any time. Title 2, Part 200.446 of the Code of Federal Regulations prohibit federal reimbursement for unused space. For this reason, long-term care facility rates generally include a provision for a minimum occupancy standard (typically 85 to 95%). This proposal would circumvent this rate-setting rule. Not only would the process require a State Plan Amendment, but the Department does not believe it would be possible to incorporate this bed reduction process into the Medicaid State Plan in a way that

would comply with federal rules and satisfy the Centers for Medicare and Medicaid Services' requirements.

In addition, this section would circumvent the Certificate of Need process related to reducing nursing home beds. This would likely result in an inconsistent and uncontrolled downsizing of beds in various areas of the state. Once an area is in short supply of available nursing home beds, this proposal would introduce the potential for increased bargaining power to leverage higher rates.

For these reasons, the Department opposes this bill.